Editorials

Integrating primary care across the prison and community interface

INTRODUCTION

The prison population is commonly misconceived as static and distinct from patients served by community primary care.[1] In reality, given an annual throughput of over 250 000,[2] an average custodial sentence length of just under 20 months,[3] and high rates of recidivism,[4] the UK prison population is highly dynamic. Responsibility for the care of most patients, therefore, regularly passes between prison and community primary care practitioners.

Prison is a challenging environment in which to deliver high-quality primary care; one that has been further complicated by the current pandemic and concomitant reduction in face-to-face consultations. Even ordinarily, health care is severely affected by austerity measures,[5] and occurs within a secure environment that imposes unique constraints on delivery. For example, clinics must be synchronised with internal regimes, and patient attendance can be adversely affected by incidents on prison wings. Prescribers need to exercise caution when prescribing analgesic medicines, which may be diverted from therapeutic use to be traded in the illicit prison economy.[2] Although international standards embody the ethical imperative to provide equivalent health care,[6] community models of care provision cannot necessarily be applied to prison settings.[2]

Prison populations have complex and diverse needs. Social, economic, and environmental disadvantages confer a disproportionately high burden of illness on people in prison, with a significantly greater prevalence of blood-borne viruses, substance misuse, and mental health problems than in the general population.[7] A prevailing focus on these conditions may overshadow other health needs.

SHIFTING HEALTH NEEDS

The prison population is ageing. The proportion of over-50s has risen from 7% in 2002 to 17% in 2020,[8] heralding the increased prevalence of long-term conditions such as diabetes, heart disease, and respiratory illnesses.[9] Indeed, diseases of the circulatory system, the most common cause of death in the UK population, have replaced suicide as the principal cause of mortality in English and Welsh prisons.[10] There is a pressing need, then, to reconfigure prison healthcare services to optimally manage such conditions, particularly because security considerations often limit access to specialist care.[11]

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CONTINUITY OF HEALTH CARE

Continuity of health care before, during, and after custody has been identified as a core objective by an alliance of national health and justice agencies,[12] yet limitations on clinical data sharing have presented an obstacle to this goal. Prisons in England and Wales use SystmOne, whereas only around a third of community GP practices in England use this system, with over half using EMIS and around 10% using Vision.[13] The limited interoperability has been partly rectified with the introduction of a national system permitting the transfer of summary care records. Sharing of this dataset does not, however, obviate the need for *ad hoc* communication between prison and community staff, particularly regarding clinical indications for tradable medications. This can lead to delayed treatment with consequent risks to patient health. Improving the data interface, therefore, has the potential to positively impact on healthcare quality. In England, an initiative to connect the prison estate with the NHS Spine is laying the foundations for an eventual link with lifelong patient electronic records held by community GPs via the patient registration system (GMS1).

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PERFORMANCE MEASUREMENT

Responsibility for prison healthcare provision passed from the Home Office to the NHS in 2006. This facilitated the adoption of evidence-based clinical guidelines, National Service Frameworks, and clinical managerial leadership equivalent to (and theoretically comparable with) community primary care.

Limitations persist nevertheless. Commissioning processes in prison and community primary care differ: the Quality and Outcomes Framework (QOF) incentivises performance in the community, but the application of QOF tools in prisons is not similarly rewarded. Improved access to electronic healthcare records via the NHS Spine may pave the way towards a corresponding commissioning model for English prisons. Currently, use of the QOF relies on, and varies according to, clinical leadership in individual prisons. Typically, performance measurement takes the form of performance matrix returns based on the Health and Justice Indicators of Performance (HJIPs), which enable commissioners to assess whether health needs are being met. Although HJIPs have increased the transparency of prison healthcare delivery,[14] many are prison specific, enabling evaluation of performance across prisons but limiting comparability with community primary care.

RECOMMENDATIONS FOR POLICY AND PRACTICE

Improvements in prison health care have undoubtedly been made,[14] but more could be done. Given that most patients travel between prison and the community, attention must be paid to the community–prison interface to reduce the risk of fragmented care. For instance, community practitioners may have to arrange overdue

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specialist care, which was problematic for prison healthcare teams to coordinate because of imminent release. Equally, prison practitioners may have to reduce community-prescribed analgesic medicine to minimise the risk of diversion and misuse in the prison setting. Anecdotally, as prison GPs appropriately reduce such medication, patients may ask their community GP to restart it post-release. National Institute for Health and Care Excellence guidance on pain management, out for public consultation in 2020, may eventually support community prescribers in such challenging decisions.[15]

Effective continuity of care between prisons and the community for this largely transient population will be enhanced by the improved linkage of electronic healthcare records in England. NHS England and NHS Improvement have commissioned development of the Health and Justice Information Services to permit linkage of patient records for individuals transferred between prison and community NHS services. The new system will also allow patients to register with a GP from the Justice healthcare team for continuity of care.[16] This innovation is currently being rolled out and will facilitate community–prison data linkage of QOF templates for individual patients, potentially harmonising standards in long-term condition management across the community–prison interface.

Sustainable changes in care for people with complex health needs moving between prison and the community take time. Identifying improvements necessitates appropriate measurement and comparative analysis. Effective measures that are transferable between settings must be robust, evidence based, and relevant to the health needs of the prison population. Identifying variations in the quality of prison primary care can point towards appropriate quality improvement initiatives.

CONCLUSION

Imprisonment is both a consequence and determinant of poor health. Nevertheless, prison presents a unique opportunity to reduce health inequalities in underserved populations through addressing complex health needs and modifying risk factors for long-term conditions.[1] For vulnerable populations moving between community and prison settings, continuity of care has the potential to optimise care and reduce harms. Refining performance measurement will provide evidence for subsequent improvements. Future developments require collaboration between stakeholders such as commissioners, healthcare providers, security providers, and people with lived experience. Representation of such groups in the key decision-making and funding forums will help realise health gains for this vulnerable population.

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