Impact of Covid-19 on healthcare in prisons in England: Early insights

Krysia Canvin & Laura Sheard
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Krysia Canvin

Academic Unit of Primary Care
Leeds Institute of Health Science
University of Leeds
Worsley Building
Leeds, LS2 9JT

k.canvin@leeds.ac.uk

Laura Sheard

Department of Health Sciences
University of York
Seebohm Rowntree Building
Heslington
York, YO10 5DD

laura.sheard@york.ac.uk

Website https://qual-p.org/what-is-impact-c19p/

Twitter @qual_p

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Key messages

- The impact on prison healthcare availability and delivery and the factors driving that impact varied across individual sites and services.

- Reports of subsequent harm and unmet need were universal.

- Despite reports of innovative attempts to maintain healthcare in English prisons, the suspension of non-Covid related healthcare at the onset of the pandemic and subsequent restrictions pose immediate and long-term risks to health.
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Summary

The pandemic led to a significant shift in the way healthcare was provided in English prisons. This review of reported changes to healthcare indicates the absence of a universal, centrally co-ordinated strategy which resulted in disparate responses around the English prison estate. This report provides an overview of the range of ways that Covid-19 has impacted on prison healthcare, the factors that drove this impact and its consequences.

Availability

Healthcare services stopped completely in some places but continued in others. Access was often restricted to urgent care or where there was significant risk.

Delivery

Where healthcare services continued, delivery was affected. Delivery involving face-to-face contact was conducted by staff wearing PPE but providers also used alternatives such as telephone appointments and delivery through the cell door.

Influential factors

Both local and national conditions such as on-site C19 outbreaks, telephony/technology infrastructure, staffing, and demand, affected the availability and delivery of prison healthcare.

Consequences

Reduced healthcare availability and changes to how services were delivered increased risks to patients but also led to unmet needs and direct harm.

Despite the variations observed, we identified some commonalities across the prison estate: most non-Covid related healthcare was initially suspended at the onset of the pandemic; subsequent availability and delivery was influenced by local conditions; and harm, unmet need and immediate and long-term risks to health resulting from changes to healthcare were universally reported.

This review identified an immediate and ongoing impact on the availability and delivery of healthcare and offers early insights into the potential implications for long-term health and health inequalities.
1. Introduction

People who have been disproportionately impacted by Covid-19, such as those with chronic health conditions, from deprived communities and minority ethnicities, are overrepresented in the prison population. From the outset of the pandemic, multiple commentators highlighted the vulnerability of the prison population to infection from Covid-19. Few anticipated the consequences that measures taken to prevent the spread of Covid-19 would have on the general health and healthcare of people in prison, however. This report provides an overview of the rapid reconfiguration of prison healthcare due to Covid-19.

1.1. Background

This report was produced as part of an ongoing ESRC-funded study: *the impact of Covid-19 on the delivery and receipt of prison healthcare in England: A mixed methods study* (Impact-C19P). Impact-C19P aims to understand the implications of the reconfiguration of ‘everyday’ prison healthcare in England, such as routine primary care and chronic condition management. For the purposes of this report, we focused on documents produced outside of academia; we conducted a separate review of academic literature.

We conducted an ‘Environmental Scan’ of internet sources to identify documentation of the impact of Covid-19 on prison healthcare. We scanned 97 potentially relevant websites including prison health-specific sites, and generic health, generic prison and non-prison/non-health websites (e.g. Amnesty International) for documents that described the impact on healthcare in English prisons. We searched each website for relevant documents published between December 2019 and July 2021 using the terms: ‘Covid-19’, ‘healthcare’ and ‘prison’. We retrieved 426 documents for closer inspection and summarised the contents of 52.
More details about Impact-C19P, including the review of academic literature, and links to the sources and documents covered by this report are available at https://qual-p.org/what-is-impact-c19p/.

1.2. Overview of report contents

This report draws on a wide range of documents written from different perspectives to construct a picture of the reconfiguration of prison healthcare during the pandemic. We have included reports from independent inspectors, non-governmental organisations and healthcare providers, blogs, and statements from the Ministry of Justice. Some of these include statements from staff and people in prison and just eight contain extensive content based on accounts from people living in prison. Reports by HM Prisons Inspectorate compose one-third of the included documents. Around half of the documents made very brief references to the impact on non-Covid related healthcare, the remainder contained more substantial content. Due to the volume of material published during the pandemic, we do not claim to have conducted an exhaustive search. Instead, this report provides an overview of the range of ways that Covid-19 has impacted on prison healthcare and provides early insights into the reasons for these variations and their consequences.
2. Impact on healthcare availability

2.1. Suspension of healthcare

Initially, many prisons suspended healthcare services when the pandemic was announced leading to “drastically reduced health support.” (1) Several sources reported that mental health services and support (including listener schemes and talking therapies) that had been withdrawn in March 2020 had not been reinstated as much as 16 months later. (2) (3) (4) Group work with drug and alcohol services reportedly ceased (5) (6) (7) and drug recovery wings closed in some sites. (8) Routine dental care and check-ups were also curtailed. (8) Consultations with people living in prison during the pandemic contained accounts of being “denied access to healthcare” (9) and “refused point blank.” (10) (11) People in prison also reported difficulties accessing dental, nurse and GP appointments, (12) (13) medication and painkillers. Similar reports emerged from the youth estate. (14) Improvements to infrastructure were also interrupted and delayed, including the opening of a well-being centre with group therapy rooms and a sensory room, and the building of therapeutic units. (5) (15)

2.2. Continuation of healthcare

HM Inspector of Prisons and other sources (16) (12) (17) reported that some services at some sites (not category A) continued throughout the pandemic, including during the early stages. These included mental health services, substance use services, medicine management, allied health services (physiotherapy, podiatry), and opticians. Face-to-face contact reportedly continued between patients and health services at some category D sites. (18) (19) (20) Elsewhere by early 2021,
immunisations and screening were reportedly up-to-date. (7) (21) Physiotherapy and optometry were described as offering “a slightly reduced but effective service.” (22)

2.3. Restricted access

Where provision continued, availability was restricted. For example, hospital appointments were restricted to emergency care, urgent assessments (referrals under the ‘two-week wait’ process), and cancer referrals and reviews, (4) (6) (23) (24) (22) although routine referrals were reportedly ongoing at one site. (6) At some sites, emergency dental care remained available for those with acute clinical needs such as pain or repeat antibiotic therapy. (22) (25) (18) Similarly, mental health and substance misuse services were prioritised according to risk and available for urgent referrals and those in crisis. (4) (23) (26) The Independent Monitoring Boards reported that some sites were only offering crisis support. (27)

> Nurse and advanced nurse practitioner clinics had continued to provide urgent care, such as dressings, urgent blood tests, prescriptions and some triage. Most clinics were not fully subscribed and clinical time was wasted due to prisoners’ lack of access. No officers had been allocated to the health service for the previous eight weeks and staff had to rely on wing staff to escort prisoners to clinical rooms one at a time, although there were some improvements to this during our visit. (23)

Priority access for all types of services including dentistry was usually assessed via triage by a healthcare professional (25) but there were also examples of triage being undertaken via completion of a form or written questionnaire. (28) (12)

2.4. Reinstatement and recovery

Reinstatement of healthcare services also varied. There were conflicting reports of whether health and mental health services had been reinstated. Some reporting in June 2021 that they had not, (3) (29) and others reporting between December 2020 and April 2021 that many on-site services had resumed (some by December 2020), external appointments rebooked (6) (30) (19) (5) (25) (8) and that recovery plans were in place or under development in several sites. (2) (31) (32) (33) (5) (8)
3. Impact on healthcare delivery

3.1. Covid-related precautions

Where face-to-face services continued these had Covid-19 precautions in place, with one-way systems, “fallow time for cleaning” between appointments and staff wearing Personal Protective Equipment. (4) (22) Other special arrangements included the delivery of medication to the cell door for people who were shielding and isolating, (5) (2) isolation arrangements for people returning after an external hospital appointment, (34) (26) and the availability of “PPE grab bags“ for officers’ use in escorts or emergencies. (20)

3.2. Remote access and technology

To supplement or replace face-to-face appointments with external providers, some sites introduced consultations by telephone or video. (6) (1) (31) (26) Some primary care consultations and reviews were conducted via wing and in-cell telephones, (4) (3) (7) (1) including at long-term and high security prisons. Dedicated health and mental health support telephone lines were arranged at some sites (8) including one offered by a dental provider to advise health staff “on treating those in most distress” (18). At one site, the introduction of lockers with biometric access allowed prisoners to collect their in-possession medication without seeing a healthcare professional. (35)
3.3. Through the door

Many sites reduced movement of people around the prison by delivering services to the cell or wing, rather than prisoners going to the health centre. (15) (34) A mental health team in one prison conducted “wing walks” while people were unlocked from their cells, and being “present and seen” was seen as reassuring and comforting in and of itself. (13) Some services were delivered through the cell door (e.g. medication supply and “wellbeing checks”) (5) (3) and other supplementary or replacement measures were introduced to compensate for reduced services. In-cell therapeutic and diversionary materials were produced and supplied by multiple drug and alcohol service providers and mental health teams. (6) (7) (20) (19) (15) In some places, weekly welfare checks (12) (25) and “monitoring of the most vulnerable” were undertaken in place of mental health and substance misuse support. (18) Alternatives were also devised by services where providers were unable to be on-site or to facilitate group work, including postal sponsors (Alcoholics and Narcotics Anonymous), individual work and delivery by peers. (20) (20) (19) (25)
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4. Factors affecting healthcare availability and delivery

The availability and delivery of prison healthcare was affected by both national and local conditions.

On-site outbreaks Local, on-site outbreaks of Covid-19 interrupted services. For example, mental health practitioners maintained face-to-face contact with patients at one site, except during an outbreak, while at another, routine health provision had been restarted in June 2020 but had to stop again due to a major outbreak. (5) (20)

![Figure 4 Factors impacting on availability and delivery of healthcare in prison](image)

**INFLUENTIAL FACTORS**

<table>
<thead>
<tr>
<th>NATIONAL</th>
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<tr>
<td>C19 outbreaks</td>
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<td>Staffing &amp; staff responses</td>
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**Staffing and staff responses** Covid-19 exacerbated existing staffing shortages by causing absences due to infection and/or isolation (5) (36) (37) and by adding Covid-related workload on top their usual duties including mass testing, vaccination, identifying vulnerable patients, performing checks, prioritising patients, and cleaning. (2) (36)

“Routine hospital appointments continued to be cancelled, although they were being actively rescheduled. Greater use of telephone consultations had mitigated this issue, but staffing constraints had led to some external appointments being cancelled by the prison.” (2)
Healthcare staff also absorbed other duties. Staff reportedly undertook social care assessments where local authorities were unable to access the prison, (4) adapted their ways of working in response to the restrictions and its effects, assisting with triage, referrals and applications, working extra shifts and foregoing annual leave. (19) (38)

**Telephone and technology infrastructure** Although in-cell telephony was rare, where it existed it facilitated triage and psychological interventions. (3) (17) Good practice, however, was described as the exception. (3) HMPPS invested in mobile handsets, (39) 4G tablets, webcams and 2,000 digital licenses (40) (3) and a pilot telemedicine programme (40) (39) but this has also prompted concerns about the confidentiality and privacy of in-cell or wing telephones. (41) (7) (12) Some settings had begun to use MS Teams for staff communication. (42) (38) At one site the potential of a dedicated health telephone was limited because staff did not know about it. (8)

The dental team had attended throughout the period of restrictions, offering advice, analgesia, and antibiotics, and saw any urgent cases face to face. Prisons with in-cell phones have been able to provide access and some support for those at risk of self-harm and with mental health concerns, access to psychology and probation for progression and parole hearings, and greater access to legal advice, Samaritans, Independent Monitoring Boards, families and friends. Prisoners without this facility can be restricted to as little as ten minutes a day to make calls. These discrepancies are creating both unfairness and heightened risk for prisoners without in-cell phones. (27)

**Partnership working** Partnerships between prisons, healthcare providers and local NHS trusts facilitated remote outpatient appointments, PPE provision, and strategies for responding to outbreaks. (43) (1)

**Demand for services** Demand for services varied. According to the Care Quality Commission, patients were not asking for appointments: (43)

There were also some concerns that some non-urgent patients who require procedures like routine screening and immunisation are not being seen in a timely manner because they are worried about contracting COVID-19 during a visit to the surgery, or because they think their GP could lack capacity to see them. This may be having implications on patients’ health. (43)
The dental team had attended throughout the period of restrictions, offering advice, analgesia, and antibiotics, and saw any urgent cases face to face. Although the team had reviewed its caseload to prioritise those with urgent need, the inability to provide aerosol generating procedures (see Glossary of terms) since August 2020 had led to excessive waiting times. A ventilation system was due to be installed to recommence this work, though the delay in ordering this had lengthened waiting times. (5)

Conditions in the community Some aspects of healthcare provision in prisons were affected by national guidance directed at health services generally, i.e. in prison and the community. These included restrictions on the use of aerosol generating procedures by dentists, (5) (6) (28) reduced hospital appointments, (7) (44) and cancellation of appointments by hospitals (not prisons). (8) (25) (23)

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5. Consequences: risk, harm and unmet needs

5.1. Risks associated with reduced access

Restrictions on healthcare provision led to long waiting times at many (though not all) prisons. (41) (28) Multiple services were affected, including dentistry, (20) (25) (described as “excessive” (5) (45)) podiatry, physiotherapy, (46) and GP appointments. (23) Extended waits for mental health care (10) and for transfers to mental health hospitals under the Mental Health Act (5) were also reported. Staff shortages compounded these delays. Extended waiting times increased risks, and although people on the waiting list for some services were monitored, (22) elsewhere, some routine mental health referrals were not being assessed and those waiting were not being monitored. (4) Patients described receiving little notice of changes to mental health service provision, being referred to cancelled clinics and allocated to waiting lists for suspended services, failing to address their immediate health concerns. (13)

5.2. Risks associated with changes to delivery

In some cases, measures implemented to replace usual service provision generated new, sometimes unanticipated, risks. For example, some mental health interventions and support were delivered through cell doors, at the risk of compromising confidentiality and discouraging patients from full disclosure. (13)
Changes to the dispensing of medication meant that pharmacy staff assumed responsibility for risks associated with “having to determine which prisoners could least afford to miss their medication.” (2) Use of self-complete questionnaires for triage lead to expressions of concern by HM Inspector of Prisons that this system “lacked the monitoring and oversight needed” (28) and “could miss potential need”. (2) Risks of suicide or self-harm may also have gone unreported where ACCTs (Assessment, Care in Custody and Teamwork care planning for people at risk of suicide or self-harm) are no longer being opened by professionals from external agencies. (27)

5.3. Serious harm and unmet needs

People in prison expressed concern about immediate and long-term health implications. (29) (27) One freephone helpline was dominated by calls about difficulties accessing “medication and treatment” (26) Many people described difficulties managing their health, the anxiety of waiting for months to see a GP for a potentially serious health problem, (13) delays in the provision of inhalers for relief of asthma, (47) gaps in the continuity of mental health care, (12) and lack and even reversal of progression in substance misuse recovery. (13) Both positive and negative experiences of obtaining prescriptions were reported, including potentially inappropriate antidepressant prescribing (12) and increased sleeping tablet prescribing. (26) Prisoners also reported that they were not attended by healthcare despite describing fever, aches and breathlessness, or pressing the emergency bell (48) or loss of consciousness. (12) In the absence of medical attention to the mother, a baby died in custody. (49)
6. Early insights

6.1. Implications for long-term health and health inequalities

Multiple commentators expressed concern about the consequences of the “cumulative impact of lockdown” (27) and depleted healthcare for prisoners’ health and for health inequalities. (43) (36) (27) (50) The evidence we report here clearly demonstrates the impact that Covid-19 has had on the availability and delivery of healthcare in prison and some of the implications for the physical and mental health of people in prison. Many sources suggested that prisoners’ needs were not being met and some indicated that serious harm had been caused. It is less easy to identify evidence of health inequalities from these reports other than the stark differences between prison sites. We did not identify any clear patterns by prison category or service-type, although we did identify various factors that appeared to influence the availability and delivery of services. These included both structural factors, for example, telephony and technology infrastructure and staffing, as well as individual behavioural factors, such as individual staff facilitating care provision by working flexibly and taking on additional workload, and patients moderating their demand for services and acting as peer supporters.

We also identified some potential mechanisms that might lead to or exacerbate health inequalities.

6.2. Potential mechanisms

**Healthcare availability versus need.** A key mechanism in the production of health inequalities is access to healthcare, especially in the face of increased need. The Independent Monitoring Boards noted this irony of reduced access to mental health care and drug rehabilitation work at a time when it was needed most. (27)

**Equivalence with the community.** Healthcare provision was described as “reasonable” given “the enormous challenges arising from the restrictions associated with the COVID-19 pandemic” (51) (4) (44) (28) and the impact was sometimes described as comparable to that experienced in the community. (4) (32) (7) One key difference, however, was the faster adoption of “digital alternatives” by community providers, (3) a development which could widen health inequalities. Despite the “great potential for far reaching benefits in addition to face-to-face services,” (52) the opportunity to pilot or expand telemedicine was described as “a huge opportunity lost”. (3)
Variations across the prison estate. Prisons in England developed unique strategies in the face of the pandemic regarding the availability, delivery or reinstatement of healthcare, seemingly responding to local conditions and potentially contributing to inequalities within the prison estate.

Legacy factors. Legacy factors in the prison estate also pave the way for health inequalities. These refer to various aspects of the infrastructure, including depleted resourcing and staffing, digital inequalities, and the extensive existing health inequalities. While a combination of poor coding and low engagement may have made it difficult to identify vulnerable prisoners for early release or shielding. (36)

7. Conclusion

The pandemic led to a significant shift in the way healthcare was provided in English prisons. This review of reported changes to healthcare indicates the absence of a universal, centrally co-ordinated strategy which resulted in disparate responses around the English prison estate. No clear patterns were evident to suggest that some services were affected more than others or that changes to the delivery of services were standardised. As well as varying from prison to prison, impact also varied from service to service, with different approaches being taken by different services within the same establishment. Nevertheless, there were two commonalities. Firstly, at the onset of the pandemic, the initial immediate suspension of non-Covid related healthcare seems to have been universal. Secondly, further impact on healthcare appeared to be driven by local conditions such as on-site outbreaks of Covid-19 and the presence or absence of technology and telephony infrastructure. The latter may explain some of the variation across the prison estate.

This review identified an immediate and ongoing impact on the availability and delivery of healthcare. Although impact on health care was variable, the subsequent harm, unmet need and immediate and long-term risks to health were universally reported. At the time of writing, healthcare services have not been fully reinstated, greatly exacerbating the gap between provision and need and posing a considerable risk of exacerbating existing health inequalities.
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