



Health Services Safety
Investigations Body

Investigation report

Healthcare provision in prisons: continuity of care

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Emergency care, Communication and decision making, Continuity of care

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A note of acknowledgement

We would like to thank the patients and healthcare and prison staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

About this report

This report is intended for healthcare and justice organisations, policymakers and the public to help improve patient safety in relation to continuity of care for patients detained in prison.

Executive summary

Background

This investigation focuses on the continuity of care for patients in prison. In the context of this investigation, 'continuity of care' means maintaining a patient's healthcare throughout the prison system regardless of their location. The investigation considered the movement of patients between prisons, to and from court, and on release. It also looked at patient attendance at appointments for:

- internal primary care services (for example, GP or dental clinics provided within the prison by prison healthcare teams)
- secondary care outpatient appointments (appointments that take place outside the prison, for example consultations at specialist units at a local hospital).

The investigation explored how prisons manage these appointments to try to ensure that patients are not disadvantaged by being in prison.

This is the second of a series of reports on the theme of healthcare provision in prison. The first report explored [emergency care response](#) and further reports will explore data sharing and IT, and common themes found across all areas of healthcare provision in prisons.

These investigations were launched after discussions with 26 national organisations across the healthcare and justice systems, through which HSSIB gained knowledge of their concerns about healthcare in prisons.

Through a patient engagement group, HSSIB engaged with over 120 patients and people being detained to understand their experiences of receiving primary and secondary healthcare in prison. The investigation also engaged with stakeholders from across the prison healthcare system to gather evidence about primary and secondary patient care from their perspectives.

Findings

- 'Did not attend' (DNA) rates for outpatient appointments for patients in prison during 2024 were high, at 43% and 48% for males and females respectively. This compares to a DNA rate in the general population of 26% for both sexes.
- Female prison patients are often taken to outpatient appointments by male prison officers or a mix of male and female officers. This can affect the patients' decision making about whether to go or not, particularly for appointments that are for sensitive female clinics such as obstetrics and gynaecology.
- The use of telemedicine in prison healthcare has declined since the end of the COVID-19 pandemic and it is used rarely in comparison to face-to-face appointments. Telemedicine has the potential to reduce the burden of prison officer escort duties for outpatient appointments (which costs £48m to £50m per year), increase the number of outpatient appointments available per day to patients in prison, and reduce the number of appointments that patients refuse to go to.
- Patients in prison may not attend pre-arranged appointments because of a lack of information about the appointment caused by privacy and security issues. For example, they may not be informed about timings, the nature of the appointment, or the health reasons and importance of attending. This means they are not able to make an informed decision about their health and whether they want to attend or not.
- Patients in prison are more likely to miss outpatient appointments than patients in the community, due to the prison regime and logistics beyond the control of the patient. For example patients may be locked down in their cells, transport may not arrive or there may not be enough staff available to escort them to the appointment. This can have an impact on their long-term health.
- Prison healthcare departments rely on relationships they have developed and maintained with hospital booking teams in order to arrange appointments that fit in with the prison regime. This is due to a lack of formal arrangements between prisons and their local hospitals.
- Patients who are released following a court appearance, who had treatment planned, are not routinely given information about upcoming appointments they may have. This means they may unknowingly miss booked appointments, delaying their care and treatment.
- There is significant variability in the number of prison staff available to escort patients to outpatient appointments. This impacts on the number of appointments which can be booked, and some may be cancelled due to lack of prison staff.
- There is a misconception among healthcare teams and patients in prisons, that patients lose their place on a hospital waiting list when they are transferred to a prison in a different area. This is not the case as long as the receiving hospital is notified of the transfer.

- Details about patients who are being transferred to different areas are not always communicated effectively between prison healthcare teams and hospital booking teams. Often hospital booking teams are not made aware that a patient has been transferred until an appointment is missed, which means treatment is delayed.

HSSIB makes the following safety recommendations

Safety recommendation R/2024/044:

HSSIB recommends that HM Prison and Probation Service updates Prison Service Order 3050, 'Continuity of healthcare for prisoners', including guidance on communication of information about prison patients when transferring between prisons, and on the process when prison patients are released from court. This will reduce variation and ensure better continuity of care for patients when being transferred or on their release.

Safety recommendation R/2024/045:

HSSIB recommends that HM Prison and Probation Service standardises the approach to the provision of prison officer escorts for outpatient appointments to protect the dignity of patients and reduce variability of escort slots. This will assist in reducing the likelihood of patients refusing to attend healthcare appointments, while balancing appointment availability, thus improving the continuity and equality of care.

Safety recommendation R/2024/046:

HSSIB recommends that NHS England, via regional commissioning teams, works with HM Prison and Probation Service to identify barriers to using telemedicine for outpatient appointments, and then implements local solutions to promote and enhance the capability and usability of telemedicine. This aims to reduce the burden on prisons of providing escorts and the likelihood of patients not attending appointments.

HSSIB makes the following safety observations

Safety observation O/2024/048:

Prison healthcare departments and operational staff in prisons can improve patient safety by working together to develop internal policies in relation to clinical holds, to include a requirement for communication with any receiving healthcare team about a patient's health needs. This is to ensure patients' healthcare needs are met and that their treatment is not delayed due to the transfer.

Safety observation O/2024/049:

Prison healthcare departments can improve patient safety by increasing awareness and education for prisoners in terms of health, hygiene and the importance of engaging in their own healthcare. This will help patients to make informed decisions about whether to attend appointments and the impact on their health if they do not.

Safety observation O/2024/050:

Prison officers can improve patient safety by encouraging patients to engage with the healthcare team to discuss the reasons why they do not want to attend appointments. This will help to increase the appointment attendance rate.

Safety observation O/2024/051:

Prisons and NHS trusts can improve patient safety by working together to ensure outpatient escort availability and the timing of hospital appointments is aligned to fit with the prisons' and the trusts' regimes. This will reduce the administrative burden and the number of appointments being made and cancelled because of different regimes.

1. Background and context

1.1 Introduction

1.1.1 This investigation focuses on the continuity of care for patients in prison. In the context of this investigation, this means how care for a patient is maintained during their time within the prison system, regardless of where they are. The investigation considered the movement of patients between prisons, to and from court, and on release. It also looked at patients'

attendance at appointments, for both internal primary care services and secondary care outpatient appointments (see 1.4.8 to 1.4.9), and how these are managed to try to ensure that patients are not disadvantaged by being in prison.

1.2 Ministry of Justice

1.2.1 The Ministry of Justice is the government department responsible for the justice system.

1.2.2 The justice system includes:

- courts
- prisons
- probation services
- attendance centres (Ministry of Justice, n.d.a).

1.2.3 There are over 100 prisons and 300 courts within the justice system in England and Wales (Ministry of Justice, n.d.a).

1.3 HM Prison and Probation Service

1.3.1 HM Prison and Probation Service (HMPPS) is an executive agency sponsored by the Ministry of Justice. It works with partner organisations to enable the sentences of the courts to be carried out, either in custody or the community.

1.3.2 Within England and Wales, HMPPS is responsible for:

- running prison and probation services
- rehabilitation services for ex-offenders leaving prison
- making sure support is available to stop people re-offending
- managing contracts for private sector prisons and services such as the Prisoner Escort and Custody Service and electronic tagging.

1.3.3 Through HM Prison Service it manages public sector prisons and the contracts for private prisons in England and Wales.

1.3.4 The Probation Service is a statutory criminal justice service that supervises offenders serving community sentences or released into the community from prison in England and Wales. The Probation Service is part of HM Prison and Probation Service, itself an Executive Agency of the Ministry of Justice.

Prison categories

1.3.5 Prisons are categorised according to the risks associated with the prisoners that they hold. There are four categories of prison for male prisoners:

- 'Category A
These are high-security prisons. They house male prisoners who, if they were to escape, pose the most threat to the public, the police or national security.
- Category B
These prisons are either local or training prisons. Local prisons house prisoners that are taken directly from court in the local area (sentenced or on remand), and training prisons hold long-term and high-security prisoners.
- Category C
These prisons are training and resettlement prisons; most prisoners are located in a category C. They provide prisoners with the opportunity to develop their own skills so they can find work and resettle back into the community on release.
- Category D – open prisons
These prisons have minimal security and allow eligible prisoners to spend most of their day away from the prison on licence to carry out work, education or for other resettlement purposes.' (Ministry of Justice, n.d.b)

1.3.6 There are two categories of prison for female prisoners: open or closed. High-risk female prisoners are classed as 'restricted status' and are housed in closed prisons. (Ministry of Justice, n.d.b)

1.4 Prison healthcare

Equivalent care

1.4.1 The House of Commons Health and Social Care Committee report on prison health states that:

'Prison health and care services should be delivering standards of care, and health outcomes, for prisoners that are at least equivalent to that of the general population.' (House of Commons Health and Social Care Committee, 2018)

1.4.2 The report recommended that the National Prison Healthcare Board (NPHB) defined what was meant by 'equivalent' care. The NPHB's response and definition reads:

"Equivalence' is the principle which informs the decisions of the National Prison Healthcare Board so that member agencies' statutory and strategic objectives and responsibilities to arrange services are met, with the aim of ensuring that people detained in prisons in England are afforded provision of and access to appropriate services or treatment (based on assessed

population need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community, in order to achieve equitable health outcomes and to reduce health inequalities between people in prison and in the wider community.’ (National Prison Healthcare Board, 2019)

Prison healthcare commissioning

1.4.3 In 2012 the Health and Social Care Act directed that healthcare services should be commissioned by NHS England. This responsibility was transferred to NHS England in 2013. NHS England commissions services through specialist regional teams.

1.4.4 NHS England health and justice commissioning teams use the principle of equivalence when commissioning healthcare in prisons. This means that people who are detained by the justice system should receive an equivalent level of health service to the rest of the population.

1.4.5 NHS England is also responsible for quality assurance within the commissioned services, which aims to ensure services meet their contractual obligations and deliver services to the required standards.

Prison healthcare departments

1.4.6 Each prison has a healthcare department that provides medical services to patients within the prison.

1.4.7 Healthcare departments provide different levels of cover depending on the commissioning requirements of the prison and the population. Most departments are nurse-led with GP-run clinics. Some departments provide 24/7 care, while others only provide daytime cover and some having no cover at weekends.

Internal appointments

1.4.8 Internal appointments are those that take place at any clinic that is run within the confines of the prison. The healthcare departments provide numerous services including:

- GPs
- opticians
- dental services
- substance misuse services
- maternity services
- physiotherapy.

Outpatient appointments

1.4.9 In the context of this report, outpatient appointments are those that are conducted by a secondary healthcare provider. They may require the patient to leave the prison and visit an external healthcare provider or they can be conducted via telemedicine services (see 1.5). Specialities that are delivered by secondary healthcare providers may include services such as:

- cancer treatment
- surgery
- X-ray.

Clinical hold

1.4.10 The term 'clinical hold' refers to the practice of retaining a patient in their current prison on the basis of their medical condition. This may mean that the patient is receiving treatment, waiting for treatment or waiting for tests to confirm or rule out a diagnosis.

1.5 Telemedicine

1.5.1 The term 'telemedicine' refers to:

'... the use of information technology in the diagnosis and treatment of patients. It includes telephone conversations between physicians or between physicians and patients; tele- or videoconferencing.' (Martin, 2015)

1.5.2 In prison healthcare, telemedicine may be used for both internal appointments and outpatient appointments, depending on the clinic and the facilities within the prison.

2. Analysis and findings

This section describes the investigation's findings in relation to the continuity of care delivery within prisons. The findings are grouped within themes according to the key stages of patient care and continuity of care processes, as identified by the investigation's analysis of the evidence. The themes are as follows:

- hospital waiting lists and clinical holds
- missed medical appointments
- prison escorts to outpatient appointments
- telemedicine.

The analysis and findings show a system that does not support an engaged healthcare system where patients are involved, informed and keen to attend appointments.

The decreasing rates of attendance for internal appointments, the lack of patients' engagement in their own healthcare, and an easy acceptance of refusal to attend by patients and staff, led to non-attendance being normalised. Patients did not consider whether healthcare appointments were internal or external; it was a healthcare appointment that did not sit high in their priorities list.

The impact of this was felt through the entire prison healthcare system and continued to hospitals, where patients from prison not attending appointments increased hospital 'did not attend' (DNA) rates. Hospitals were trying to reduce DNA rates as their waiting lists increased, but efficiency was not helped by DNAs by patients from prisons that were out of hospitals' control.

2.1 Hospital waiting lists and clinical holds

Waiting lists

2.1.1 Patients in prison may be moved to other prisons in a different area of the country for various reasons, including:

- a change in the security category of the prisoner, which means they are moved to a higher or lower category prison
- being moved from a 'category B' reception prison to a training or resettlement prison after being sentenced
- security reasons
- for the prisoner's own safety
- at the request of the prisoner.

2.1.2 When patients in prison are moved, their medical treatment requirements are moved with them and their medical details are shared between the prisons' healthcare departments.

2.1.3 The investigation was told by prison healthcare staff that when patients who were on waiting lists for treatments or tests were transferred to a prison in a different area, there was no way for them to maintain their position on a hospital waiting list. For example, the investigation heard about a prisoner who needed to be moved every 3 months for security reasons, which meant they would never get to the top of a waiting list and would therefore never get the tests and potentially the treatment they needed. The prisoners who spoke with the investigation had a similar perception of the system for transferring patients on waiting lists around the country.

‘Some of the prisoners stated that they felt that prisoners who have been waiting on waiting lists for a long period of time were concerned that they would have to start again when they move prisons. They did not know the process as they perceived waiting times to be long anyway, so did not know where they stood regarding this matter. There was the perception that prisoners start again when transferring [between] establishments.’ (ABL Health, 2024)

2.1.4 Staff working in appointment booking teams at NHS trusts that provide a service to prisons stated that there was a system for transferring patients around the country that accounted for the amount of time they had been on waiting lists. The system was based on the initial referral date as this was when the patient would have been placed on the waiting list, rather than on their position in the list. This approach ensured that they received a locally appropriate position on the list when they were transferred. One member of staff told the investigation that “nobody’s penalised from moving from one place to another”.

2.1.5 All hospitals used a form to send a patient’s details to their new treating hospital, ensuring that their position on the waiting list was not lost. The form was called an ‘inter-provider transfer’ form (see figure 1). While this practice was common knowledge within the hospital booking teams the investigation spoke with, it was not well known outside of them, particularly in the prison healthcare teams or among patients themselves.

Figure 1 Inter-provider transfer form

Clinical Referral Minimum Data Set - IPT

Transferring a Patient to Another Trust (Interprovider Trust)

Receiving Organisation Details

Organisation Name	
Organisation Code	
Clinician Name	
Clinician Specialty	
Treatment Function Code	

Referring Organisation Details

Organisation Code	
Clinician Name	
Clinician Specialty	
Treatment Function Code	

Receiving Organisation Contact Details

Contact Name	
Contact Email	
Contact Phone Number	

Patient GP Details

GP Name	
GP Surgery	

Referral To Treatment Information

This referral is for: Please select

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Hospital booking teams told the investigation that communication between themselves and prison healthcare departments was often an issue. There was often a delay in the hospital booking teams finding out that a patient had been moved to a different prison. This could cause a delay in care if they were near the top of the waiting list, or meant they could miss their appointment because of the transfer, causing delays in diagnosis and treatment. Hospitals had to either transfer the patient to their new hospital or discharge them once an appointment was missed.

2.1.6 In addition, the bookings teams did not have a forwarding address for the patient once they had been transferred, another factor which could cause delays in a patient's care. The issue of communication between healthcare admin staff and acute trust booking teams is also covered in 2.2.22.

Clinical holds

2.1.7 Prison Service Order (PSO) 3050, 'Continuity of healthcare for prisoners', states:

'Patients may sometimes need to be placed on 'clinical hold' (i.e. withheld from transfer for a period of time for clinical reasons when indicated). This system will require local audit through clinical governance arrangements to ensure that;

- Clinical risk is managed
- The operational running of the prison is not adversely affected by excessive numbers of clinical holds.

'For instance, it will almost never be appropriate to transfer a patient awaiting urgent cancer referral. However, where prison population turnover is high, as in local prisons, it may only be possible to hold those patients with clinically urgent appointments. Training prisons may be able to hold more patients awaiting outpatient appointments.

'Patients may sometimes be transferred after having waited a considerable time for hospital treatment. In these circumstances details of the wait should be included in the referral letter from the new establishment to determine whether this may be taken into account at the new hospital. Clinicians should attempt to reach agreement that the waiting time will not be reset when the patient is transferred to a new list. In exceptional circumstances, prisoners may need to be transferred for security reasons and these may take priority.' (HM Prison and Probation Service, 2006)

2.1.8 The investigation observed during visits, and was told by staff, that individual prison stances on clinical hold varied. Many of the prison healthcare staff stated that they were not allowed to keep patients at the prison on a clinical hold, while others described a more collaborative system with the operational side of the prison, where they could keep the patients as long as they could justify it.

2.1.9 A common justification for a clinical hold was that a patient was waiting for a cancer diagnosis or was receiving treatment. However, staff from some prisons said that they had received patients who they 'wouldn't have transferred' because they were undergoing or awaiting such treatment. The variation in standards for clinical hold had caused frustration within some healthcare departments, as they felt that were being held to a different set of rules.

2.1.10 Clinical holds were a particular concern for category B local prisons (see 1.3.5). Because of their high turnover of prisoners, they regularly had patients who the healthcare teams felt should be held while they waited for appointments, but they were under the most pressure, from the operational side of the prison, not to have clinical holds. Staff stated that the pressure on the prison system to make space for remand prisoners was affecting the ability of staff to make best treatment decisions.

2.1.11 The investigation was told that healthcare facilities differed between prisons and this affected their ability to provide the required level of care for some conditions. Therefore, the healthcare department within a prison might try to reject the transfer of a particular prisoner into their prison on the basis that they did not have the facilities necessary to manage their healthcare needs. One healthcare team told the investigation that they had on occasion been overruled (that is, a clinical hold at the transferring prison had been refused) by the operational side of the prison and a transfer into the prison had to take place. They explained that this caused challenges for the healthcare team as they had to provide a level of care they were not set up for.

HSSIB makes the following safety observation

Safety observation O/2024/048:

Prison healthcare departments and operational staff in prisons can improve patient safety by working together to develop internal policies in relation to clinical holds, to include a requirement for communication with any receiving healthcare team about a patient's health needs. This is to ensure patients' healthcare needs are met and that their treatment is not delayed due to the transfer.

2.2 Missed medical appointments

Internal prison primary care appointments

2.2.1 Patients who have medical appointments at primary care clinics (for example to see a GP) that are delivered within the prison, may be taken to the healthcare department during the main moves that are carried out as part of the prison regime (when prisoners are escorted around the prison to places of work, education or other activities). Some prisons do allow unsupervised movement or have supervised 'free-flow' (where prisoners move without specific escorts). The patient waits for their appointment in a waiting room, and after the appointment they wait again until the next set of moves. This is due to the requirement to escort prisoners from location to location within the prison estate, and because prisons are unable to facilitate the escort of individual patients around the prison estate for each appointment.

2.2.2 As there are no external security risks, information about the appointment could be made available to the patient so they know when the appointment is and what it is for. However, the investigation heard from healthcare staff and patients that appointment information slips (paper slips delivered to the patient to tell them they have an appointment) were not always delivered in time for the appointment or with sufficient information on them for the patient to know what the appointment was for. In addition, the investigation heard that some patients were being taken to work instead of to the healthcare department for their appointment. Some healthcare staff told the investigation that some patients may be recorded as not attending, but when this was discussed with the patient they explained that no one had come to collect them for their appointment.

‘The main reasons are for not attending appointments, the main issue was around not receiving a notification that they had an appointment. Many [patients] stated that they receive their appointment slip after the date of their appointment, and they believed that they are then put down as not attending.’ (ABL Health, 2024)

2.2.3 As with patients in the community, in prisons there can be wait times of a couple of weeks for GP appointments. However, the investigation heard that in most cases the wait for GP appointments was shorter in prison than in the community. There was a lack of awareness among patients in prison that while the wait times were sometimes in line with the community, in many cases wait times were shorter in comparison.

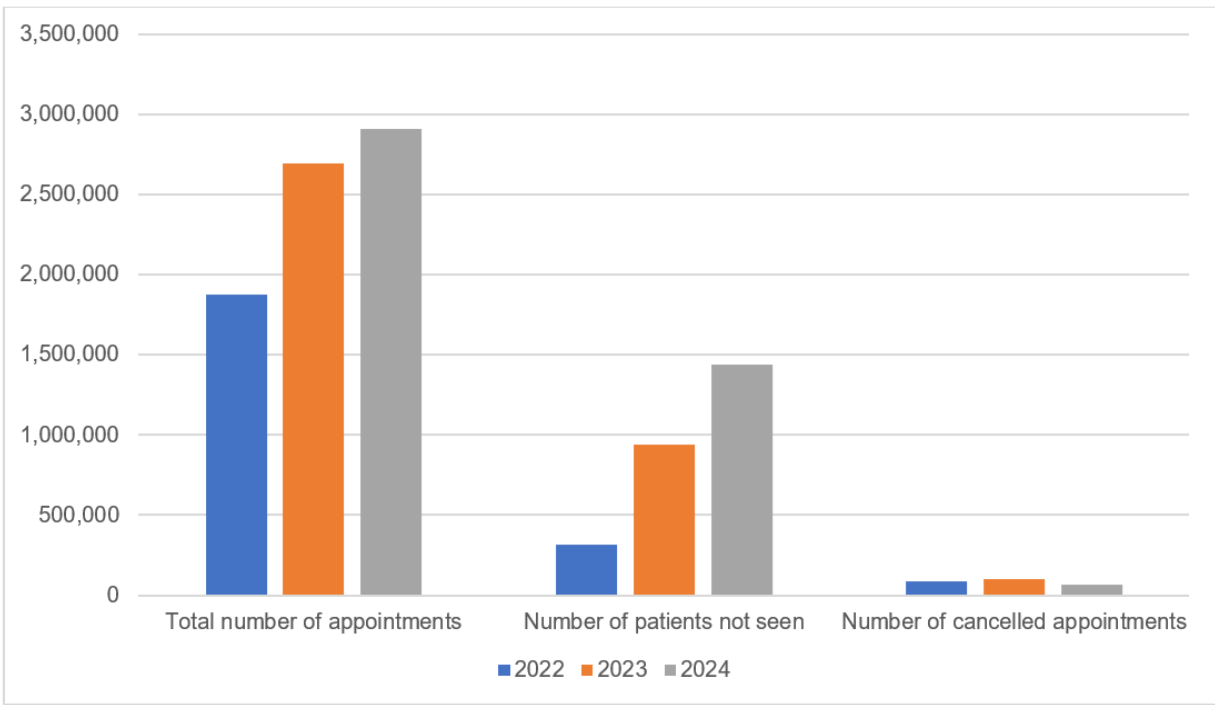
‘Waiting times can be longer than anticipated and thus when they [patients] receive an appointment slip, they cannot recall why they requested the appointment and therefore they may choose [not] to go as they are not informed what the appointment is about.’ (ABL Health, 2024)

2.2.4 The investigation found that there was wide variation in attendance rates for clinics depending on the nature of the clinic, and also large differences in attendance rates between the male and female populations. In data supplied by two of the male prisons visited, clinics that dealt with substance misuse or addiction were very well attended with rates above 90% and often at 100%. By contrast, monthly attendance rates for other clinics, such as podiatry, dropped as low as 27%, with an average attendance rate of approximately 64% across a 4-month period. The investigation was told by patients and healthcare staff that patient awareness and health education may be a factor in non-attendance at some clinics.

2.2.5 In female prisons attendance rates and general interaction with healthcare were significantly higher. In one of the female prisons visited, the overall attendance rate for all internal clinic appointments was 94% to 97% over a 6-month period, with every female prison telling the investigation that they had good engagement with and attendance from their patients.

2.2.6 National data, supplied to the investigation by NHS England, showed that across all prisons, attendance at internal clinic appointments was not as high as was indicated by the data provided by the prisons visited by the investigation. Across five different clinic types (GP, dental, mental health, nurse, and substance misuse), the national data shows a sharp increase in the number of patients not being seen after appointments had been booked. Figure 2 shows the rise in the number of patients not being seen.

Figure 2 Patient attendance at prison primary care appointments



2.2.7 While there was an increase in the total number of appointments being booked by healthcare departments from 2022 to 2024, the percentage of those appointments that resulted in a patient not being seen rose sharply from 16.7% in 2022 to 49.4% in 2024. The investigation was told that there were several reasons that contributed to patients not being seen, which included:

Patient refusal:

- prioritisation of visits, gym or social time with peers
- not wanting to potentially spend hours in an uncomfortable waiting area, with no facilities to occupy the patients (books, magazines, TV, radio).

- forgetting why they had the appointment
- dismissing the health concern
- the initial concern had gone, such as colds and sore throats- patients not being escorted to the healthcare department.

Patients not being escorted to the healthcare department:

- restricted to their cells due to operational reasons (such as, the prisoner count being wrong or an incident on the wings)
- taken to place of work
- appointment slips not delivered in time
- no officers available to escort the patient.

2.2.8 Healthcare staff told the investigation that patient engagement in their own health decisions could be low. Education and awareness of the risks played a part in the decisions that were being made by the patients. One prison had started to send healthcare staff to speak to the patient if they refused an appointment. Healthcare staff would explain to the patient the importance of attending and the effect that refusing treatment could have on their health and wellbeing. The staff told the investigation that engagement had increased and they had seen a drop in their non-attendance rates.

‘Some of these prisoners would not attend appointments mainly because they do not have as much awareness, education or knowledge about the importance of looking after themselves and therefore if they receive an appointment for a health service, they might not attend and do other things instead such as hang out with their peers, or attend the gym, work or just stay in their cells.’ (ABL Health, 2024)

2.2.9 Where healthcare department appointment slips were used, the investigation was told that these were often delivered to patients late, or did not contain any information about what the appointment was for. In many of the prisons visited by the investigation, appointment slips were delivered by fellow prisoners. This meant that medical information was not included on the slip to avoid breaking medical confidentiality, adding a further complication to the routes of communication between the healthcare department and patients. Healthcare staff who had worked in other prisons stated that the same system had been used, and had caused the same issues, in those prisons. The investigation did not hear about the same issues within prisons that used an electronic booking system for the patients.

2.2.10 The investigation heard that there was variation in the amount of encouragement prison officers gave to patients to attend appointments. This was likely affected by the officers not knowing about the nature and importance of the appointments because of medical confidentiality. However, all healthcare appointments should be treated with the same degree of importance. Healthcare staff are the only people in a position to discuss specific treatments or tests the patient needs.

HSSIB makes the following safety observations

Safety observation O/2024/049:

Prison healthcare departments can improve patient safety by increasing awareness and education for prisoners in terms of health, hygiene and the importance of engaging in their own healthcare. This will help patients to make informed decisions about whether to attend appointments and the impact on their health if they do not.

Safety observation O/2024/050:

Prison officers can improve patient safety by encouraging patients to engage with the healthcare team to discuss the reasons why they do not want to attend appointments. This will help to increase the appointment attendance rate.

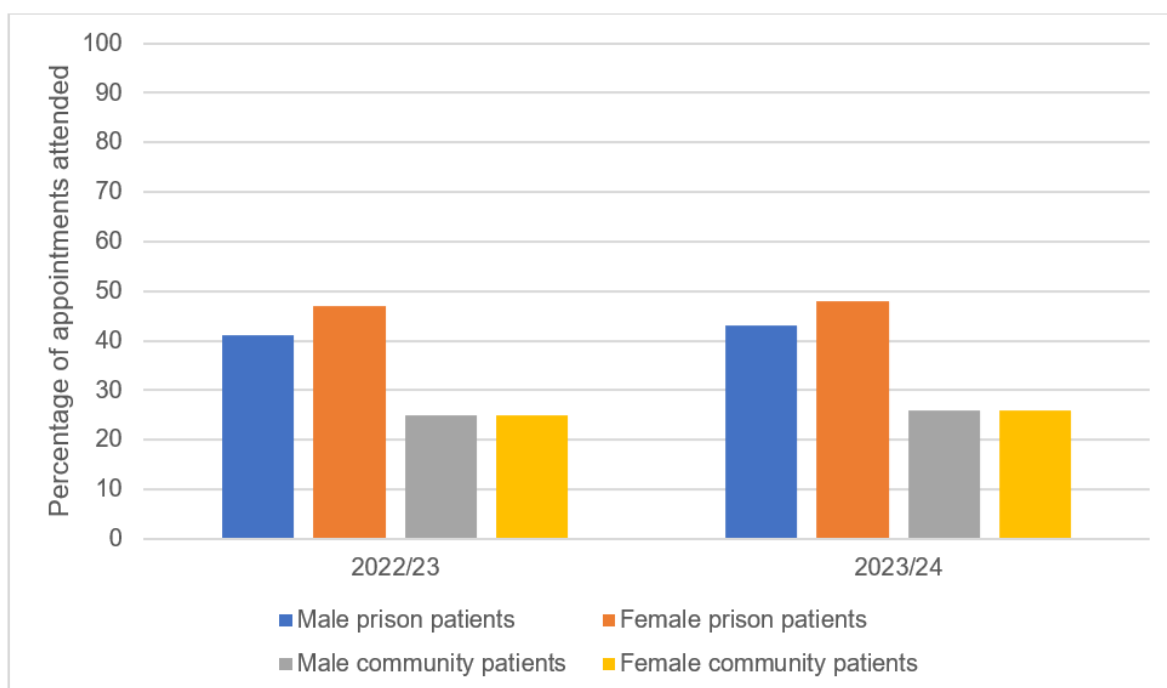
Outpatient appointments

Attendance rates

2.2.11 The investigation found large differences in attendance rates for outpatient appointments (see 1.4.9) between patients in the community and patients in prison. The investigation received attendance data from prisons it had visited, as well as national data (supplied by NHS England) that showed attendance rates from all prisons across the country.

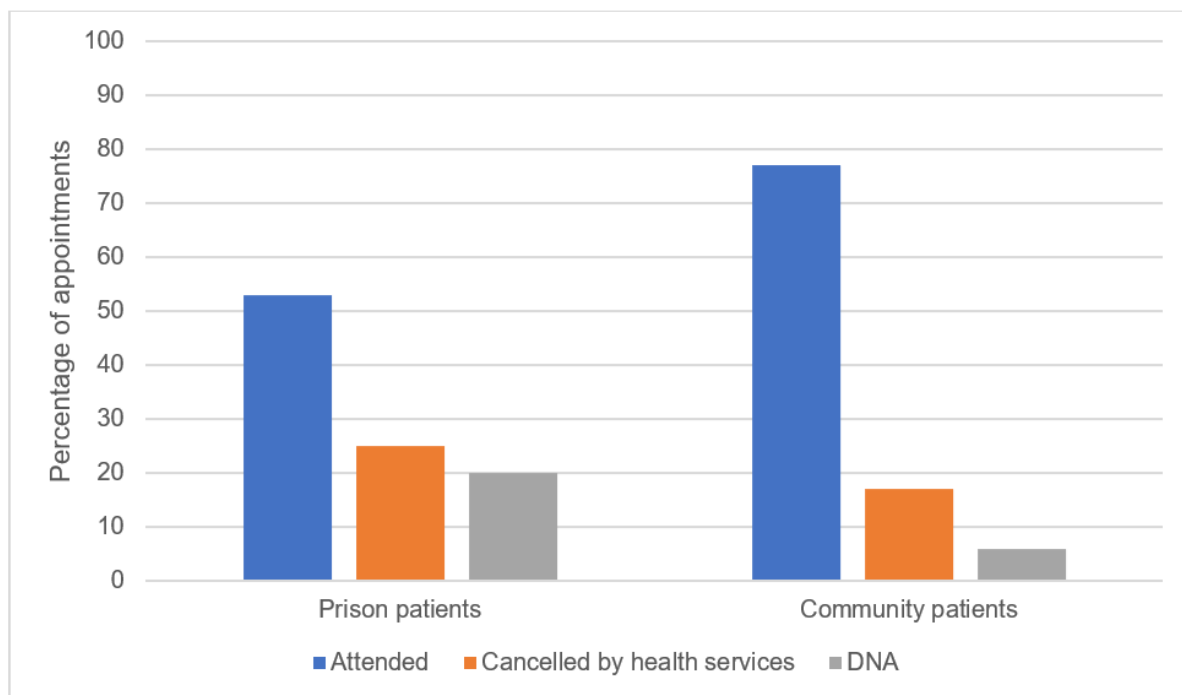
2.2.12 Figure 3 shows non-attendance rates in 2023/24 of 26% for both males and females in the community, in contrast with 43% for male and 48% for female patients in prison (see 2.2.18). It shows consistency in attendance rates, which remained at similar levels for the last 2 years for both groups of patients. While the attendance rates for patients in prison were considerably lower than for community patients, the impact on the health service was not as large as this may indicate. Nationally there were almost 7 million DNAs for outpatient appointments, with patients from prison contributing 13,000 to that figure.

Figure 3 Outpatient appointment non-attendance rates



2.2.13 Across the male and female patients in prison, 25% of appointments that were not attended were cancelled by either the prison (see 2.2.14) or by the hospital. However, 20% of the appointments were not attended because the patient refused to attend. In the community the number of patients that did not attend was markedly lower at 6%, and the percentage of cancellations by healthcare services was also lower at 17%. These figures have remained consistent for outpatient appointments for many years, with the Nuffield Trust reporting almost identical figures for 2019/20 in their report 'Injustice? Towards a better understanding of health care access challenges for prisoners' (Nuffield Trust, 2021). Figure 4 shows the comparison between prison patients and patients in the community in 2023/24.

Figure 4 Overview of outpatient appointment attendance/cancellation for prison and community patients, 2023/24



Prison impact on patient attendance

2.2.14 The higher health services cancellation rate within prisons was mainly caused by appointments being cancelled by the prison healthcare department. The investigation was told that there were various reasons why the healthcare department would cancel appointments, which included:

- the prison regime clashing with the appointment – particularly the appointment time given by the hospital being outside of the prison officers' escort availability hours
- the patient could not be located as they may be in a different location such as, a visit, court or at the workshop
- taxi/transport not turning up on time or being unsuitable
- the prisoners being restricted to their cells.

2.2.15 At one prison the investigation observed two wheelchair users who had been waiting for taxis to take them and their prison officer escorts to hospital, and who had had to cancel their appointments because the taxis were not wheelchair adapted. The healthcare staff said that they often had to cancel appointments because the transport either arrived late or was not suitable for the patients.

2.2.16 As with internal appointments, patients and healthcare staff described a lack of notice prior to patients being collected and taken for their outpatient appointments. Patients told the investigation that they were afforded little time to prepare themselves for the appointment and

were given limited information about the appointment they were being taken for. Patients reported that the lack of communication meant they often forgot that they had been referred to an outpatient clinic and this would affect their decision making about attending the appointment.

2.2.17 Healthcare staff reported the same concerns about individuals' level of awareness about their health and engagement with healthcare, and how this affected their decisions about attending clinical appointments.

2.2.18 While female patients were more engaged with healthcare for clinics within the prison, this was not the case for outpatient appointments. The DNA rate for female outpatient appointments was higher than for the males. The investigation found this was largely attributable to patient dignity issues (see 2.3.6). Healthcare staff described a reluctance among some patients to attend outpatient appointments which did not exist for internal clinics.

Informed consent

2.2.19 Patients must consent to treatment and this 'must be voluntary, informed, and the person consenting must have the capacity to make the decision' (NHS, 2022). Informed consent means:

'... the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.' (NHS, 2022)

2.2.20 The investigation found that patients were being asked to go to their medical appointments and they were refusing, prioritising other activities or simply not wishing to attend. When this happened, in most cases, the patient had to sign a disclaimer that stated that they took responsibility for not attending their appointment. However, as stated previously, little information was given to the patient, and the prison officers collecting the patient were not aware of the nature of the appointment or the seriousness of the condition/appointment.

2.2.21 Other than in one prison, the investigation did not see or hear about a system where patient refusals were made with informed consent. Most patients were making decisions with very little information, particularly about 'what will happen if treatment does not go ahead'. If they were informed then they may choose to prioritise healthcare appointments over their other activities.

‘Prisoners stated that the main reasons [for not attending appointments] is likely to be the clashing with work commitments and family ‘release on temporary leave’ (ROTL) that they would always choose over appointments.’ (ABL Health, 2024)

Appointment rebooking

2.2.22 Prison healthcare admin teams told the investigation that they co-ordinate appointments for patients. If an appointment was missed and they were made aware in time they would advise the hospital. However, they often did not find out until afterwards. In this case they would speak to the hospital and try to rebook the appointment.

2.2.23 The admin teams generally described having good relationships with the hospital booking teams or the medical secretaries. This was important when it came to rebooking appointments as they felt they had a good understanding.

2.2.24 Healthcare staff described varying levels of understanding at hospitals when appointments were missed for reasons that were out of the patient’s control, such as a taxi being unable to collect them. Some hospitals were empathetic to the situation; however, they were aware of the regularity of the appointments being missed because the patient refused to go.

2.2.25 The investigation was told that patients were generally held to the three-strike rule for non-attendance of appointments (if they missed three appointments they were discharged back to their GP), regardless of whether this was in their control or not. There were occasions when patients were discharged back to their GP after one DNA, but this was not the normal process.

2.2.26 There were no formal agreements between prisons and their local hospitals about rebooking patients who had missed appointments. The rebooking of patients who had missed appointments was reliant on the relationships between the admin staff at the prison and the staff they dealt with at the hospitals.

Release from prison

2.2.27 HM Prison and Probation Service (HMPPS) and NHS England have worked together to ensure that continuity of care for patients who are being released from prison is maintained. The GP2GP service is part of the Spine (the shared NHS IT infrastructure) and was launched with the aim making it easy for medical records to be passed from one GP practice to another when a patient moves. Two of the stated benefits of the service are:

- ‘full electronic health records available for the patient’s first and subsequent consultations, which improves continuity of care for ongoing medical conditions

- no need for patients to provide a detailed account of their previous medical history to their new clinician, as the integrated electronic health record is visible'. (NHS Digital, 2024)

2.2.28 To prepare for a prisoner's planned release from prison, the investigation found that there was generally good co-ordination between services.

The prisoners said they were aware that Substance Misuse Services had supported those due for release in many aspects including referral to onward services. The prisoners said that they thought it would be helpful if in the 6 weeks before release the Health Care Teams (drug and alcohol, MH [mental health], Clinical) could hold a forum with all those who were due for release to explain the processes, how to register, what information would be passed to their GP in terms of forward care and how to access services such as the physio, optician etc.' (ABL Health, 2024)

Healthcare and prison staff described meetings of organisations to discuss the patient and their needs. At these meetings the specific services the patient may need, such as substance misuse services or mental health services, were discussed and local arrangements were made to continue their treatment after release. However, patients described not knowing the processes or what was happening as they were not always involved in the meetings.

2.2.29 A national organisation stated that this system did not always work well and that there were times when people were released and the relevant community services were not aware of their needs. The investigation was informed that this generally occurred when people were released from prisons that were not in their resettlement area, meaning that the services they had received in prison that would be local to the person after release, were not represented at the meeting, or given the required information.

2.2.30 Healthcare staff described passing on medical information to patients prior to release, including the details of any outpatient appointments that were outstanding and any referrals that had been made for them. This information was also sent direct to the patient's community GP as well through the GP2GP programme (which will be covered in more detail in the next HSSIB investigation within the prison healthcare theme, which will look at data sharing and IT), as long as the patient had registered with the GP2GP system and therefore had been allocated a GP in the community.

Release from court

2.2.31 The investigation was told that in cases where patients were released straight from court it was difficult to pass information to the patient about ongoing medical treatment and appointments. Patients held on remand will receive court dates and be taken to court to appear

at their trials or sentencing. The outcome of these appearances may be that the patient (prisoner) is released straight from court. In this instance the patient does not go back to the prison as their belongings are taken with them in case this is the outcome.

2.2.32 The investigation heard that patients with booked outpatient appointments for treatment or tests were not made aware of these appointments before they attended court due to the security risks. If patients were then released direct from court there was no process in place to pass on information about any outstanding outpatient appointments. Of the healthcare departments that the investigation spoke to, some took action to try to pass the information on, either to the patient's GP in the community or direct to the patient via a supplied address/ telephone number. However, this was locally managed, relying on individual attitudes and diligence, rather than a national process.

2.2.33 The GP2GP programme allows information to be passed from one clinical information system to another, including details of any outstanding appointments; however, this would not be seen by the patient. This gap in information flow to the patient has resulted in missed appointments for treatment or tests, delaying appropriate care for the patient and increasing the DNA rate for the healthcare trust.

2.2.34 PSO 3050 states:

'In cases where prisoners are released unexpectedly from custody there must be an agreed local protocol, where possible, ensuring continuity of care after release for patients with significant health problems. For example, contacting a prisoners' GP/consultant where known.' (HM Prison and Probation Service, 2006)

2.2.35 The investigation spoke with healthcare staff and prison officers who expressed concern about the continuity of care for patients being released from court. There is little detail in the PSO and it specifically mentions 'patients with significant health problems', whereas many patients who attend court have ongoing medical care that requires co-ordination and communication.

2.2.36 Chapter 7 of PSO 3050 deals with 'release/discharge' and states:

'Where a prisoner is receiving medical care which needs to continue after discharge, it is important, as set out in the Transfer and Release Section of the Health Services for Prisoners Standard, that information to ensure continuity of care is communicated, with the prisoner's consent, to his or her GP and/or other responsible community agencies on discharge. (see also para.7.6).' (HM Prison and Probation Service, 2006)

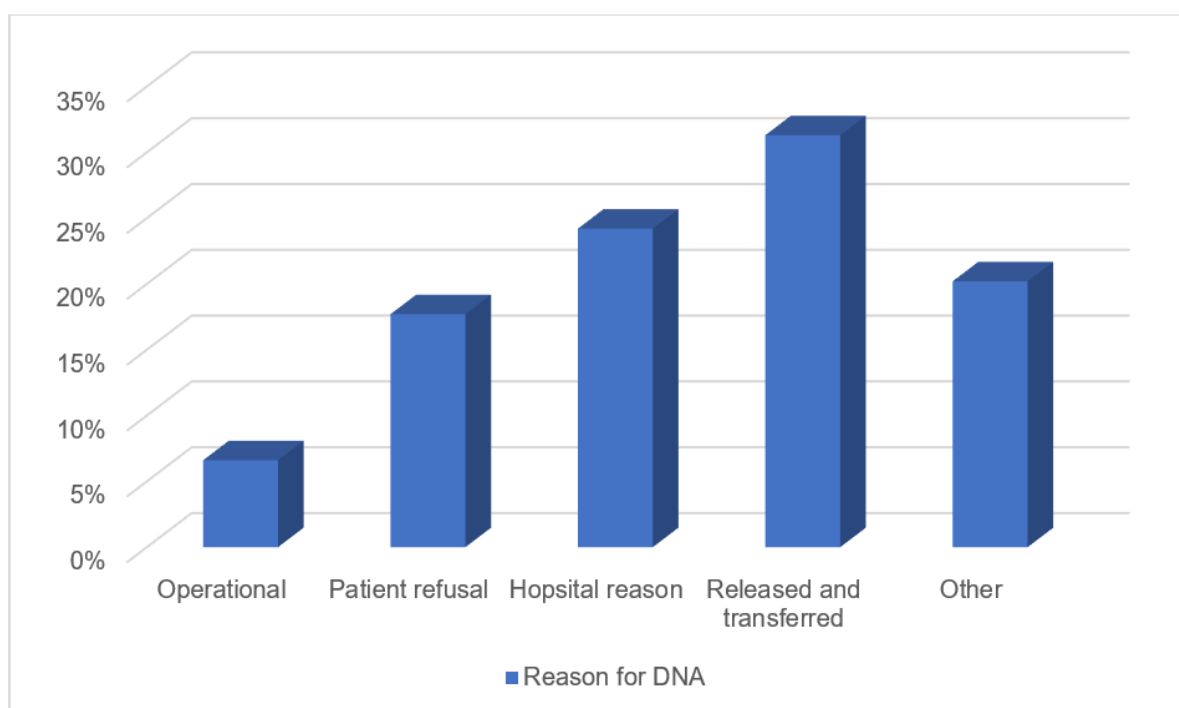
Paragraph 7.6 of the PSO states:

'Where a prisoner who is receiving medical care that needs to continue after discharge, does not have an external GP, it is important that health care staff help the prisoner to register with one prior to discharge. Similarly, health care staff must arrange follow-up appointments with NHS providers for all continuing secondary health care needs, and supply medication appropriate to clinical need to ensure supply until a GP prescription can be obtained. (Resettlement PSO 2300).' (HM Prison and Probation Service, 2006)

2.2.37 The PSO does not refer to the GP2GP programme and is written in the context of patients being released from a prison. Communication of healthcare appointments with patients, such as outpatient appointments or appointments for internal clinics, is not covered by the PSO. There are gaps in these processes that result in patients being released from court without knowing what healthcare appointments they have, which has resulted in further DNAs at local hospitals, but also in patients not continuing with their healthcare once released. PSO 3050 has not been updated since it was issued on 10 February 2006.

2.2.38 Category B local prisons, which have a high turnover of prisoners and many people being taken to court every day, expressed concerns about being able to ensure good continuity of care for patients. This was highlighted by data supplied to the investigation by one of the category B local prisons, which showed that nearly one third of its DNAs, in a 6-month period, were accounted for by patients who had either been transferred or released (see figure 5).

Figure 5 Reasons for patient DNAs in a 6-month period at a category B prison visited by the investigation



HSSIB makes the following safety recommendation

Safety recommendation R/2024/044:

HSSIB recommends that HM Prison and Probation Service updates Prison Service Order 3050, 'Continuity of healthcare for prisoners', including guidance on communication of information about prison patients when transferring between prisons, and on the process when prison patients are released from court. This will reduce variation and ensure better continuity of care for patients when being transferred or on their release.

2.3 Prison escorts to outpatient appointments

Escort availability

2.3.1 For security purposes prison officers are required to escort patients to outpatient appointments (two prison officers per patient). There was variation between prisons in the number of escorts each prison made available for healthcare departments. This in turn determined how many outpatient appointments healthcare departments were able to book patients into. The investigation received data from the prisons on escort availability per day and compared it to the number of prisoners. This showed ratios of outpatient appointment availability per prisoner per day ranging from 1:164 to 1:365, indicating a health inequality based upon which prison patients were sent to. The investigation found there was greater variation in the male prisons compared to the female prisons, with the ratio of appointments available per prisoner per day in all the female prisons visited being approximately 1:160.

2.3.2 Healthcare staff at the prisons with the worst ratios expressed frustration at the lack of ability to book patients onto outpatient appointments. An added complicating factor was that some patients required daily treatment such as dialysis. These patients used escort slots and therefore reduced the number of outpatient appointments available for other patients. The waiting lists in prisons for some clinics were considerably longer than their community equivalent, with some prisons describing 9 to 10 month waits for appointments. This was directly caused by the lack of appointment availability due to escorts, which then caused patients in prison to wait longer for their appointment than the hospital waiting list suggested. Patients would be offered appointments that could not be fulfilled and this would delay their care.

2.3.3 In addition, some prisons would assign security staff to facilitate escorts to emergency departments following a medical emergency, which resulted in no ability to support outpatient appointments. This added extra pressure onto the healthcare waiting lists, and resulted in short-notice cancellations for the hospital, with not enough time to reallocate the appointment to a patient from the community.

2.3.4 Healthcare administration staff shared with the investigation that they were being asked to decide which appointments to cancel, and this put them in a position that made them feel uncomfortable. One staff member said: “This is one of the few prisons I have worked at where I don’t feel like God having to decide which appointments to cancel due to a lack of guards [prison officers].”

2.3.5 Staff also told the investigation that prisons in the same region had different regimes and, therefore, had different hours within which patients were permitted to attend outpatient appointments. While one prison might allow patients to attend appointments from 09:00 hours to 11:00 hours and 14:00 hours to 16:30 hours, another prison in the same area would only allow appointments to be made from 09:00 hours to 10:30 hours and 14:00 hours to 15:30 hours. The differing times caused problems for hospital staff who were booking patients into appointment slots, as they did not know which prisons had which restrictions. Prison healthcare staff described having to cancel and rebook many appointments because they had initially been booked outside of the hours allowed by the prison regime. They stated that they regularly had to have conversations with hospital booking team staff who were frustrated with the complications caused by different prison regimes.

HSSIB makes the following safety observation

Safety observation O/2024/051:

Prisons and NHS trusts can improve patient safety by working together to ensure outpatient escort availability and the timing of hospital appointments is aligned to fit with the prisons’ and the trusts’ regimes. This will reduce the administrative burden and the number of appointments being made and cancelled because of different regimes.

Prison patient dignity

2.3.6 Patients and healthcare staff told the investigation about issues of dignity when attending outpatient appointments. The common dignity issues reported to the investigation were:

- male and female patients being seen handcuffed in public and in prison clothing
- patients being escorted to outpatient appointments by prison guards of the opposite sex
- prison guards being present at the clinical appointment
- a lack of notice to enable patients to sort out personal hygiene and personal preparation for the outpatient appointment.

2.3.7 The investigation recognises the security requirement for patients from prison to be handcuffed during external appointments. However, both male and female patients commented to the investigation that being seen handcuffed in public, in prison clothing and escorted by prison officers, had an impact on their thought process when attending outpatient appointments.

2.3.8 The investigation heard that hospitals were concerned about other patients (the general public) feeling anxious about waiting with a prisoner in the room. One national organisation stated that it had heard of patients (prisoners) being made to wait in broom cupboards to avoid interaction with or being seen by other patients.

2.3.9 Healthcare staff from one of the female prisons the investigation visited, said that they had made efforts to try to reduce privacy and dignity concerns by using side entrances at one of the hospitals and not taking the patient into the hospital until the appointment was about to start. This removed the need to sit in a waiting room with other patients, which had helped to reduce the concerns of the patients from the prison, with a resulting improvement in appointment attendance.

Female patient dignity

2.3.10 The investigation was also told that female patients had dignity and privacy concerns, particularly when going to obstetrics and gynaecology appointments. One national organisation told the investigation that it had heard reports of a woman being handcuffed to a male prison officer while they were having a mammogram. Healthcare staff in the female prisons visited by the investigation stated that the prisons tried to only send female prison officers as escorts for patients going to obstetrics and gynaecology appointments. However, they said this was not always possible due to the limitation of staff availability. There was a higher percentage of male staff in one of the female prisons visited, which was said to make things difficult when it came to all-female escorts. Therefore, female patients may be escorted by either a mixed gender crew (one male and one female prison officer) or an all-male escort crew.

2.3.11 The investigation was told by HMPPS that they had an escort policy which made it 'clear' what was expected. They provided a copy of the policy, which was reissued in July 2024. The specific section of the policy that was relevant stated:

'All HMPPS external escorts must consist of at least two prison officers, with at least one of them being the same legal gender as the prisoner, unless there are exceptional circumstances.'

'In order to maintain decency, prisons are required to consider appropriate staffing in respect of gender for all hospital appointments, but particularly those that are related to gender specific services such as gynaecology.' (HMPPS, 2024)

2.3.12 While the policy goes some way to detailing the expectation for sensitive female outpatient appointments, there is sufficient latitude that female patients may be escorted by escort crews containing male prison officers to any appointment, depending on staffing levels. The investigation did not observe a shortage of female prison officers that would appear to have restricted the escorts on those days.

2.3.13 Some actions had been taken to try to address privacy and dignity concerns, such as male prison officers staying outside clinical consulting rooms while patients were being treated. This did not always reduce patients' concerns, as the male officers were still aware of what the appointment was for. The investigation was told that for some female appointments, any male officer on the escort crew could result in a patient declining the appointment.

2.3.14 In addition to their concerns about privacy and visual dignity, patients and healthcare staff told the investigation that personal hygiene was not taken into consideration. This was particularly the case for women who were going to obstetrics and gynaecology appointments. The women stated that they wanted to shower before these appointments but were not given enough notice. Typically they were collected from their cells and told to get ready and taken to be escorted to their appointment. This was cited as a reason for not attending appointments.

Medical confidentiality

2.3.15 The privacy and dignity concerns described by national organisations, healthcare staff and patients were also complicated by the issue of medical confidentiality. Patients often had their clinic appointments with prison officers in the clinic room, removing patient medical confidentiality. The investigation was told that some patients were put on an 'escort chain' which meant the officer could sit just outside the room while still attached to the patient; however, this was still within earshot of the conversation between the patient and the clinician.

2.3.16 In addition to the other dignity issues, the lack of medical confidentiality added to the likelihood that patients would not attend their outpatient appointments.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/045:

HSSIB recommends that HM Prison and Probation Service standardises the approach to the provision of prison officer escorts for outpatient appointments to protect the dignity of patients and reduce variability of escort slots. This will assist in reducing the likelihood of patients refusing to attend healthcare appointments, while balancing appointment availability, thus improving the continuity and equality of care.

2.4 Telemedicine

Service use

2.4.1 The use of telemedicine (see 1.5) across the prisons visited was low. Data supplied by prisons showed that monthly outpatient telemedicine appointments ranged from none to two per month. One prison visited by the investigation had received the facilities for conducting telemedicine appointments 9 years ago, but reported that the use of telemedicine services had steadily reduced, rather than increased, over time. There had been no telemedicine appointments in the 3 months before the investigation's visit.

2.4.2 A reduction in the use of telemedicine was a common story across the prison estate, although staff stated that it had increased during the COVID-19 pandemic. Since then, it had reduced for a number of reasons, which included:

- a degradation in the capabilities (laptops, TV screens)
- a lack of awareness among GPs of its availability
- a reported dislike of the service by hospital clinicians
- a lack of infrastructure in the prison.

2.4.3 Key benefits of telemedicine that were highlighted to the investigation were:

- no requirement for external travel, and therefore no need for escorts
- increased number of outpatient appointments available
- the ability to give patients more notice of upcoming appointments
- reduced time away from patients' normal regime.

2.4.4 Telemedicine facilities that had been made available to some healthcare departments had been removed when the pandemic ended. Rooms that had been used to house the equipment had been repurposed and therefore there was nowhere for the telemedicine appointments to take place.

2.4.5 One healthcare department had recognised some of the benefits of using telemedicine and was reminding the prison's GPs of the services that they were able to refer patients to under their telemedicine contract. The prison's head of healthcare told the investigation that they had had limited success, but it was early stages and they were seeing some increased use. The staff said that due to the increased number of appointments that were available and the reduction in security requirements, they saw no reason for not using telemedicine as much as they could.

2.4.6 The investigation heard that the attitudes of clinicians at hospitals varied, with some not liking the use of the telemedicine service. Healthcare staff had problems with clinicians not turning up for appointments or arriving late. They stated that they had been told the clinicians could not guarantee making the appointment time because of their workload at the hospital. This conflicted with the much tighter regime controls being run at the prison, and patients often had to be taken back to their wing before the clinician had dialled in.

2.4.7 However, the investigation also spoke with a trust that was using the telemedicine service well and where it was popular among clinicians. They were using the service for multiple prisons in their region, across multiple specialities, and there were fewer issues with DNAs across the service. Patients were also described as liking telemedicine because it reduced the disruption to their routine.

'When asked about telemedicine, none of the prisoners who were spoken to had ever made a video medical call and most of them did not know that this was an offer.' (ABL Health, 2024)

2.4.8 A research paper, 'Patient safety in prisons: a multi-method analysis of reported incidents in England', stated:

'With the COVID-19 pandemic as a catalyst, the volume of 'telemedicine' and remote consultations has increased across all healthcare settings. Remote access appointments could remove many of the physical and security constraints ... and could improve prisoners' access to healthcare.' (McFadzean et al, 2023)

While the increase in use has not been sustained, the same paper recommended:

'Increased adoption of telemedicine and remote consulting, when possible, to reduce the requirement of prisoners needing to leave the premises.' (McFadzean et al, 2023)

2.4.9 NHS England told the investigation that on average over the last 6 years, HMPPS charged them approximately £48m to £50m for prison officers escorting patients to outpatient appointments. HMPPS stated that this was not the full cost of escorts and bed watches (prison officers staying with patients who are admitted to hospital for treatment). The use of telemedicine has the potential to significantly reduce this cost and also to support patients with previously unmet needs and in accessing timely/regular healthcare, leading to improved equality of care.

Contracts

2.4.10 An extensive range of services was included in telemedicine contracts. Some examples of specialities that could be used were:

- diabetes
- neurology
- general surgery
- breast surgery
- dermatology
- cardiology
- orthotics
- rheumatology.

2.4.11 Telemedicine contracts were held by trusts that may have been local to the prisons or an out of area trust providing a national service. The contracts were either locally commissioned or commissioned by NHS England (see 2.4.14), occasionally prisons had both the NHS England service facilities and a locally commissioned service as well.

2.4.12 One contract that the investigation was made aware of had 13 specialities that could take referrals through their telemedicine contract. However, the prison healthcare staff stated that they made very limited use of the service, as the contract was held by a trust that was out of their area. The healthcare staff stated that this meant that a patient referred to the service could start the process of diagnosis/treatment, but eventually would need to be seen by a clinician in a face-to-face consultation. The consultation would be with a local trust and the clinician to whom the patient was referred would want to start the process of diagnosis from the beginning.

2.4.13 However, the investigation was later informed by the telemedicine provider that a consultant would review each referral, and only referrals that could complete the full course of care would be accepted into the service. Healthcare staff were unaware of this, which greatly

impacted on the use of the service. Additionally, a locally held contract provider that the investigation spoke to said, they used a combination of telemedicine and face-to-face appointments to reduce the amount of escorts required and the burden on the system.

2.4.14 The staff told the investigation that of the 13 specialities that were included in the contract, only 2 would be able to complete a patient's treatment without a face-to-face consultation; therefore the other 11 specialities would not be used. They said that they were not getting full value from the contract.

2.4.15 There were very few prisons that were using telemedicine other than for a couple of appointments per month. However, one prison the investigation visited, and a trust that the investigation spoke to, were increasingly using telemedicine and they stated that the service was working well. Both the prison and the trust, from different areas, were working with a local trust and prisons respectively. Both stated that they were able to conduct at least the initial assessments via telemedicine, therefore reducing the number of face-to-face appointments needed.

NHS England

2.4.16 During the COVID-19 pandemic, NHS England bought laptops with telemedicine software installed. The laptops were sent out to prisons as they tried to increase the number of patients being seen via telemedicine. The programme was created through necessity by the pandemic; however, there were problems with integration with prison internet networks. In addition, the system was based on licences and each member of prison healthcare staff and each trust consultant required their own login to use the system, which one provider told the investigation caused issues.

2.4.17 The initial plan was for patients to be seen in their cells as it was not possible for them to go to the healthcare department or to the local trust. Problems with SIM cards and laptop Wi-Fi signal connectivity meant that the prisons were not able to get the system working properly. NHS England stated that the programme failed and after the pandemic, as observed by the investigation, the laptops and other equipment were left unused and use of telemedicine declined. NHS England has continued to try to find a solution, although the focus has been on a telemedicine capability that is mobile and can be taken to patients' cells, which adds additional connectivity issues.

2.4.18 The prisons and trust that were successfully using telemedicine had implemented a system that was used within the healthcare department. Patients were moved to the department with the other patients who had internal healthcare appointments. A laptop was used in an existing clinic room within the healthcare department. The service was web-based and did not require additional software. The trust sent a link to the healthcare department for a waiting room, which the patient joined, and the clinician at the trust admitted the patient into the

appointment when they were ready. There were also agreed appointment times that were reserved for the prisons and both the trust and prison knew when these were, resulting in a simple booking system that worked for both organisations.

'They [prisoners] felt this was a really good offer and could be beneficial for minor ailments, but they stated that for more serious illnesses such as cancer or things that they felt needed to be seen in person, these appointments should be face to face. They did state that using telemedicine would improve waiting times and therefore build the reputation of the health department.' (ABL Health, 2024)

HSSIB makes the following safety recommendation

Safety recommendation R/2024/046:

HSSIB recommends that NHS England, via regional commissioning teams, works with HM Prison and Probation Service to identify barriers to using telemedicine for outpatient appointments, and then implements local solutions to promote and enhance the capability and usability of telemedicine. This aims to reduce the burden on prisons of providing escorts and the likelihood of patients not attending appointments.

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4. Appendix: Investigation approach

The investigation report '[Management of chronic conditions in prisons](#)' (Healthcare Safety Investigation Branch, 2019) identified areas of healthcare which were out of scope for that investigation that would likely warrant an investigation. To identify topics for investigation within

the healthcare provision in prisons theme, the investigation reviewed intelligence from service and professional regulators, national reports, academia and research. Discussions also took place with a large number of national stakeholders to understand their concerns in this area.

Evidence was collated and analysed to identify common areas across the stakeholders, which were directly related to patient safety concerns. These areas were then placed into a hierarchy based on the number of stakeholders that mentioned it, the breadth of the concern across the prison estate, whether it affected male and female prisons and the estimated seriousness of the concern. As a result of this work the investigation was formally launched in February 2024 looking at three main topics:

- emergency care response
- continuity of care
- data sharing and IT.

Evidence gathering

The investigation undertook a programme of visits that was designed to be as efficient as possible and to account for all aspects of the prison estate, covering all three topics. All evidence was grouped into the different topic areas for analysis.

The investigation undertook site visits that covered:

- category A to D prisons (male) and closed prisons (female)
- prison buildings of a range of ages (1800s to 2020s)
- four geographical areas across England (south-east, midlands, north-west, north-east)
- three prison operators
- four prison healthcare providers.

The investigation engaged with:

- prison officers and security staff
- prison management
- ambulance crews
- emergency centre call handlers and dispatchers
- national and local commissioners
- healthcare staff and healthcare provider management.

Stakeholder engagement and consultation

The investigation engaged with stakeholders to gather evidence and check for factual accuracy, and for overall sense-checking. The stakeholders contributed to the development of the safety recommendations based on the evidence gathered.

Table A Investigation stakeholders

National organisations	Other organisations
HM Prison and Probation Service	Observations at 13 prisons
NHS England	Acute trusts
Ministry of Justice	Prison healthcare providers
	A Better Life