

COVID-19: digital equivalence of health care in English prisons



The importance of achieving health-care services for prisoners that are equivalent to those for the community is an international ethical and moral principle.¹ Less discussed is digital equivalence, a term that we have coined to reflect equivalence of digital innovation, considered in relation to prison telemedicine and COVID-19.

At outset of the pandemic, it was hypothesised that COVID-19 outbreaks within prisons could lead to high levels of illness and death. Prisons quickly implemented a full lockdown, including stopping external visitors, isolation within prison cells for up to 23 h a day, plans for early release of prisoners, and compartmentalisation.² In alignment with community responses, a spotlight was cast on the notion of prison telemedicine. UK National Health Service (NHS) bodies within English community settings had reacted quickly to the pandemic by adopting digital innovations, including the widespread use of video consultations.³ NHS bodies rallied to provide streamlined support for the mass roll-out of telemedicine, with centralised review, coordination, and procurement of software solutions for community health-care settings.⁴

Yet at the commencement of the pandemic, prisons were triply disadvantaged: first, in regard to the baseline poor health status of residents; second, by the closed and crowded prison environment; and third, by their poor adoption history of digital technologies. Widespread prison telemedicine implementation efforts previously struggled to find traction in England,⁵ yet were suddenly perceived as one of the most important tools to maintain health-care service continuity throughout the pandemic (appendix). Despite the clear rationale for a rapid deployment programme to mirror community efforts, several issues emerged that inhibited the ability to transform health care in prison settings at the same speed.

Prisons, by their nature, are secure environments, concerned primarily with delivering the order of the courts. Access to health care and permissions for the introduction of digital technologies must be operationalised within the constraints and security policies of Her Majesty's Prison and Probation Service (HMPPS).⁶ HMPPS rules surrounding technology surpass those of the NHS and must be adhered to.

Any digital technology outside the Prison Authority's direct control is inherently perceived as a risk. HMPPS must investigate and approve any digital solution that is to be implemented within prisons to assure security, including health-care technologies. At the commencement of the pandemic, only two telemedicine solutions were approved for use in prisons, having been subject to HMPPS scrutiny lasting several years. These technologies were not among centrally procured and deployed NHS solutions. This digital divide meant that prisons could not benefit from the widespread national support for telemedicine.

Video consultations require an internet connection sufficient to support use. At the point of the pandemic declaration, approximately 50 of 117 prison sites had connectivity that was too poor for videoconferencing. In community health-care settings, poor connectivity is negated with the availability of secure virtual private network connections, widespread availability of Wi-Fi, and a 4G signal, yet HMPPS prohibits these solutions to reduce the risk of unauthorised communications by prisoners. This issue of connectivity, despite being critical to NHS service delivery, became an issue to be solved through HMPPS channels and cooperation.

Prison health-care commissioning was transferred to the NHS in 2006, meaning service delivery and clinical IT remain in their infancy.⁷ The English prison estate has many competing prison health-care providers from private, voluntary, and NHS sectors. This competitive tendering system for offender care has been suggested to increase incoherence among services and provide fragmented care.⁸ Procurement of a centrally mandated telemedicine service for use by all prisons was further complicated by provider multiplicity and compatibility with existing IT services.

The pandemic did not only expose the limiting factors precluding prison digital revolution but also presented an opportunity to lift barriers. To mitigate issues with poor connectivity, HMPPS supported legislation changes to allow introduction of 4G-enabled tablets in the prison environment for telemedicine. This unprecedented change was welcomed by health-care management, yet still took months to deploy, and at large expense, because of

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See Online for appendix

For more on complexities associated with undertaking stringent risk assessments on individual cases see <https://prison-governors-association.org.uk/prison-governors-association-pga-evidence-to-justice-committee-on-covid-19/> and <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-06-08/56203/>

the bespoke configurations required to operationalise tablets in a secure environment. This meant that despite rapid permissions, devices remained unavailable until the first pandemic peak had passed; should a second peak occur, prisons will be more prepared. As a result of the pandemic, all prisons, immigration removal centres, and secure children's homes in England (n=135) will have 4G-enabled tablets, telemedicine capability, and mobile use of electronic health records. COVID-19 has acted as a catalyst for a new era of digital innovation in prison health care. We cannot wait for another future crisis to prompt digital innovation in prisons, and we must nurture the partnership approach established between HMPPS digital teams and the NHS. We must undertake responsive, robust security evaluations of new digital technologies to ensure that prisons cannot only adopt innovations after they have become commonplace in the community. Digital innovation will accelerate advancement in other aspects of prison health care, improving health outcomes.

The prison health system was pushed to consider rapid implementation of digital technology to support the pandemic response and maintain essential health-care services for their vulnerable population. However, prison services started from a lower digital baseline, were unable to use software rapidly procured and deployed in community settings, and were bound at all times to the additional rules of the prison system on use of technology. Failure to keep pace with the rapid adoption of digital innovation in the community in response to the pandemic will widen this digital inequivalence. Prisons are already behind the accelerating curve of community implementation, and risk falling further behind, bringing even greater patient disadvantage, if momentum is not maintained. Although this discussion focuses on prison telemedicine, we argue that these principles apply across the whole spectrum of health-care technology, such as wearables and electronic health records.

The long-term repercussions of reduced in-prison health-care services due to in-cell confinement and reduced health-care staffing will echo past the pandemic. Despite hopes for the early release of up to 15 000 prisoners nearing the end of their sentence, so far less than 80 have been successfully released, probably as

a result of the complexities associated with undertaking stringent risk assessments on individual cases. Although people remain in prison, we must ensure that we have the ways and means to deliver health care to them under pandemic conditions, and to catch up with any health-care shortages that have arisen as a consequence. Telemedicine promises to improve health service access in prisons, reduce widening health inequalities, and contribute to improved health outcomes. We must evaluate future progress to ensure that it does not further disadvantage patients by harming doctor-patient relationships or acting purely as a cost-saving mechanism. We hypothesise that telemedicine will reduce referral to treatment times for patients, increase access to a wider range of specialist services (eg, gender identity clinics), reduce the waiting time for gatekeeping assessments under the Mental Health Act, and increase overall access to health-care appointments. Prisoners traditionally access secondary care offsite at local hospitals, handcuffed and accompanied by prison officers (escorts). They report feelings of dehumanisation, stigma, and judgment from the public and hospital staff.⁹ Clinical information handover to prison health-care teams can be poor, and patients might face long waits for routine appointments given that the availability of prison officer escorts is limited by staffing pressures. Use of prison telemedicine for secondary care can alleviate all of these issues and improve patient experience. All of these factors must be rigorously assessed, alongside cost-effectiveness and the safety and quality of remote prescribing, to understand whether telemedicine in prisons delivers the benefits envisioned for patients during the pandemic and beyond. In parallel, HMPPS will continue to monitor and appraise the telemedicine system for security and safety within secure establishments.

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