Prison healthcare.... possibly the most important setting for improving quality and access

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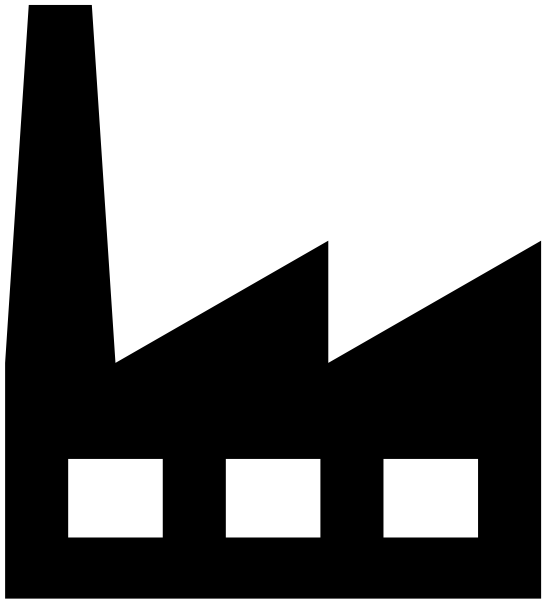
Qualitative methodologist
Taking a systems/macro/organisational level perspective
What am I interested in?
“Qual-P”, “Impact”, “Amicable”
There is some quant (help!)




Prisons map
Wormwood Scrubs
Pentonville
Thameside
Belmarsh
Isis
Brixton
Wandsworth
Feltham
London
Northumberland
Low Newton
Frankland
Durham
Holme House
Deerbolt
Kirklevington Grange
Haverigg
Lancaster Farms
Full Sutton
Askham Grange
Wetherby
Kirkham
Preston
Wealstun
Humber
Garth
Buckley Hall
Leeds
Wakefield
Hull
Wymott
Forest Bank
New Hall
Hatfield
Moorland
Manchester
Lindholme
Liverpool
Hindley
Doncaster
Altcourse
Risley
Barton Moss
Thorn Cross
Styal
Ashfield
Lincoln
Ranby
Morton Hall
Berwyn
Wrexham
Clayfields House
Nottingham
North Sea Camp
Lowdham Grange
Sudbury
Stoke Heath
Foston Hall
Lincolnshire
Stafford
Wheatfield
Drake Hall
Dovegate
Stocken
Bure
Oakwood
Featherstone
Leicester
Norwich
Swinfen Hall
Brinsford
Peterborough
Wayland
Oaken Parva
Gartree
Wilsborough
Birmingham
Littlehey
Rainsbrook
Onley
Highpoint
Hewell
Rye Hill
Bedford
Holesley Bay
Woodhill
Ostrill
Warren Hill
Long Lartin
Bullingdon
Grendon/Springhill
Chelmsford
Lilly/Prescoed
Aylesbury
The Mount
Swansea
Hillside
Eastwood Park
Leyhill
Hunterscombe
Pare
Bristol
Bronzefield
Coldharbour Wood
Ashfield
Elmley
Swaleside
Standford Hill
Cardiff
Vinney Green
High Down
Rochester
Mickley
Dovertown
Maidstone
Coldingley
Send
East Sutton Park
Eastmoor
Winchester
Blantyre House
Guys Marsh
Lewes
Ford
Exeter
Isle of Wight
Dartmoor
The Verne
Portland
Channings Wood
Key
Foreign Nationals Prison (FNP)
Immigration Removal Centre (IRC)
Young Offenders Institution (YOI)
* Temporarily closed

105

12


4.1%
79,744


>50
16%


27%


12.8%

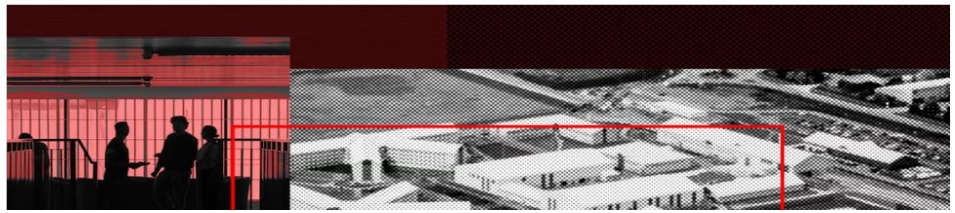
Geo-spatial-architectural nature

- Victorian era boom in prison construction…
- ….which still holds 22,000 prisoners
- Ageing building unfit for purpose
- Plans to build more modern prisons curtailed
- Shock closure of Holloway in 2016
- Overcrowding

Overcrowding in prisons is a 'powder keg waiting to blow'

Exclusive: Record number of inmates doubled up in single cells - with government forced to build 1,000 portacabins to ease overflow

Lizzie Dearden Home Affairs Editor • Friday 19 May 2023 18:02 BST • 90 Comments

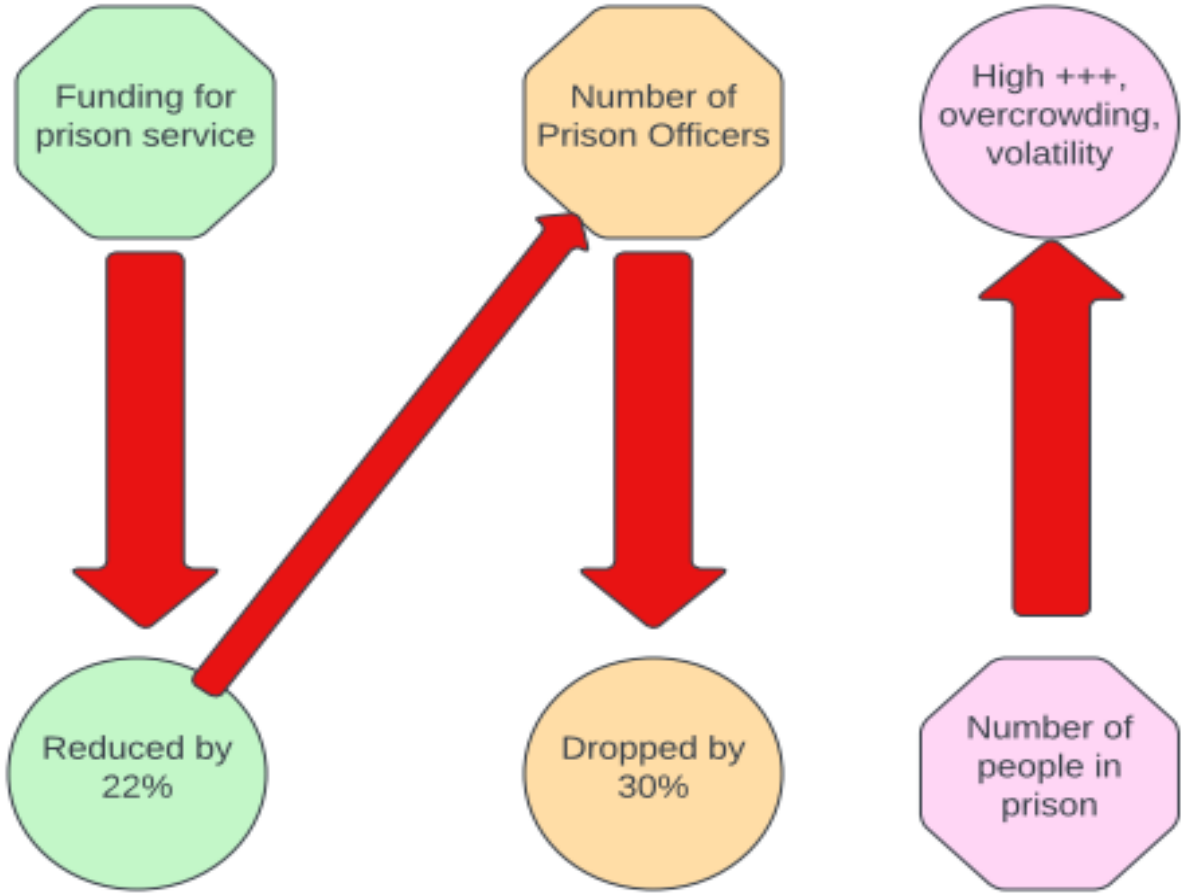


- Challenging environment with high number of complex patients living in overcrowded conditions
- Prison regime has security as its main concern
- Viewed as a Cinderella area of healthcare provision, hidden away from public scrutiny whilst being underfunded and undervalued
- Patients with complex health problems, chronic conditions and multi-morbidity are over represented

Fractured and competitive healthcare provision

- Funded by NHS and free at point of use but not provided by NHS…
- For profit, non-profit, third sector
- Competitive four year tendering cycle
- Can even be different providers in same prison
- Less attractive terms and conditions compared to NHS career inc pension, annual leave & sick leave etc

Macro-economics of prison healthcare (2010 to date)

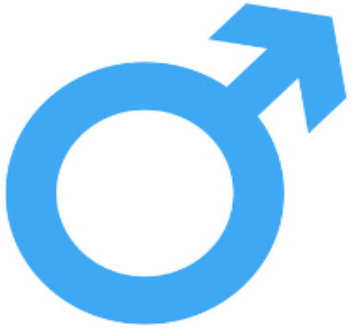


Why is it important to pay attention to primary care in prisons?

- Possibly the most disadvantaged group in terms of health profile
- Average age of death for prisoners is 56 vs 81 in community
- Unique opportunity to intervene & improve
- ‘Churn’
- Public health +++
- Close relationship of health with re-offending
- Moral imperative

Research swamps and research deserts

- Research on health in prisons is weighted towards:

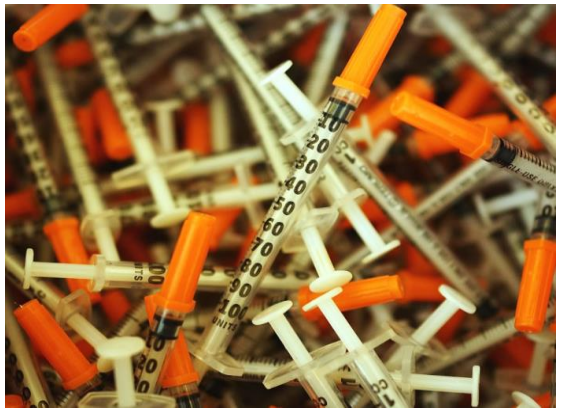


mental health and substance use

self harm and pregnancy

- Little research on quality of routine, everyday healthcare for conditions e.g. asthma, diabetes, high blood pressure, cervical screening
- And hardly any health services research

My research experience (in relation to prisons)



Research

Nat MJ Wright, Laura Sheard, Clive E Adams, Bruno J Rushforth, Wendy Harrison, Nicole Bound, Roger Hart and Charlotte NE Tompkins

Comparison of methadone and buprenorphine for opiate detoxification (LEEDS trial):

a randomised controlled trial

Abstract

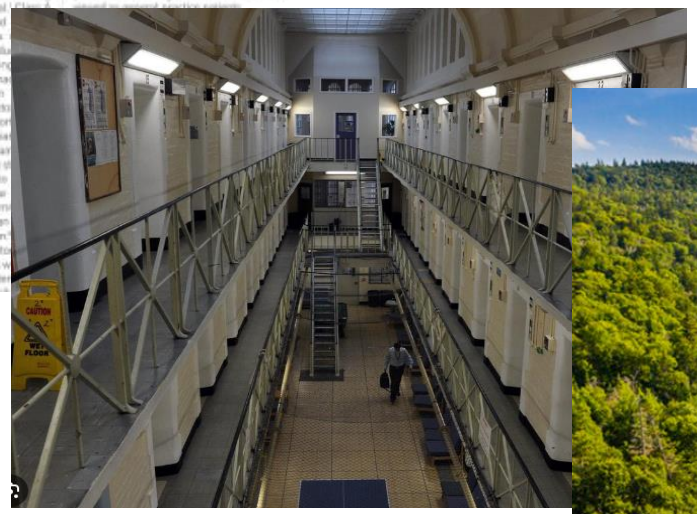
Background

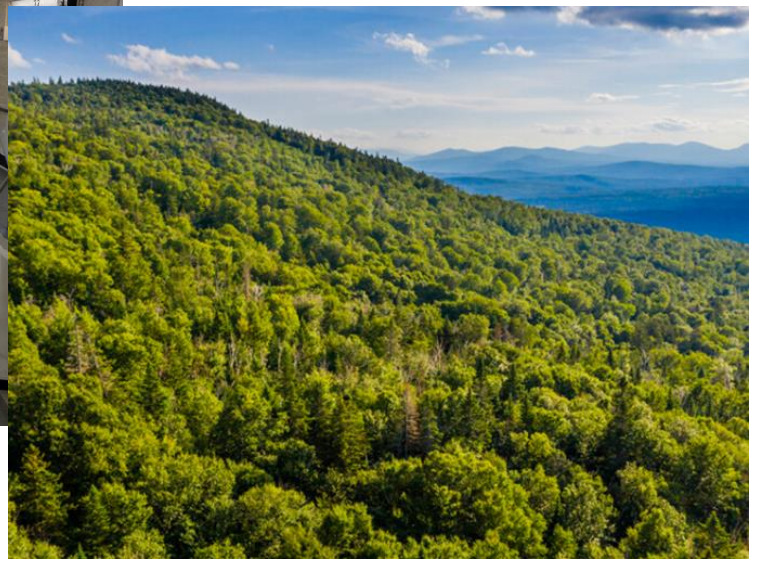
Aim

Design

Method

INTRODUCTION





What sticks out in my mind

Qual-P: mixed methods (2019-2022)

- Aim: To understand the quality of primary care in prisons in the North of England, including gaps and variations in care, in order to recommend improvement

- Qual – interview study with 43 participants

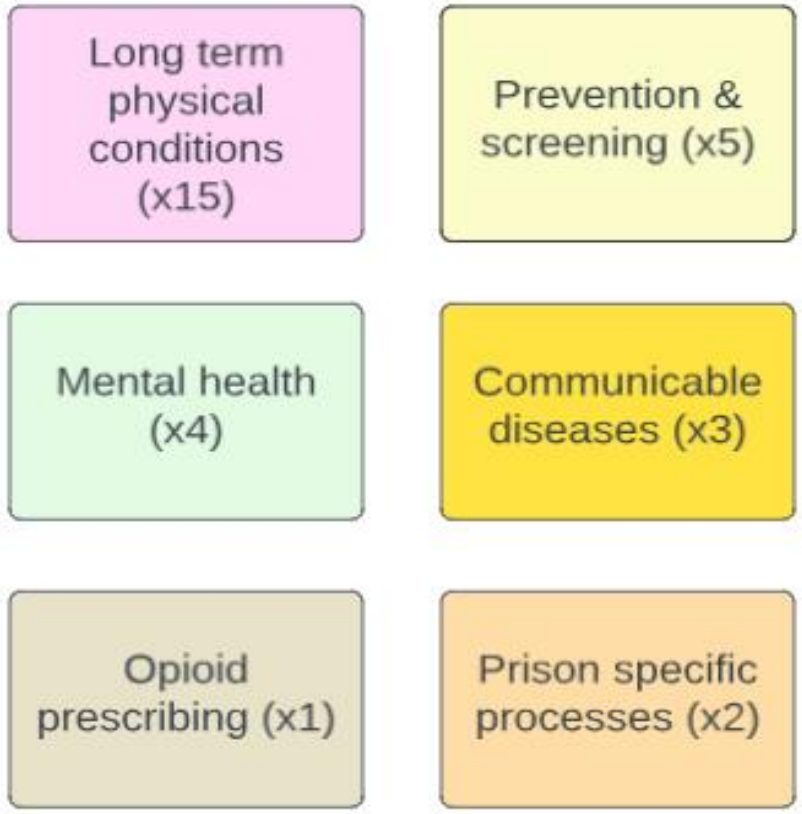
(21 prison leavers, 22 frontline healthcare staff)

Qual-P: mixed methods

- Scoping review of quality indicators in prison healthcare

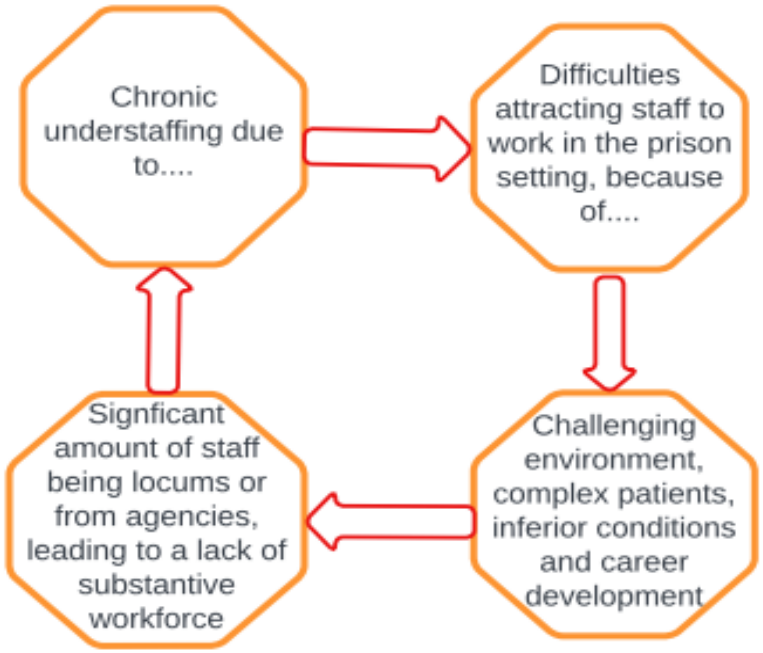
- Quality indicator selection (371 to 30!)

- Quant – analysis of ~25,000 anonymised healthcare records across 13 prisons measuring achievement against the 30 indicators, from 2017 to 2020 (multi-level mixed effects logistic regression models)



High level influential factors

Chronic understaffing (Qual)



Laura Sheard, Sue Bellass, Kate McLintock, Robbie Foy and Krysia Canvin

Understanding the organisational influences on the quality of and access to primary care in English prisons:

a qualitative interview study

Abstract

Background
Primary care for routine healthcare conditions is delivered to thousands of people in the English prison estate every day but the prison environment presents unique challenges to the provision of high-quality health care. Little research has focused on the organisational factors that affect quality of and access to prison health care.

Aim
To understand key influences on the quality of primary care in prisons.

Design and setting
This was a qualitative interview study across the North of England from 2019 to 2021.

Method
Interviews were undertaken with 43 participants: 21 prison leavers and 22 prison healthcare professionals. Reflexive thematic analysis was undertaken.

Results
The overarching organisational issue influencing quality and access was that of chronic understaffing coupled with a workforce in flux and dependence on locum staff. This applied

INTRODUCTION

Primary care is delivered across a diverse range of settings in England including prisons, young offender institutions, secure mental health facilities, and immigration detention centres. Almost 80 000 people currently live in prisons across England and Wales[1] but high rates of reimprisonment lead to a throughput of 250 000 contacts with the prison service per year.[2] People in prison are more likely to have mental health or substance use problems, cognitive disability, communicable diseases, and long-term conditions than people who have never been incarcerated.[3] Delivery of high-quality health care in prisons is important in order to reduce health inequalities and to affirm society's commitment to social justice.[4]

The healthcare system in England, both inside and outside the prison gates, is under extreme pressure. However, the prison environment presents unique and difficult challenges for the delivery of care such as overcrowding, security concerns, a lack of

comprehensive range of services was almost at its ceiling'.[7]

A qualitative study found that long waits for health care were a knock-on effect of a lack of custodial staff who did not have capacity to unlock people from their cells in time for healthcare appointments.[8] Further, security concerns can disrupt access to treatment for people in prison and there is no equivalent comparison with health care delivered in the community.[9]

There is little research that focuses on the organisational factors influencing primary care in prisons and even less literature that pays attention to how these factors have an impact on quality and access. A notable exception are two papers by Ismail[8,10] that concentrate on macroeconomic conditions, governance structures, and the impact of austerity. Further, most prison healthcare studies tend to prioritise discrete areas of health such as communicable diseases, mental health, or drug treatment services to the exclusion of routine healthcare conditions

High variability in quality (Quant)

- Achievement of indicators low when compared to community care
- Improvement over time for:

Hep B & flu vaccine uptake

- Declined over time for:

antipsychotic medication monitoring

- No clear pattern of achievement by:

type of indicator; clinical domain; age, gender, ethnicity; prison category

- Length of stay associated with quality (longer stay = higher achievement)
- Variations cannot be attributed solely to prison population characteristics

The quality of prison primary care: cross-sectional cluster-level analyses of prison healthcare data in the North of England

Kate McLintock,[a] Robbie Foy,[a] Krysia Canvin,[b] Sue Bellass,[c] Philippa Hearty,[d] Nat Wright,[d] Marie Cunningham,[e] Nicola Seanor,[e] Laura Sheard,[f] and Tracey Farragher[g,*]

[a]Leeds Institute of Health Sciences (LIHS), University of Leeds, Level 10, Worsley Building, Clarendon Way, Leeds, LS2 9NL, UK
[b]School of Medicine, Keele University, David Weatherall Building, Staffordshire, ST5 5BG, UK
[c]Faculty of Science and Engineering, Institute of Sport, Manchester Metropolitan University, 99 Oxford Road, Manchester, M1 7EL, UK
[d]Spectrum Community Health CIC, Hebble Wharf, Wakefield, WF1 5RH, UK
[e]North of England Commissioning Support (NECS), John Snow House, Durham, DH1 3YG, UK
[f]Department of Health Sciences, University of York, Seebohm Rowntree Building, York, YO10 5DD, UK
[g]Division of Population Health, Health Services Research and Primary Care, University of Manchester, Room 2.544, Stopford Building, Oxford Road, Manchester, M13 9PT, UK

Summary

Background Prisoners have significant health needs, are relatively high users of healthcare, and often die prematurely. Strong primary care systems are associated with better population health outcomes. We investigated the quality of primary care delivered to prisoners.

Methods We assessed achievement against 30 quality indicators spanning different domains of care in 13 prisons in the North of England. We conducted repeated cross-sectional analyses of routinely recorded data from electronic health records over 2017–20. Multi-level mixed effects logistic regression models explored associations between indicator achievement and prison and prisoner characteristics.

Findings Achievement varied markedly between indicators, prisons and over time. Achieved processes of care ranged from 1% for annual epilepsy reviews to 94% for blood pressure checks in diabetes. Intermediate outcomes of care ranged from only 0.2% of people with epilepsy being seizure-free in the preceding year to 34% with diabetes having sufficient blood pressure control. Achievement improved over three years for 11 indicators and worsened for six, including declining antipsychotic monitoring and rising opioid prescribing. Achievement varied between prisons, e.g., 1.93-fold for gabapentinoid prescribing without coded neuropathic pain (odds ratio [OR] range 0.67–1.29) and 169-fold for dried blood spot testing (OR range 0.05–8.45). Shorter lengths of stay were frequently associated with lower achievement. Ethnicity was associated with some indicators achievement, although the associations differed (both positive and negative) with indicators.

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High variability in access (Qual)

- Access depends on patient being unlocked in time for appointment (escorted)…
- …which relates to Officer staffing levels and relationships with patients
- Healthcare staff sometimes had to persuade Officers of healthcare need of patients
- …particularly for outside transfer to A&E
- All the above related to an excessive DNA rate (15-30% primary care, 40% outpatient apt)

Prison-community interface (quant & qual)

- Continuity of medication issues +++
- Opioid prescribing carousel
- Incompatibility of IT systems
- Lack of urgency for medical records request

Facilitative relationships (Qual)

- Personalities and actions of individual healthcare professionals
- Prison leavers spoke about being treated with respect and dignity
- Some clinicians talked about how personally rewarding it was to work with patients in prison

Access, access, access….

- Funding applications:
- Mixed methods study about DNAs, targeting NIHR HS&DR

- Harkness fellowship, comparative study between US and UK

Qual-P acknowledgements and thanks

- Robbie Foy (Leeds)
- Sue Bellass (Man Met)
- Krysia Canvin (Keele)
- Kate McLintock (Leeds)
- Tracey Farragher (Manchester)
- Nat Wright (formerly Spectrum CIC)
- Pip Hearty (York & Spectrum CIC)
- Marie Cunningham & Nicola Seanor (NECSU)

Qual-P was funded by NIHR HS&DR (17/05/26). Standard disclaimer.

Project website: www.qual-p.org

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RESEARCH ARTICLE Open Access

Quality indicators and performance measures for prison healthcare: a scoping review

Sue Bellass[1*], Krysia Canvin[1], Kate McLintock[1], Nat Wright[2], Tracey Farragher[3], Robbie Foy[1] and Laura Sheard[4]

Abstract

Background: Internationally, people in prison should receive a standard of healthcare provision equivalent to people living in the community. Yet efforts to assess the quality of healthcare through the use of quality indicators or performance measures have been much more widely reported in the community than in the prison setting. This review aims to provide an overview of research undertaken to develop quality indicators suitable for prison healthcare.

Methods: An international scoping review of articles published in English was conducted between 2004 and 2021. Searches of six electronic databases (MEDLINE, CINAHL, Scopus, Embase, PsycInfo and Criminal Justice Abstracts) were supplemented with journal searches, author searches and forwards and backwards citation tracking.

Results: Twelve articles were included in the review, all of which were from the United States. Quality indicator selection processes varied in rigour, and there was no evidence of patient involvement in consultation activities. Selected indicators predominantly measured healthcare processes rather than health outcomes or healthcare structure. Difficulties identified in developing performance measures for the prison setting included resource constraints, data system functionality, and the comparability of the prison population to the non-incarcerated population.

Conclusions: Selecting performance measures for healthcare that are evidence-based, relevant to the population and feasible requires rigorous and transparent processes. Balanced sets of indicators for prison healthcare need to reflect prison population trends, be operable within data systems and be aligned with equivalence principles. More effort needs to be made to meaningfully engage people with lived experience in stakeholder consultations on