Literature review

Towards a better understanding of health care access challenges for prisoners

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Summary

To put our latest analysis into context, we conducted an update to the literature review we carried out for our previous research (Davies and others, 2020). This covered the period from 2018 to present. 51 papers were included which identified a number of themes related to prisoners' health care needs and experiences accessing health care services.

The themes we identified were:

- Public health programmes
- Specific health needs
- Needs of particular groups of prisoners
- Quality of health care in prison
- Impact of Covid-19 on prisons and prison health care

Prisoners are at greater risk of a number of potentially preventable conditions and should be offered the same access to screening programmes as the general population. But, across these programmes, a number of common challenges emerged including the fear and stigma associated with screening and testing, barriers resulting from the prison environment itself such as location of testing and security concerns and lack of awareness of the purpose of the various programmes. Similar challenges were identified in the context of opt-out blood-borne virus (BBV) testing, which was rolled out across the prison estate in 2018. We also identified research relating to the needs of particular groups of prisoners including women prisoners, younger prisoners and older prisoners, the latter being the subject of a recent Justice Committee inquiry.

In line with our previous findings, we identified research which highlighted a number of issues relating to the quality of prison health care. For example, although natural causes are the leading cause of death for prisoners, evidence suggests this is often a result of inadequate health care such as failure to identify deterioration or poor management of long-term conditions. It is important to note the context in which prison health care is operating – prisons are over-crowded, old-fashioned, have been subject to staff shortages and borne the brunt of austerity – security constraints often affect the services available and how they are accessed.

Covid-19 has had a significant impact on prison life including prison health care services. In March 2020, a strict lockdown was imposed in prisons where people were effectively confined to their cells for most of the day. Evidence so far suggests people's experience of health care during

the pandemic has been variable, and there is also significant concern about the long-term impact of the regime changes on prisoners' mental and physical health.

Similar to the previous review, most of the papers had small sample sizes or were conducted in individual prison environments. With Covid-19, much of the literature are policy reports and grey literature, and describe the impact of the first wave of the pandemic. Information about the second wave and impact on prisoners' experiences and particularly the impact on physical health needs and services is limited at this stage. Continually monitoring the impact of the pandemic on prisoners' health will be essential for ensuring that their needs are addressed.

Approach and methods

For this project, we conducted a rapid review of the literature to take account of recent research and policy developments since the publication of *Locked Out*, including the impact of Covid-19 on health care services in prison and the health of prisoners.

We carried out the review using electronic databases accessible via the Health Services Management Centre at the University of Birmingham, which included CINAHL (Cumulative Index to Nursing and Allied Health Literature), Embase, HMIC (Health Management Information Consortium), MEDLINE, PubMed and the Social Sciences Citation Index.

We replicated the original literature search and also used handsearching to identify additional studies and grey and policy literature. Search terms included:

- the establishment – prison/secure estate/immigration removal centre/young offender institution/secure training centre
- the individual – prisoner/people in prison/detainee
- health (both general and specific) – health/health care/palliative care/communicable diseases/non-communicable diseases/maternal health/women's health.
- Covid-19 and coronavirus

The initial search yielded 630 results. The authors reviewed the titles and abstracts to identify articles which met the inclusion criteria. We then reviewed 66 full text articles and excluded a further 33. We also identified a series of papers (n=18) through hand-searching. This resulted in 51 included papers.

Articles were included if they related to the secure estate setting in England and Wales, and were published from 2018 onwards (the cut-off date in the previous literature review). Articles were excluded if:

- they focused exclusively on children in secure children's homes; prisoners' mental health needs, given that the focus of our research was on physical health; prisoners' needs during release or probation or which concerned impact on reoffending
- they did not contain any empirical research (i.e. commentary or editorial pieces)
- data collection took place prior to 2018 (even if publication was 2018 onwards).

The majority of academic papers used qualitative methods to explore the experiences and attitudes of both prisoners and prison staff regarding different aspects of prison health care and there were limited numbers of studies exploring prisoners' health care needs or experiences at a national level. Most papers concerned small sample sizes or were conducted in individual prison environments making generalisability limited. With Covid-19, much of the literature are policy reports and grey literature, and describe the impact of the first wave of the pandemic. Information about the second wave and impact on prisoners' experiences and particularly the impact on physical health needs and services is limited at this stage.

Below we provide a summary of the findings according to the themes we identified.

Findings

Public health programmes

People in prison are entitled to access all appropriate cancer and non-cancer screening programmes for their age, sex and other risks factors as well as the NHS Health Check programme (NHS England and Public Health England, 2019). Recent guidance has been published to improve access to screening for people in the prison estate, given that the population has a higher prevalence of risk factors identified through screening, and often poorer access to these programmes in the community (Public Health England, 2021). For example, women in prison are less likely to have had cervical screening despite having higher rates of cervical cancer, and knowledge of cervical health is low (Public Health England, 2021 and IAP, 2020). The guidance notes (amongst other things) the importance of ensuring sufficient staffing and resources to provide services including a named screening lead within each establishment

and, providing reasonable adjustments for people who need them to support accessibility (Public Health England, 2021).

Blagden and others (2020) conducted a qualitative service evaluation of a bowel cancer screening programme in one male prison in North West England to understand beliefs and perceptions amongst staff and prisoners (Blagden and others, 2020). Facilitators included the importance of a dedicated staff member to lead the programme and clear communication with a verbal discussion followed by written information the most favourable approach, particularly given low literacy levels. However, there were also barriers such as fear, anxiety and stigma and the logistical challenge of identifying eligible prisoners within the prison estate. The evaluation also noted that there was a high willingness to engage with screening from prisoners who saw it as a way to identify any issues early and get them treated, with prison seen as an important opportunity to make use of health care services.

Williams and others (2020) also used a qualitative approach to examine attitudes and barriers to the NHS health check programme. The main barrier identified was the restrictive environment including an inability to physically access the health care department due to the need for escorts, long waiting times and events occurring which caused disruption in the prison. There were also psychological barriers such as the perception of not needing to attend if the person felt well, stigma and fear. There were also challenges around lack of awareness and understanding about the process and purpose of the Health Check programme (both amongst the prison population and the staff).

However, at the same time, prison was noted as being a valuable environment for addressing health needs for example, by providing people with greater motivation to look after themselves within a more structured environment – both of these were noted as factors for increasing uptake to the Health Check programme (Williams and others, 2020). Conducting checks on the prison wing itself was considered an important facilitator given the challenges of access and stigma.

Healthy Prisons

The Healthy Prisons agenda was introduced by the World Health Organisation in 1995, and requires that prisons support a 'whole prison approach to promoting health and wellbeing ' (Ismail and de Viggiani, 2018). This includes not just equal access to health care services but a wider focus on prevention, health promotion and education within the prison environment itself. Ismail and de Viggiani (2018) have examined the implementation of this approach within English prisons using interviews with prison stakeholders – they identified a number of barriers to successful implementation including financial and staff constraints (as a result of austerity), an overly top-down approach and limited strategic oversight from government (Ismail and de Viggiani, 2018). HMIP uses four tests of 'healthy establishments' during its inspections comprising of safety, respect, purposeful activity and rehabilitation and release planning (HMIP, 2021). Woodall and Freeman (2020) reviewed prison inspection reports from 2018 to identify learning on how prisons were implementing this in practice. The study showed that although there was notable good practice, it was not widespread and that there was no consistency on what is meant by a 'whole prison approach'.

People who arrive in prison should receive an assessment within seven days of arrival which includes screening for blood-borne viruses (BBV) such as Hepatitis C (NICE, 2016 and NHS England, 2020). Opt-out blood borne virus testing was introduced in a pilot project in the prison estate in 2013, and rolled-out across the whole adult estate in England in 2018. Effective diagnostic and treatment pathways are an important part of achieving this and all 112 prisons in England have access to hepatitis C diagnostics through a 'point of care' antibody test, a dry blood spot test or onsite polymerase chain reaction (PCR) testing machines (House of Commons question, 2021). However, testing uptake is still below the 75% target. Testing soon after the offer of a test and accelerating pathways to treatment, as well as providing accessible information on BBVs including Hepatitis C are considered important to increasing uptake (Public Health England, 2017).

Jack and others (2020) conducted a qualitative study of prisoners entering a male prison which had a 13.4% uptake compared to the 75% target. Multiple themes were identified which related to the fear and stigma surrounding a positive Hepatitis C virus (HCV) diagnosis and the process of testing (such as anxiety around needles). There were also barriers within the prison environment itself such as lack of privacy, insufficient numbers of staff or escorts to take people to testing, as well as a lack of awareness and understanding about HCV transmission and risk factors. Facilitators included education, the need to 'normalise' the process and the value of peer

support (Jack and others, 2020). Another study explored the role of risk factors in testing uptake (Jack, 2020) – the principal risk of injecting drugs was reported by 35% of respondents and other risk factors included non-professional tattoos, sharing prison hair clippers and fighting (Jack, 2020). 82% of respondents provided details on not being tested - 60% of those not tested said they were not at risk and other reasons were previous negative result, fear of HCV diagnosis and memories of injecting drugs (Jack, 2020). Jack (2020) noted that those who perceive themselves not to be at risk may decline the offer of testing.

Given one of the challenges with managing HCV is that many people are on short sentences, studies have examined how to streamline the pathway. Connoley and others (2020) used a case study of the development of a HCV pathway in one prison for people who inject drugs, especially chosen because they tend to receive shorter sentences and rapid population turnover necessitates a pathway to progress from diagnosis to cure quickly. At the time, almost 60% spent 3 months or less in prison. The pathway developed over two phases with challenges from the first phase addressed in the second – for example, challenges included new arrivals being missed or refusing to attend secondary screening and confusion about how to deliver opt-out test offer. To address this, staff received additional training and an offer script was developed, as well as a new engagement strategy. To address delays between diagnosis and referral to a multidisciplinary team (MDT), the assessment process was streamlined so that a sexual health nurse was responsible and referred positive patients directly to the MDT. Although this resulted in some improvements, not all outcomes improved – for example, staff shortages, changes in teams, frequent lock downs and a breakdown in handing out 'health care slips' (appointment notifications) may be potential justifications. Testing was also limited by security considerations. Other findings included delays from prisoners refusing to attend clinics (ensure clinics do not clash with other activities); need to consider methods to shorten pathway (direct referral reduced attrition); biomedical innovation may also assist (reduce time waiting for test results); consider training staff to initiate and monitor HCV treatment.

Mohammed and others (2020) compared two HCV care pathways in one London prison – the first was the conventional NHS England recommended pathway involving testing at the primary and secondary screen and all eligible patients for treatment discussed at a bi-monthly MDT meeting and the second involved an additional rapid ‘screen and treat’ pathway for individuals for opioid substitution therapy, where a health care assistant (HCA) conducted a 20 minute HCV antibody test - all positive patients were offered direct-acting antiviral treatment (DAA), approved by a fast-track MDT. The alternative pathway resulted in higher rates of screening,

clinical assessment and implementation of streamlined initiation onto treatment. It also highlighted the need to shorten the time for 'cascade of care' given that many individuals are on short sentences.

Another study considered the link between diagnosis and treatment of HCV with early release from prison being the main reason that individuals did not commence antiviral treatment (Bhandari and others, 2020). Furthermore, in 41% of people who started antiviral treatment they were unable to document response to treatment due to release from prison prior to end of follow-up period (Bhandari and others, 2020). There was also a high rate of reinfection, highlighting the importance of harm reduction advice on release (Bhandari and others, 2020).

Specific health needs

Prisoners are at risk of a range of different conditions including cardiovascular disease (CVD) – natural causes are the leading cause of death for prisoners with diseases of the circulatory system being the most common cause (IAP, 2020). Packham and others (2020) explored risk factors and uptake of the NHS Heath Check programme in six male prisons. 76.4% of those invited took up the offer and 12.1% found to have new significant CVD comorbidity (hypertension, Type 2 diabetes (T2DM) or chronic kidney disease). Although this was similar to community levels, this population was 10 years younger. However, current policy suggests offering Health Checks to people in prison for more than two years, highlighting concerns that people might miss out.

Gray and others (2021) conducted a study to identify the prevalence of diabetes within the prison population (Gray, 2021). Using data from risk assessments conducted in one male prison, Gray used the diabetes risk score to predict the prevalence of T2DM. The study estimated that in the next decade, 6.4 individuals per 100 would develop T2DM increasing to 16.4 in people aged 50 and older. There was a prevalence of known risk factors for diabetes including obesity and family history of Type 2 diabetes. However, this was only conducted in one prison which only housed male prisoners. HbA1C results suggested undiagnosed cases in prison population. Given these risk factors, prisoners are a 'target population' for prevention strategies.

Another study in the same prison also considered the risk factors for diabetes, as well as other CVDs and found that the majority of the men found to be either overweight (43.5%) or obese (37.5%) and/or demonstrated evidence of central obesity (40.1%). Overall, 15.4% increased risk of CVD and 31.8% moderate or high risk of type-2 diabetes. (Gray, 2020). Despite the prevalence of these risk factors, the study did also note that a number of participants had made lifestyle changes as a result of being in prison. This included a reduction in smoking (as the prison was

smoke-free), falls in levels of some drug use (not methadone) and improved physical activity in those under 50. So, despite these risk factors prison could provide an environment for proactive prevention.

Another study explored the development of a treatment pathway for insomnia using a Delphi study (Dewa and others, 2018). This highlighted the importance of greater emphasis on self-management, peer group involvement and psychological approaches as opposed to hypnotics (Dewa and others, 2018).

Needs of specific groups of prisoners

Younger prisoners

The prevalence of Attention Deficit Hyperactivity Disorder (ADHD) in prison is thought to be around five times higher than in general population (Baggio and others, 2018). But, there are particular challenges for diagnosis including limited staff training and the compounding effect of complex mental health problems (Lennox and others, 2020). Lennox and others (2020) is conducting a feasibility study on using the QbTest (a computer-based assessment for ADHD) for those considered at risk by the Comprehensive Health Assessment Tool (CHAT) in order to improve the process of identification and diagnosis of ADHD in younger prisoners. Asherson and others (2019) is also conducting a randomised control trial on the efficacy of MPH in the CYPSE (Asherson and others, 2019). Effective intervention and treatment pathways are essential for improving ADHD symptoms and increasing engagement with rehabilitation (Asherson and others, 2019). Linden and others (2020) examined the prevalence of brain injury in one male young offenders' institution – just over 87% of the 62 prisoners who took part exhibited some level of traumatic brain injury (TBI), compared with just under 57% in the control group although awareness and knowledge were low (Linden and others, 2020).

Women prisoners

Women in prison have particular needs with regards to their health and wellbeing including mental health, drug and alcohol dependence and self-harm (Public Health England, 2018). Many women have experienced trauma and come from deprived backgrounds which has an impact on their health needs while in prison and in the community (Public Health England, 2018). Specific standards have been developed which aim to improve the health and wellbeing of women in prison (Public Health England, 2018). These standards were developed through a literature review and Delphi study, which noted the limited available evidence from the UK on the health

needs of women in prison (McCann and others, 2019). A literature review examining this topic has recently been commissioned by NHS England and is due to be published in Autumn.

McGinley and McMillan (2019) conducted a systematic review of the literature to explore the prevalence of head injury in the female prison population and associated characteristics. They found that prevalence ranged from 19%-95% although they concluded there was a high risk of bias and inconsistency in terms of assessment and definition of head injury. Prevalence was noted to be similar to the male prison population (both of which were higher than the general population) but that the needs of women may be different - for example, females with head injury had a greater occurrence of trauma and a reported history of physical and sexual abuse (McGinley and McMillan, 2019).

Pregnant women in prison also have unique needs and experiences. The Ministry of Justice has recently conducted a review of its policy on pregnancy, Mother and Baby Units (MBUs) and maternal separation. This identified a number of challenges including a lack of awareness of MBUs across the prison estate, a complex application process and lack of clarity around roles and responsibilities of relevant organisations (Ministry of Justice, 2020). The review made a number of recommendations to address this including the need for better use of data to inform practice (Ministry of Justice, 2020). This review also noted the importance of rolling out the dedicated perinatal pathway identified in the NHS Long Term Plan, which had been delayed by Covid-19 (NHS England, 2019).

Older prisoners

Our previous literature review identified a number of studies relating to the physical health care needs of older prisoners (Davies and others, 2020). The Justice Select Committee recently conducted an inquiry which looked specifically at the needs of older prisoners (Justice Select Committee, 2020). Although this noted the challenge of defining 'older prisoner' the Committee recommended that a definition be developed.

The inquiry highlighted a number of distinct health and social care issues facing older prisoners including high physical and mental health needs, prevalence of conditions such as CVD and diabetes and challenges accessing health care services whilst in prison (Justice Select Committee, 2020). The Committee recommended that there should be a dedicated national strategy for older prisoners, and highlighted the importance of accurately predicting the age profile of the future prison population. A previous Committee inquiry into the needs of older prisoners also recommended this in 2013 (Justice Select Committee, 2013). This would be to

ensure that prisons are properly resourced and prepared to address the needs of this population (Justice Select Committee, 2020). The government has so far not accepted this recommendation and instead emphasised the need to treat prisoners according to their individual level of need, and not based on their age (HM Government, 2020).

There are particular challenges with the identification and management of dementia in prisons including limited awareness and understanding amongst staff, the confounding effect of the prison environment and regime and the practical barriers caused by the design of the prison estate (Chamberlain and Dening, 2020 and Forsyth and others, 2020). Forsyth and others found that the adjusted prevalence of dementia and mild-cognitive impairment was 8%, which would equate to 1090 people with dementia or mild cognitive impairment (MCI) in prisons in England and Wales (Forsyth and others, 2020) – this was much less than what was estimated by staff which could suggest significant under-recognition in prison. However, the study did note other factors which may contribute to this figure such as higher prevalence of brain injury, vascular disease and alcohol misuse (associated with vascular dementia and Korsakoff's syndrome respectively) (Forsyth and others, 2020).

Social and end of life care provision for people in prison is also variable, and particular concerns have been raised about the process for compassionate release, which is seen as complex and inefficient (Justice Committee, 2020 and Hospice UK, 2021).

Characteristics of older prisoners including the nature of the crime and sentence may also be relevant to health needs such as whether the person enters prison at an older age or is growing old in prison (Wilkinson and Caulfield, 2020). In particular, an increasing older prison population has been in part attributed to the increasing convictions for sexual offences resulting in an increase in people entering prison for the first time at an older age (Justice Select Committee, 2020).

Transgender prisoners

The Ministry of Justice (MoJ) collects data on the number of transgender prisoners as part of the Offender Equalities Annual Report which contains information relating to prisoners with protected characteristics. There were 163 transgender prisoners in 2019, an increase from 139 recorded in 2018 (Ministry of Justice, 2019).

We identified one study which used three qualitative interviews to explore the experiences of transgender prisoners in prison. Regarding health care specifically related to the process of

transitioning, there were challenges regarding the resources required to support prisoners attend specialist clinics given the physical distance of the prison, and stress related to long waiting lists and lack of support regarding the process (Nulty and others, 2019).

Guidance has been developed by the MoJ and HM Prison and Probation Services (HMPPS) which outlines how transgender people in prison should be cared for and managed (Ministry of Justice, 2020). This acknowledged the wider research context which has shown that transgender people in prison are more likely to experience mental health problems and self-harm (Ministry of Justice, 2020). Regarding support for gender dysphoria specifically, the guidance states that individuals should be able to access the same care they would receive on the NHS including counselling, pre-operative and post-operative care and continued access to hormone treatment (Ministry of Justice, 2020).

What do we know about quality of health care in prison?

Natural causes are the main cause of death for people in prison with the leading cause being disease of circulatory system (43%) followed by cancer (32%). However, the Independent Advisory Panel on Deaths in Custody (IAP) has suggested that many are preventable and a result of failings in health care management such as failure to recognise deterioration or poor management of long-term conditions – this is a particular concern for older prisoners (IAP, 2020). INQUEST conducted a review of inquests and coroners reports and identified a number of areas of concern including cancelled or delayed appointments, poor communication between health care and prison staff and poor understanding of appropriate procedures (INQUEST, 2020).

Studies have explored prisoners' perspectives on their access to health care. Quinn and others (2018) conducted a qualitative study exploring prisoner's perspectives on factors that contributed to, or worked against, creating and sustaining their access to health care. This highlighted the significant role of GPs in facilitating access including the value of trusting relationships, flexibility and good communication (Quinn and others, 2018). Edge and others (2020) explored the role of security constraints in prisoners' access to secondary care and identified a number of challenges including the need for escorts, stigma arriving handcuffed and lack of confidentiality when prison officers are present at consultations (Edge and others, 2020).

Access and quality of prison health care must be understood within the wider context of prison policy and practice. Ismail (2019) used a qualitative study to understand the impact of austerity on prison health by conducting interviews with a number of international policymakers. This identified a number of issues including the "disappearing chain of accountability", increase in prison instability and longer waiting times (Ismail, 2019). Another study looked at the impact in England specifically including a reduced workforce, increased availability of drugs and prevalence of violence and political turnover (Ismail, 2020). This wider instability has an impact on the prison's ability to deliver health care services for example by contributing to staff shortages, increasing waiting times and increased security concerns.

What has been the impact of Covid-19 on prisons and prison health care?

Covid-19 has resulted in substantial changes to the prison regime. The risk posed to people in prison were identified at an early stage, key being overcrowding, cramped living conditions and generally poor access to health care (O'Moore, 2020). Early modelling suggested that without intervention, a worst-case scenario would result in between 2,500 and 3,500 deaths (O'Moore, 2020). This led to the introduction of lockdown restrictions whereby people in prison were effectively confined to their cells for 23 hours a day (HMIP, 2021). As well as this, activities including educational classes, libraries, gyms and social visits were suspended or curtailed (HMIP, 2021).

Specific measures were introduced to address the risks including compartmentalisation strategies (grouping together clinically vulnerable people or those with symptoms), isolation for new arrivals and actions to reduce the prison population through temporary and early release schemes (O'Moore, 2020). Similar to the community, testing was limited at the start of the pandemic – if a certain number of prisoners tested positive, other symptomatic prisoners were also treated as though they had the virus (O'Moore, 2020).

One study covered an outbreak investigation at a large prison between March and June 2020 - 62.1% of symptomatic residents were 50 and over which placed them in at risk group of severe Covid (Wilburn, 2020). The study noted the rapid implementation of lockdown measures which prevented wider spread. A screening event followed which aimed to test all prisoners and staff over five days. However, around one third of prisoners and staff did not take part in the screening event.

By April, testing was available for symptomatic people in prison, and now people in prison and staff should be regularly tested (HMPPS, 2021). In reality, this presents a number of challenges such as how to gain trust, and the practicalities of conducing mass testing in the prison estate (Lambert and Wilkinson, 2021).

Although some services were reinstated in summer 2020, strict restrictions have remained throughout (Ministry of Justice and HMPPS, 2020). The National Framework sets out the criteria for easing coronavirus restrictions within the prison environment which include the levels of infection present in the prison and the community, as well as staffing levels within the prison itself (Ministry of Justice and HMPPS, 2020). Preservation of life (which includes ensuring continued access to health care) is one of three key objectives which should guide decisions alongside maintaining security, stability and safety and providing sufficient capacity (Ministry of Justice and HMPPS, 2020). The IAP conducted a review of prisoners' experiences between March and May 2020 in partnership with National Prison Radio (NPR) which highlighted the negative impact of lockdown isolation on mental health and wellbeing (IAP, 2020).

Commentary on the management of Covid-19 in prisons especially in the first wave suggests that outcomes were largely better than expected (Crest, 2020). In April 2020, evidence suggested that outbreaks were being contained and at that point fears of "explosive outbreaks" had not materialised (O'Moore 2, 2020). Since then, inspections also noted the rapid response of the prison service to contain the spread of the virus (Criminal Justice Joint Inspection, 2021). However, this has been matched with concerns about the long-term impact of restrictions on health and wellbeing, and the variation in prisoners' experiences regarding access to health care, education and rehabilitation (Criminal Justice Joint Inspection, 2021). HMIP has questioned whether the right balance has been achieved between managing the risk posed to prisoners and providing them with enough time out of their cells and meaningful activity (HMIP, 2021). There is also significant concern about the impact on rates of self-harm (Hewson and others, 2020).

As of 31st August 2021, 18,442 prisoners or children in custody have tested positive for COVID-19 since the start of the pandemic and 223 prisoners, children in custody and supervised individuals have died having tested positive within 28 days of death or where there was a clinical assessment COVID-19 was a contributory factor in their death (HMPPS, 2021) .[1] Although

[1] Data from the early stages of the pandemic must be treated with caution given the limited availability of testing.

prisons have not seen the numbers of cases and deaths originally feared, when controlling for age and sex, case rates in prison have been higher than in the community (Davies & Keeble, 2020). This has also been the case for mortality rates in prison (Braithwaite and others, 2021).

Given their increased risk, some have advocated for people in prison being a priority group for vaccination (Braithwaite and others, 2021). Currently however, people in prison have been vaccinated in line with the priority groups identified in the general population. As of 19th April 2021, 85% of eligible prisoners had received a first dose of the vaccine (UK Parliament, 2021).

Covid-19 has resulted in significant disruption to health care services during the pandemic. In March 2020 access to health care services was scaled back – routine appointments were cancelled and access to hospital was restricted to urgent and emergency care (HMIP, 2021).

It has been suggested that the experience of the pandemic provides a significant opportunity for the prison service to 'build back better' as it looks to recover from Covid-19 by focussing more broadly on creating a "healthy prison environment." (Prison Reform Trust, 2021). But, evidence so far suggests that people's experience of prison health care during the pandemic has been variable. Research conducted between the end of April and mid-August 2020 showed that while 60% of people in prison felt their needs had been met despite the lockdown, in one prison, over ¾ of patients felt that services such as GPs were "unattainable" with requests for appointments going unanswered (EP:IC, 2021). Recent HMIP reports also highlight variation with examples of positive management of ongoing health care services, innovation and continued access and reasonable waiting times but also examples of challenges accessing services (HMP High Down and HMP Peterborough). Staff shortages (for example as a result of sickness or self-isolation) have also had a significant impact on the health care services prisons have been able to provide.[2]

Similar to the wider community, Covid-19 has also led to some changes in prison processes such as the increased use of remote consultations to provide access and continuity of care (Prison Reform Trust, 2021). Prior to the pandemic, the implementation of remote consultations in prison was limited by numerous barriers such as poor digital infrastructure (Edge, 2020). For example, at the start of the pandemic, approximately 50 of 117 prison sites did not have sufficient

[2] Peak staff absence due to Covid-19 was in January 2021 - https://www.gov.uk/government/statistics/her-majestys-prison-and-probation-service-workforce-quarterly-march-2021/hmpps-covid-19-experimental-statistics-annex-30-april-2021#sickness-absences

internet connections to enable video consultations to take place (Edge, 2020). By Autumn 2020, there were still some prisons which did not have a secure video calling facility (Criminal Justice Joint Inspection, 2021).

Although remote consultations offer opportunities to address some of the challenges delivering health care in prison, the experience of people throughout the pandemic has been varied and prison presents a unique set of challenges. For example, there are concerns about confidentiality, privacy and accessibility particularly where people did not have English as a first language (EP:IC, 2021). Thorough evaluation is required to understand how telemedicine can improve access and quality of health care for people in prison in the most effective way (Edge and others, 2020).

There is also significant concern about the impact of the wider regime changes on physical health such as curtailed opportunities for exercise, the provision of unhealthy food, weight management and exacerbated long-term conditions such as asthma and high blood pressure from being confined to cells (HMIP, 2021).

Conclusion

This is an area of research which is constantly developing and there are a number of other relevant ongoing studies which will provide insight into prisoners' physical health care needs and their experiences. This includes: an NIHR-funded study (see NIHR.ac.uk, n.d) exploring how best to provide cancer care to people in prisons; Qual-P, a mixed-methods study exploring primary care for people in prison (qual-p.org) and; an ESRC-funded project looking specifically at the impact of Covid-19 on prison health care services and health inequalities. The All-Party Parliamentary Group on Women in the Penal System is also presently conducting an inquiry into the health and wellbeing of women in prison (See Howard League for Penal Reform, 2021).

There are also noticeable gaps and limitations in the literature. Most papers concerned small sample sizes or were conducted in individual prison environments making generalisability limited. Given the wide variation which exists between prisons in terms of the services available, it is important that research takes account of this and how it impacts prisoners' experiences of health care. With Covid-19, much of the literature are policy reports and grey literature, and describe the impact of the first wave of the pandemic. Information about the second wave and impact on prisoners' experiences and particularly the impact on physical health needs and services is limited at this stage.

The context of prison health care is constantly evolving – the impact of the pandemic within prison and wider society, and changing nature of commissioning are likely to influence the management of health care services as well as prisoners' experience of these services. Monitoring the impact of these changes is vital to understanding the experiences of people in prison with regards to their health care and ensuring that services meet their needs. The importance of the 'whole prison approach' which acknowledges the importance of the wider prison environment in supporting prevention and health promotion, as well as access to and quality of services is crucial – effective partnership working and leadership will be key to this.

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