Public Health England

Protecting and improving the nation's health

Summary report:

National engagement event for blood-borne virus (BBV) opt-out testing in prisons in England, 2017

Kia Oval, London, 30 November 2017

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Maciej Czachorowski and Éamonn O'Moore
For queries relating to this document, please contact: health&justice@phe.gov.uk

Published May 2018
PHE publications
gateway number: 2018071

PHE supports the UN
Sustainable Development Goals

Contents

Abbreviations

AIDS	acquired immune deficiency syndrome
BBV	blood-borne virus
CQUIN	Commissioning for Quality and Innovation
CRC	Community Rehabilitation Company
DAA	directly acting antivirals
DBS	dried blood spot
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HJIPs	health and justice indicators of performance
HMPPS	Her Majesty's Prison and Probation Service
NHS	National Health Service
ODN	Operational Delivery Network
PCR	polymerase chain reaction
PHE	Public Health England
PHPQI	public health prison quality indicators

1. Introduction

Event background

People in prison have a high prevalence of infection with blood-borne viruses (BBV) (HIV, Hepatitis B and Hepatitis C) but have traditionally been under-tested. Prior to 2010, levels of BBV testing in English prisons did not exceed 4% of the prison population (1). Since October 2013, PHE, NHS England and Her Majesty's Prison and Probation Service (HMPPS) have been implementing a programme of 'opt-out testing' which has been underpinned by a formal partnership agreement (2). Programme roll-out has been informed through phased implementation and evaluation of 'pathfinder prisons' over three phases. Pathfinder evaluation reports for each phase of the programme have been published by PHE [phase 1 (1), phase 2 (3) and phase 3 (4)]. Full implementation of the programme in all adult prisons in England was extended to the end of financial year 2017-18 (ie March 2018) due to pressures within the prison estate impacting on delivery.

The BBV opt-out engagement event (www.phe-events.org.uk/BBV17) was led by PHE working in partnership with NHS England and HMPPS to promote the final implementation stage of BBV opt-out testing for consenting eligible adults in prisons in England. The main aim of the meeting was to share lessons learnt from the early phases of BBV opt-out testing implementation in prisons in England and promote good practice in the final stages of implementation. We aimed to replicate a previously successful function (5) held in Birmingham in May 2015 which had a measurable impact on the early phases of programme implementation.

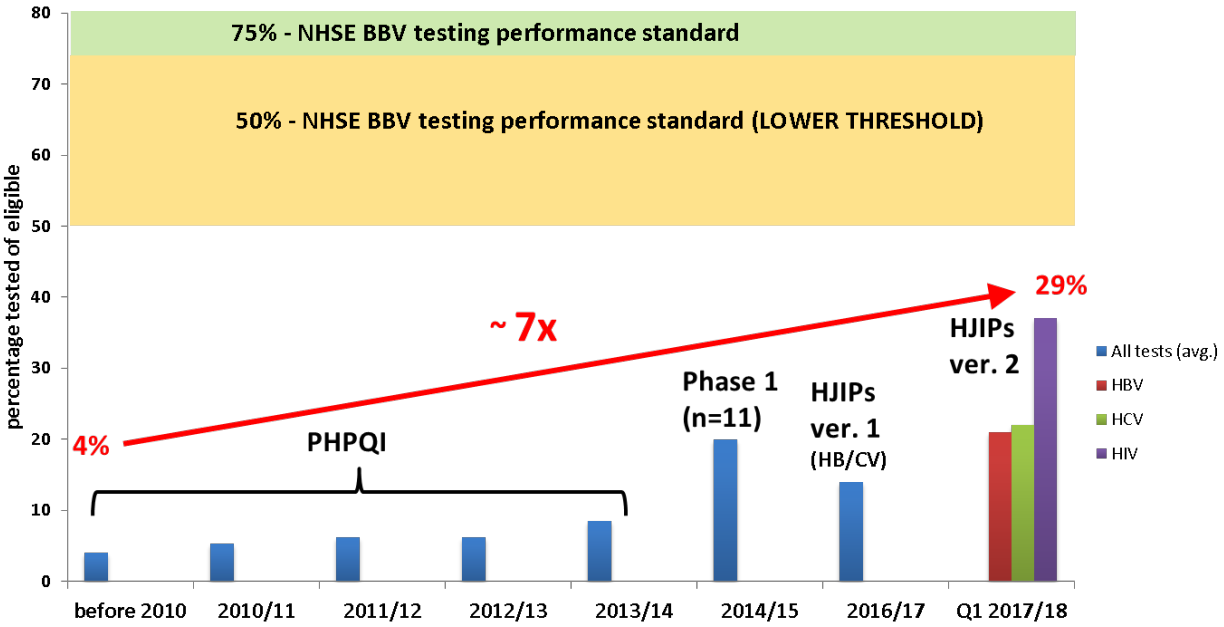
Event overview

The meeting was held at the Kia Oval in London and over 160 delegates from various organisations participated (see Appendix 1 for delegate representation). Speaker presentations reported on the current state of BBV opt-out testing in the English prison estate and highlighted some lessons learnt from programme implementation in early adopter prisons. Leading experts in the fields of prison healthcare, public health and virology as well as patients themselves, were invited to share their knowledge and experience of the current challenges and opportunities for providing BBV treatment and care in prisons. Participants were also encouraged to actively take part in plenary discussions and table-top exercises which focussed on identifying and proposing mitigation strategies for the key barriers to treatment and care of patients with BBV infection in prison. The event programme, which includes the names and topics of invited speakers and lays out the themes around the group exercises, is included in Appendix 2 of this report.

2. Programme coverage and testing uptake

Data was presented on the uptake of BBV opt-out testing in English prisons as well as programme coverage across the English estate. NHS England reported that as of November 2017, 75% of adult prisons in England were implementing BBV opt-out testing with full implementation by March 2018 agreed between PHE, NHS England and HMPPS. Since the introduction of the programme, there has been a reported seven fold increase in collective (HBV, HCV and HIV) testing uptake observed compared to the traditional prison testing baseline before BBV opt-out programme implementation (increase from 4% to 29%) (Figure 1). While this increase in testing is welcomed, current levels are still well below even the lower BBV testing threshold proposed by NHS England (50-74%), and well below the target threshold of at least 75% uptake.

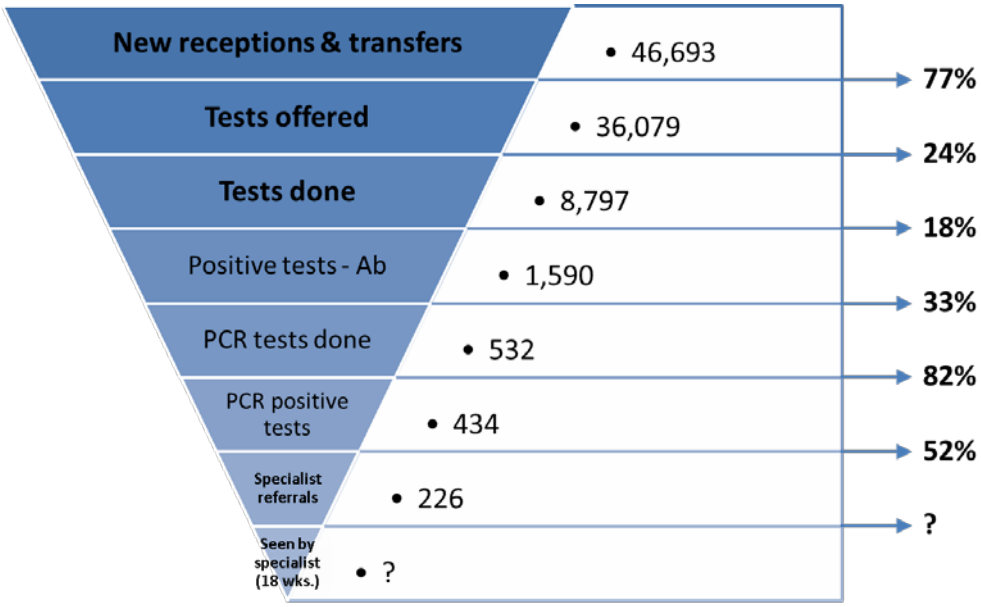
Figure 1: Average blood-borne virus (BBV) testing rates in the English prison estate by financial year*(source: NHS England, PHE).* PHPQI: Public health prison quality indicators; HJIPs: Health and justice indicators of performance (HJIPs ver. 1: before data quality improvement).



The data on testing and access to treatment was derived from the NHS England Health and Justice Indicators of Performance (HJIPs), with most recent reports from Q1 FY2017/18. This information showed that of the 46,693 new receptions or transfers into the prison estate during the first quarter of this financial year, about 80% (36,079) were offered tests for hepatitis C of which only about a quarter accepted (8,797). Of these, nearly 1,600 were found to have evidence of previous infection with Hepatitis C virus (had +ve antibody test) but only a third of these (532) had a test for viral replication (PCR) which is both evidence of active disease and a requirement for referral for

assessment and treatment. Of those tested for PCR, over 80% (434) were positive but only 226 were referred for specialist assessment (Figure 2). Similar proportions through the 'testing and care cascade' were noted to be observed for hepatitis B and HIV (although reflex testing PCR testing is not done for these two infections). Currently, data sources available to PHE cannot provide information on how many of those were seen in specialist services and how many were commenced on treatment with directly acting antivirals (DAAs). This treatment data is collected by NHS England and will be shared with PHE later in 2018.

Figure 2: Hepatitis C testing and referral cascade in the English prison estate; Financial year 2017/18, Qtr.1 (*Source: Health & Justice Indicators of Performance, NHS England*).



3. Learning and feedback

The engagement event provided an opportunity to identify obstacles, and discuss potential solutions to improving testing and treatment of people in prison. In addition to a range of presentations (6) (see 'Agenda' in Appendix 2), three 'table-top' group exercises were organised around the themes of:

- improving the uptake of BBV testing in prisons
- the main obstacles to linking patients into care both in and beyond the prison walls
- overcoming short-term and long-term barriers to programme success

The key learning points identified in the presentations and groups sessions are summarised in the sections that follow.

Improving BBV testing uptake and linkage into care

Ensure offer of testing is accompanied by immediate testing: Many prisons reported that when prisoners are offered testing and consent to do so, the actual blood test may not take place until many days later. This risks patients getting 'lost to follow-up' or changing their minds or both. It is therefore recommended that BBV testing, not only offer of testing, should be done at the same time and preferably at second reception screening to reduce patient loss to follow-up.

Many prisons are still using venous blood sampling for testing (although fraction has decreased over time). PHE recommend dried blood spot (DBS) testing methodology which is easier to do and may increase uptake particularly in injection drug users in whom peripheral venous access may prove difficult.

Increasing prisoner awareness/education of the BBV opt-out policy and available treatments: BBV testing programmes can be further promoted through media such as National Prison Radio and via peer support programmes offered by Third Sector agencies (eg The Hepatitis C Trust, National AIDS Trust, British Liver Trust etc.). Specifically prisoners should be made aware of advances made especially in HCV treatment and the reduced side-effects and ease of administration of new Directly Acting Antivirals (DAAs) versus traditional interferon-based treatments.

Increasing Third Sector engagement in prisons: BBV opt-out early adopter prisons ('pathfinders') were shown to engage very little with the third sector to support patient rehabilitation and treatment. This misses the opportunity to have further support in education and additional resources provided by charities and advocacy groups. For example, the National AIDS Trust has recently updated their BBV prison framework which provides excellent guidance to prison healthcare teams as well as information resources useful to people undergoing testing or treatment.

Reducing heterogeneity in BBV testing methodology and offer of testing throughout the prison estate: consolidation and strict adherence to standardised and nationally recognised testing/care algorithms is essential. Regular education sessions for new and existing staff will enable them to maintain their skills and knowledge and instil confidence when speaking with patients about BBVs.

Improving ability to track patients beyond the prison walls transitioning into the community should be provided with information about their condition thereby empowering patients seek treatment. This should be further facilitated by establishment of links between prison healthcare teams and community services likely to engage with people leaving prison eg community rehabilitation companies (CRCs); drug services; "Find and Treat" services.

Assisting prisoners without NHS numbers to register with a GP while still in prison and recording patients' next of kin or address after release to enable required treatment monitoring and post treatment tests so as to facilitate continuity of care.

Specific funding for dedicated BBV nurses in prisons: supporting BBV 'in-reach' clinics/services in the prison

Opportunities for prison-based programmes to contribute to wider HCV eradication strategy

It is estimated that approximately 68,000 people in England do not know they have HCV (7); this cohort acts as a reservoir for the disease enabling transmission to others. Active case finding programmes, such as the BBV 'opt-out' programme in prisons, can help to substantially reduce the size of this 'reservoir' especially given the overlap of a common risk factor for both infection and imprisonment - injecting drug use.

Initial strategy was to focus on the sickest patients (eg those with advanced fibrosis) first until the price of DAAs came down- but now we have treated most of those in this category.

Prison populations represent a 'low hanging fruit'- traditionally so-called 'hard-to-reach' populations with high levels of infection. Treating this population can contribute significantly to wider efforts to eradicate HCV infection and possibly within a shorter timeframe than previously imagined.

Operational Delivery Networks (ODNs) (8)are now financially incentivised by NHS England to establish links with prisons to facilitate identification and treatment of HCV cases in the prison population through the Commissioning for Quality and Innovation (CQUINs) payments framework.

New models of care can be implemented given the ease of use of DAAs which allows a wider range of healthcare professionals to prescribe and review patients under oversight of ODN- means need to have expensive in-reach or outreach services could be replaced by a primary care model with effective links to clinical experts within ODN.

Implementing a 'whole prison approach' to tackling BBVs in prisons is required as many prisons report custodial staff side issues impacting on ability to test and treat patients.

4. Next steps

NHS England, PHE and HMPPS have committed that by April 2018 the entire prison estate will be offering BBV opt-out testing to new receptions in adult prisons in England. The challenge moving into the future will be to get testing levels to within the upper performance standard ie more than 75% testing uptake. To this end, some headway will be made by tackling the attrition points in the testing and care pathway as shown in Figure 2, above. A simple and effective step that can be taken is to make sure that healthcare teams across the estate offer testing in the same way in an 'opt-out' manner. The NHS England Health and Justice Commissioning team for London use the following recommended offer for new receptions:

> *"We screen everybody entering this prison for hepatitis B, hepatitis C, and HIV. Screening is free, confidential and the sample will not be used for anything other than this test. You can be infected and still feel healthy, so it is important to test even if you feel fit and well. If you have hepatitis C, we can treat you with new medication that works in almost all cases, usually with no side effects. Are you happy to proceed?".*

While it was agreed that a lot of progress has been made since the BBV opt-out programme had been introduced back in October 2013, a lot of work still lies ahead. All stakeholders at the event reaffirmed their commitment to collectively work together "to ensure that no one would leave prisons without the offer of a test for HIV, Hepatitis B and Hepatitis C, and, that those found to be infected, would be offered treatment in prison and/or in the community, according to their choice". This will be aim of the BBV opt-out programme moving into the future.

References

1. Blood-borne Virus Opt-Out Testing in Prisons: Preliminary Evaluation of Pathfinder Programme Phase 1, April to September 2014. *PHE.* [Online] 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/428942/BBV_pathfinder_evaluation_Phase_1_FINAL.PDF.

2. National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016. *NHS England, PHE, NOMS.* [Online] 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460445/national_partnership_agreement_commissioning-delivery-healthcare-prisons_2015.pdf.

3. BBV bulletin: Special Edition. Quarterly update report of the introduction of opt-out BBV testing in prisons from PHE, NHS England and NOMS. Issue 11, October 2016. *PHE.* [Online] 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560863/BBV_bulletin_October_2016.pdf.

4. BBV bulletin: Special Edition. Quarterly update report of the introduction of opt-out BBV testing in prisons from PHE, NHS England and NOMS. Issue 13, December 2017. *PHE.* [Online] 2017. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/666850/BBV_bulletin_Dec_2017.pdf.

5. Summary report: National event for early lessons learnt from the opt-out blood-borne virus (BBV) testing policy in prisons, 2015. *PHE.* [Online] 2015.

6. BBV opt-out engagement event presentations. *PHE.* [Online] 2017. https://www.phe-events.org.uk/HPA/media/uploaded/EVHPA/event_741/30.11.17_PHE_BBV_event.pdf.

7. *Operational Delivery Networks and Prisons: What are the challenges? personal communication, "BBV opt-out testing engagement event".* **Foster, GR.** London, 2018.

8. List of Hepatitis C operational delivery networks in England. *NHS England.* [Online] 2017.

Appendices

Appendix 1: Delegate representation

160 people registered to attend the event. There was representation from a wide range of organisations including the following:

Providers	Prisons
Betsi Cadwaladr University Health Board Cardiff and Vale University Health Board Care UK Central and North West London NHS Foundation Trust G4S Ipswich Hospital NHS Trust King's College Hospital NHS Foundation Trust Lancashire Care NHS Foundation Trust North Middlesex Hospital NHS Trust Northamptonshire Healthcare NHS Foundation Trust Nottingham University Hospitals NHS Trust Nottinghamshire Healthcare NHS Foundation Trust Oxford University Hospitals NHS Foundation Trust Oxleas NHS Foundation Trust Pennine Acute Hospitals NHS Trust Queen Elizabeth Hospital Royal Free London NHS Foundation Trust Sodexo Justice Services South Eastern Health and Social Care Trust St George's University Hospitals NHS Foundation Trust Surrey County Council Sussex Partnership NHS Foundation Trust University Hospitals Birmingham NHS Foundation Trust Virgin Care Limited Wiltshire Council	Altcourse Belmarsh Brixton Bure Coldingley Durham Ford Hollesley Bay Isis Lewes Liverpool Lowdham Grange Norwich Onley Peterborough Ranby Send Thameside Wandsworth Warren Hill Winchester Woodhill Wormwood Scrubs

PHE	NHS England
Alcohol, drugs & tobacco leads Health & Justice public health specialists Laboratory staff National Health & Justice team members	Local teams National Health & Justice team members Specialised commissioning

HMPPS	Third sector
Health and wellbeing	National AIDS Trust The Hep. C Trust Turning Point

Other	Pharmaceutical companies
House of Lords, UK Inspirit Lexington Communications London Joint Working Group Public Health Wales	AbbVie Gilead Sciences Ltd MSD UK

Surrey County Council University College London Visions Consultancy Ltd Wiltshire Council	

Appendix 2: Event agenda

Public Health England | HM Prison & Probation Service

NHS England

Protecting and improving the nation's health

Blood borne virus (BBV) opt-out testing in prisons: lessons learnt and looking ahead

London

30 November 2017

#PHEprisonhealth #BBV

10:00 - 10:05 **Welcome and introduction**
Dr Éamonn O'Moore, Director, Health and Justice, Public Health England and Director, UK Collaborating Centre for WHO Health in Prisons Programme, European Region

10:05 - 10:25 **Working in partnership to deliver the BBV opt-out testing policy in prisons**
Rupert Bailie, Acting Head of Custodial Health & Wellbeing, HMPPS
Mark Gillyon-Powell, National Lead - Public Health (Secure & Detained), NHS England
Dr Éamonn O'Moore, Director, Health and Justice, Public Health England and Director, UK Collaborating Centre for WHO Health in Prisons Programme, European Region

10:25 – 10:35 **BBV opt-out testing in prisons by the numbers: a look at what we've achieved**
Maciej Czachorowski, Epi-scientist, Health and Justice, Public Health England

10:35 - 10:50 **Regional focus: BBV opt-out testing and progress made in London prisons**
Michelle Storer, Interim Commissioner and Project Manager NHS England (London Region)

10:50 - 11:05	**The patient voice: challenges to receiving care in prison** *Julia Sheehan, Hepatitis C peer and former patient*
11:05 - 11:30	**Coffee**
11:30 - 12:20	**Facilitated table discussions: Improving the uptake of BBV testing in prisons** • how to promote BBV testing in prisons • examples of good practice in early adopter prisons and implementation across the wider prisons estate
12:20 - 13:05	**Lunch**
13:05 - 13:15	**BBV infection in the prison population: a public health inequality** *Baroness Randerson, Peer, House of Lords*
13:15 - 13:30	**Operational delivery networks: engaging with prisons - what are the challenges?** *Prof. Graham Foster, Hepatitis C Operational Delivery Network Clinical Lead, NHS England*
13:30 - 13:45	**Effective delivery of care within and beyond the prison walls** *Dr. Mary Cannon - Locum Consultant Hepatologist, King's College London*
13:45 - 14:35	**Facilitated table discussions: What are the main obstacles to linking patients into care both in and beyond the prison walls?** • how can these obstacles be overcome? • how to engage patients into treatment or care
14:35 - 15:00	**Tea**
15:00 - 15:10	**Looking ahead: meeting BBV opt-out testing targets by March 2018 and ensuring programme continuity** *Mark Gillyon-Powell, National Lead - Public Health (Secure & Detained), NHS England*
15:10 - 16:00	**Facilitated table discussions: Identification of barriers to short-term (until March 2018) and long-term (beyond completion date) programme success** • identification and prioritisation of actions to overcome these obstacles
16:00 - 16:20	**Working in partnership: the role of voluntary and charity sector partners** *Kat Smithson, Director of Policy and Campaigns, National AIDS Trust*

Rachel Halford, Deputy Chief Executive Officer, Hepatitis C Trust

Conclusions

16:30 *Chair*

Close