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Department of Health

# An audit of hepatitis C services in a representative sample of English prisons, 2013

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


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# An audit of hepatitis C services in a representative sample of English prisons, 2013

**Prepared by:**

**Authors and lead contributors**

**Clare Humphreys**, Public Health Specialty Registrar, Department of Health

**Professor Martin Lombard**, Clinical Director for Liver Disease, Department of Health

**Dr Autilia Newton**, Chair of Public Health England Prison Network, Head of PIP Team and Local Director for Health Protection North Yorkshire and Humber Team, Public Health England

**Dr Éamonn O'Moore**, Director, Health and Justice Team, Public Health England

**Cathie Railton (nee Gillies)**, PIP Team Scientist, Health and Justice Team, Public Health England

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## Acronyms used

| | |
|---|---|
| Ab | Antibody |
| Arm's length body | ALB |
| BBV | Blood-borne virus |
| BVHG | British Viral Hepatitis Group |
| CARAT | Counselling, Assessment, Referral, Advice and Throughcare |
| CCDC | Consultant in communicable disease control |
| CCG | Clinical Commissioning Group |
| DBST | Dried blood spot testing |
| DH | Department of Health |
| FNP | Foreign National Prison |
| GUM | Genito-urinary medicine |
| HCV | Hepatitis C virus |
| HPA | Health Protection Agency |
| HPU | Health Protection Unit |
| IDTS | Integrated Drug Treatment Service |
| IDU | Injecting drug user |
| MDT | Multi-disciplinary team |
| NAT | National Aids Trust |
| NHS | National Health Service |
| NHSE | NHS England |
| NOMS | National Offender Management Service |
| OH | Offender health |
| PCR | Polymerase chain reaction |
| PCT | Primary Care Trust |
| PHE | Public Health England |
| PHEC | Public Health England Centre |
| PHPQI | Prison Health Performance Quality Indicators |
| PIP | Prison Infection Prevention |
| RCGP | Royal College of General Practitioners |
| RCN | Royal College of Nursing |
| ROCR | Review of Central Returns |
| SHA | Strategic Health Authority |
| SOP | Standard operating procedure |
| SVR | Sustained virological response |
| YOI | Young Offenders Institute |

# Contents

# 1 Executive summary

Hepatitis C is the third most common risk factor for liver disease in the UK (following obesity and harmful drinking). The Chief Medical Officer in her report highlighted the pressing need to address rising rates of liver disease (Davies SC, 2012). The hepatitis C strategy for England identified prisons as a specific setting in which hepatitis C testing and treatment should be delivered (DH, 2002). This is because many people with a history of injecting drug use (IDU), the main risk factor for hepatitis C in the UK, pass through the prison estate. In addition, prison provides an ideal opportunity to treat and prevent further infection in a population which are often defined as „hard to reach'.

In July 2012, a survey of hepatitis C services in prisons in England was published by the Health Protection Agency's Prison Infection Prevention team[1] (HPA PIP team) in partnership with Offender Health[2] (OH) and the liver disease strategy team in the Department of Health (DH). This revealed variation in the structure, accessibility and quality of hepatitis C services delivered in prisons across England. Following the survey, an audit tool was developed based on the „best practice guidance' in the report as well as existing national guidance. The audit tool covered key areas of best practice with regards to health promotion, testing, treatment and care for hepatitis C in prison. In December 2012, the tool was used to audit a representative sample of 20 prisons in England. The ultimate aim of the audit is to improve the care of people with hepatitis C in prison as well as the quality of clinical services. The audit also aimed to ascertain the extent to which best practice guidance was being followed by prisons, and provide objective evidence and intelligence for the future commissioners and service providers of hepatitis C services. **It is important to note that the audit was carried out prior to April 2013 by the DH and the HPA – a predecessor organisation of Public Health England (PHE) that was formed in April 2013, and hence there are references to the HPA throughout the document. However, it is important to be aware that the recommendations made in section 7 of the report are reinforced by PHE.**

The participation rate for the audit was 95% (19/20 prisons). However another prison from the same region and of the same category was used to replace the non-responding one. In the analysis, the pilot prison was also used resulting in a denominator of 21 for the questions. The audit is based on self-report and was mainly completed by prison primary healthcare. Evidence was requested to support assertions made by audited prisons e.g. written care pathways or policy documents. The key results of this audit are highlighted below:

**Prison-based hepatitis C steering group and clinical leadership**

- 6/21 (29%) had a steering group to oversee the testing, treatment and care strategy in prisons.
- 17/21 (81%) had a clinical lead.

[1] The Health Protection Agency's PIP team is commissioned by OH to co-ordinate the surveillance of infectious diseases affecting the prison population. The PIP team is now part of the Health and Justice Team, PHE.

[2] Offender Health is responsible for leading on development and delivery of a cross government health and criminal justice programme. The programme's common aim is improving health and social care outcomes for adults and children in contact with the criminal justice system, focusing on early intervention, liaison and diversion. This function has now moved into the Health and Justice Team within PHE.

- 10/21 (48%) had a clinical team who would oversee the operational side of treating and caring for prisoners with hepatitis C.

**Policy and governance**

- 13/21 (62%) prisons had a written hepatitis C policy or equivalent document. These documents varied in quality. Of those with a written policy:
  - 12/13 (92%) included criteria for testing;
  - 9/13 (69%) included guidance on providing results;
  - 7/13 (54%) included post-test discussion information for those with positive results;
  - 6/13 (46%) included post-test discussion information for negative results;
  - 9/13 (69%) included guidance on managing positive results;
  - 9/13 (69%) included guidance on managing negative results.
- 15/21 (71%) of prisons reported some testing and treatment data in 2011 (calendar year). 95% reported testing information to the Prison Health Performance Quality Indicators (PHPQIs) for 2011/12[3]. According to prison data, the number tested in 2011 ranged from 0 to 465 per prison. However, according to PHPQI data, the number tested in 2011/2012 ranged from 0 to 370 and according to sentinel data 1 to 416. There is generally not a good correlation between the prison reported data, PHPQI data, PIP team records and data recorded by the Health Protection Units (HPUs) on HPZone[4].

**Prevention**

- There are different types of health promotion material available in prisons:
  - 21/21 (100%) had leaflets and booklets;
  - 6/21 (29%) had DVDs;
  - 16/21 (76%) had posters.
- 11/21 (52%) of prisons had blood-borne virus (BBV) material available in the induction programme for new receptions.
- Disinfectant tablets were available in 17/21 (81%) prisons. These were accessed in a variety of means:
  - 9/17 (53%) were available from dispensers;
  - 7/17 (41%) were available directly from prison officers (mainly wing staff);
  - 2/17 (12%) were available from healthcare staff[5];
  - A variety of staff were responsible for monitoring and replenishing disinfectant tablets, however in most cases these were prison officers.

**Testing**

- Testing is offered in 20/21 prisons (95%) and in all these prisons the testing is carried out by healthcare staff. Testing is also carried out by genito-urinary medicine (GUM)

[3] PHPQI data is collated annually from April to March.
[4] HPZone is a web based case management and surveillance tool designed by the HPA to support their health protection work.

services (15/21, 71%); Integrated Drug Treatment Service (IDTS) / Counselling, Assessment, Referral, Advice and Throughcare (CARAT) teams (13/21, 62%), and GP / medical officer (2/21, 10%).

- Venous blood testing is carried out by all prisons (21/21, 100%)[6] and it is the predominant mode of testing in 20/21 (95%). One prison uses dried blood spot testing (DBST) as the main test.
- 13/21 (62%) of prisons stated that blood samples were automatically tested by polymerase chain reaction (PCR).
- 16/21 (76%) of prisons have a documented pre-test discussion and 15/21 (71%) have a documented post-test discussion.

**Service delivery**

- The most common service delivery model is hospital outpatient (52%, 11/21), followed by hospital in-reach (43%, 9/21) and GP led (1/21, 5%).
- Most prisons are not able to provide further investigations for hepatitis C in prison. 2/21 (10%) of prisons have a Fibroscan and 3/21 (14%) have access to an ultrasound.
- Some form of psychosocial support was available in 52% (13/21) of prisons, but only around half of these were provided by mental health services.

**Continuity of care**

- 86% (18/21) prisons reported that they either always or sometimes place prisoners on medical hold[7] if they had started treatment and 3/21 (14%) prisons stated that they did not place prisons on medical hold.
- If a prisoner on treatment for hepatitis C is released into the community, prisons had a variety of ways to ensure that he/she is referred to the appropriate service:
    - 11/21 (52%) contacted local service providers;
    - 5/21 (24%) contacted local service providers and GP;
    - 1/21 (5%) either contacted local service provider or GP;
    - 3/21 (14%) gave the prisoner a SystmOne[8] summary to give to his/her GP;
    - 1/21 (5%) no detail was provided.
- When a prisoner who is hepatitis C positive is transferred to another prison, the action taken by prisons to ensure continuity varies:
    - 6/21 (29%) use SystmOne only;
    - 13/21 (61%) use SystmOne and contact by fax or phone to receiving prison healthcare;
    - 2/21 (10%) Use SystmOne and contact by fax or phone to receiving prison healthcare and consultant treating patient.

**Training**

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[5] The mode of accessing disinfectant tablets are not mutually exclusive and so the percentages do not add up to 100%.
[6] One prison does not offer testing but prisoners may be referred or self referred for testing, in which case an in-reach testing service is provided.
[7] The term medical hold refers to when a prisoner is prevented from being moved to another prison for health reasons.
[8] SystmOne is a patient clinical management system used by GPs and primary care staff in prison.

- Most prisons 81% (17/21) had training on BBVs for healthcare staff; 48% (10/21) had training for prison officers and 57% (12/21) had training for drug workers. This varied considerably in frequency.

**Overview**

- The main points to come out of the audit were that although there were many areas of good practice, the quality and content of hepatitis C service provision is variable. There are a number of areas for improvement. In particular:
    - Ensuring there is a written policy in place covering the key areas of testing, treatment and care. Prisoners should ideally only be tested for infection if there is a clear care pathway in place to ensure those who test positive receive high quality care in an appropriate and timely fashion.
    - Ensuring that testing is offered to all prisoners with proactive targeting of high risk individuals and that prisoners are aware of how to get tested for BBVs as well as prevention, testing and treatment options.
    - Ensuring that there is adequate training available for healthcare staff, substance misuse services and prison officers not formally in healthcare roles. This would vary depending on the person's role, but all staff working with prisoners play an important part in promoting health and encouraging at-risk prisoners to be tested.
    - Ensuring psychosocial support is available for all prisoners with hepatitis C. There are a number of different services and organisations which can provide support, including The Hepatitis C Trust free phone line, drug and alcohol services and mental health services. Current provision is variable and possibly requires further investigation.
    - The reliability of the data from the five sources published in this report needs to be investigated further as it appears that the sentinel surveillance data does not seem to capture all prisoners tested. It is important that there is a reliable source of intelligence to inform commissioning and service development in order to drive forward quality improvement.

# 2 Background

## 2.1 Hepatitis C in prisons

Hepatitis C is a BBV which is particularly prevalent among groups common in prison populations. Around 75% of people who are chronically infected with hepatitis C will have some degree of active liver disease and approximately 25% will progress to liver cirrhosis over the next 20 years, of whom 1-4% will develop liver cancer each year (Hawker et al, 2012). Hepatitis C is curable in many cases. However, many people living with the disease are unaware of their infection as it is largely asymptomatic in the early stages. Early detection and, as a result, early intervention improves the success rate of the treatment, and avoids expensive and difficult future treatment of the long term conditions which can result from chronic hepatitis C infection.

Injecting drug use (IDU) is the primary risk factor for infection in the UK (over 90% of new infections are acquired through this [HPA, 2012]). Research from the Ministry of Justice (Stewart, 2008) on a sample of newly sentenced adult prisoners from 49 prisons in England and Wales found that 68% had used an illicit drug in the past year and 40% had injected a drug during the four-week period prior to custody. Prison provides an ideal opportunity to identify, test and treat high-risk „hard-to-reach' groups and reduce the prevalence of hepatitis C both in prisons and in the wider community. This strategy will avoid downstream costs to the NHS from untreated hepatitis C, including management of cirrhosis and liver cancer.

## 2.2 Policy priorities

The Chief Medical Officer's first annual report was published in December 2012 (Davies SC, 2012). One of the key issues to emerge from this report is that comprehensive action is needed to address the rising rates of liver disease. Liver disease is the only major cause of mortality and morbidity that is on the increase in England while it is decreasing among our European peers. Between 2000 and 2009, deaths from chronic liver disease and cirrhosis in the under 65s increased by around 20% while they fell by the same amount in most EU countries. All three major causes of liver disease – obesity, undiagnosed infection, and, increasingly, harmful drinking – are preventable (Davies SC, 2012). Both the NHS Outcomes Framework and the Public Health Outcomes Framework detail the need to address liver disease:

**NHS Outcomes Framework**

| | |
|---|---|
| Domain 1: | Preventing people from dying prematurely. |
| Overarching indicator: | 1.3 Under 75 mortality rate from liver disease. |

(DH, December 2011)

**Public Health Outcomes Framework**

| | |
|---|---|
| Domain 4: | Healthcare public health and preventing premature mortality. |
| Objective: | Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. |

Indicator: Mortality from liver disease (4.6i: Under 75 mortality rate from liver disease).

(DH, January 2012)

In the original hepatitis C strategy for England, prisons were identified as a specific setting in which hepatitis C testing and treatment should be delivered (DH, 2002). Subsequently, PHPQIs were developed to measure performance of some aspects of hepatitis C service provision in prison. Hepatitis C detection, treatment and prevention in prisons is also a key part of the DH's liver strategy and the HPA and OH have been working in partnership with the liver strategy team to assist with improving hepatitis C services for prisoners.

In addition to the national hepatitis C survey published in 2012, work has been done nationally to raise the profile of hepatitis C in prisons and encourage the sharing of good practice between estates through national events and literature. Examples of this include the HPA prison health conference held at Newbold Revel in September 2012 and the suite of publications developed for prisons by the British Liver Trust, in partnership with the HPA and OH, around BBVs. The national survey has shown that whilst some prisons offer a range of interventions to address hepatitis C amongst prisoners, others have limited provision and this is something that needs to improve.

## 2.3 Governance

**The Health Protection (Notification) Regulations 2010 (Regulation2)**

The Health Protection (Notification) Regulations 2010 oblige registered medical practitioners to notify the proper officer (usually the Consultant in Communicable Disease Control – CCDC) of the relevant local authority if a patient they are attending is believed to have a disease listed in Schedule 1. This includes acute infectious hepatitis. Laboratories (the corporate body that operates the laboratory or the director of the laboratory if there is not a corporate body) is obliged to report to the HPA causative agents of infectious disease listed in Schedule 2. HPUs are therefore notified of all cases of hepatitis C, both acute and chronic, wherever the patient is tested, including prisons (DH, 2010).

**Prison Health Performance Quality Indicators, 2012**

In 2007, OH issued a set of Prison Health Performance Indicators (PHPIs) to guide Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and prisons in judging their own performance in delivering healthcare services to prisoners. In 2009, in line with measures being developed in the wider NHS, Offender Health redeveloped the PHPIs to become broader indicators of the quality of healthcare in prisons, as well as the performance of other contributing health and prison services. These are now referred to as Prison Health Performance and Quality Indicators (PHPQIs). This development has enabled commissioners to assess how appropriately the needs of prisoners are met, how well commissioned services map to health priorities identified through health needs assessment, and how stakeholders, especially prisoners, value these services.

Prisons are asked to measure themselves against PHPQIs using national definitions. One of the PHPQIs relate to hepatitis C (see text box below).

**Figure 1: Prison Health Performance Quality Indicator 2012 – Hepatitis C**

**1.29 Hepatitis C**
**Green Indicator**
The following are all evidenced:

- Hepatitis C policy agreed by the PCT/Prison Partnership Board, including as a minimum, health promotion, criteria for offering testing and a care pathway with clear criteria for referral to specialist treatment where this is indicated.
- Access to information on harm minimisation, provided through both healthcare and education programmes.
- All those at risk are offered confidential screening for hepatitis C: the numbers of tests performed should be recorded.

**Suggested Supporting Evidence**

- A written hepatitis C policy which includes health promotion, criteria for offering testing and a care pathway with clear criteria for referral to specialist treatment where this is indicated.
- Data on the numbers of tests offered and tests performed should be recorded on a monthly basis and submitted as part of quarterly hepatitis B/C returns to the SHA.

## 2.4 New commissioning arrangements for offender health

From April 2013, NHS England (NHSE) took over direct responsibility for commissioning offender health services. This brings new opportunities to address health needs of people in prison but also new challenges. Effective partnership work between prisons, PHE, NHSE, local authorities and other statutory and third sector organisations will be the key determinant of success in the new system. Co-ordinated arrangements between NHSE and local Clinical Commissioning Groups (CCGs) will be crucial to ensure continuity of care for offenders released before their course of treatment has been completed, or for those testing positive who may more appropriately be treated in the community. The HPA's work with regard to offender health will continue now that the organisation has become part of PHE. This report aims to inform NHSE of the current extent of hepatitis C service delivery across the prison estate and make recommendations for the further development of best practice guidelines and commissioning of robust services for hepatitis C in prison.

## 2.5 National survey of hepatitis C services in prisons in England

Between September and November 2011 the HPA's PIP team, in partnership with OH and the liver disease strategy team at the DH carried out a survey of hepatitis C services in prison in England (DH, July 2012). This provided the following results:

- 110/128 (86%) of prisons in England responded to the survey.
- The overwhelming majority of prisons use venous blood sampling for testing but 10% (11/110) also provided DBST.
- Only 40% (44/110) of blood samples were routinely tested by PCR if they had a positive antibody test result. This step is essential in assessing whether or not there is active infection requiring treatment.
- 82/110 prisons (74%) have written care pathways in place to describe what happens following a positive result.
- The model of hepatitis C treatment delivery varies considerably across the English prison estate with a combination of in-reach services provided by local hospitals,

treatment provision in-house overseen by prison doctors and hospital outpatient appointments.

- From the 70/110 prisons (64%) that were able to supply data, 999 offenders had been referred for specialist assessment and more than 280 individuals from 74 prisons commenced antiviral treatment in 2010.
- 95/110 prisons (86%) provide follow-up for prisoners being discharged into the community but there is no specification on how this may be delivered.

Following the survey, it was agreed that the „good practice guidance' highlighted in the report in addition to existing national guidance should form the basis of standards of care and quality against which prison services could be audited. It was decided therefore to identify an appropriately representative sample of prisons in England and conduct a detailed audit of hepatitis C services provided against this guidance.

### 2.6 Objectives of the audit

The main objectives of this audit are to:

- Describe national best practice standards relating to hepatitis C services in prisons in England.
- Compare hepatitis C services in a representative sample of 20 English prisons against these national best practice standards.
- Provide objective evidence and intelligence for commissioners and service providers to assist in the development and delivery of high quality hepatitis C services in prisons.
- Contribute positively to improving the care of people in prison and the quality of clinical services provided.
- Identify areas of good practice which can then be shared across the prison estate using the information from the audit.
- Identify whether there are impediments to best care which can be addressed by the commissioning body.

### 2.7 Working group

A working group was established for the audit consisting of representatives from the HPA, DH, the prison service and The Hepatitis C Trust (representing service user views). Full membership of the working group is listed in **Annex A.**

### 2.8 Review of Central Returns (ROCR) process

Prior to any research being carried out by the DH, a proposal has to be approved via the ROCR process to ensure that the data being collected is appropriate and necessary. The ROCR process is concerned with supporting the DH and its Arm's Length Bodies (ALBs) to implement the government's policy in 'Reducing the burden' of data collections from the NHS. In order to obtain ROCR approval the audit also had to be approved by the equalities team at the DH and by a Minister. ROCR approval was gained to proceed with this audit (reference: ROCR/12/2179VOLU).

# 3 Audit tool

## 3.1 Audit tool development

The audit tool was developed based on the good practice guidance detailed in the survey of hepatitis C services in prisons in England (DH, July 2012). The audit tool was designed to capture different elements identified as essential to the development and delivery of high quality care for people living with hepatitis C infection in prisons:

- Prison hepatitis C steering group and clinical leadership;
- Policy and governance;
- Prevention;
- Testing;
- Service delivery;
- Continuity of care;
- Staff training.

The tool went through several iterative design stages by the working group. The refined tool was also piloted within a large local prison in order to ensure that it was easy to use, collected data and information which was accessible and acceptable, and gathered the intelligence that was required. Following this pilot stage, minor changes were made to the audit tool before it was disseminated to the prisons selected as part of the national audit. The period for the collection of data relating to testing a treatment was January to December 2011. The final audit tool is available in **Annex B**.

## 3.2 Criteria for judging performance

This section highlights how the audit was designed to test whether the best practice standards are being met.

| **Criterion 1** | **Prison hepatitis C Lead** |
|---|---|
| Best practice guidance | The NICE Public Health Guidance (NICE, December 2012) state that all prison healthcare services should designate a member of staff to be a hepatitis lead who has the knowledge and skills to promote testing and treatment of hepatitis B and C and vaccination for hepatitis B. |
| Audit Question | 2.1 Is there a nominated lead for the hepatitis C service in prison? |
| **Criterion 2** | **Steering group** |
| Best practice guidance | The British Viral Hepatitis Group (BVHG, 2010) recommends that a local multidisciplinary network is in place to develop services and ensure that high quality care is available to all. |
| Audit Questions | 2.2 Is there a steering group for the hepatitis C service in prison?<br>2.2.1 How often does this steering group meet? |

| **Criterion 3** | **Core clinical team** |
|---|---|
| Best practice guidance | There should be regular multidisciplinary meetings (BVHG, 2010). The audit working group also agreed that for prisons, the core clinical team should include prison healthcare and specialists that meet regularly (preferably weekly) to discuss all prisoners on treatment. |
| Audit Question | 2.3 Is there a clinical team that meets regularly to discuss all prisoners on treatment for hepatitis C? |
| **Criterion 4** | **Policy and governance** |
| Best practice guidance | The NICE Public Health Guidance recommends that prison (and immigration removal centre) healthcare services should develop a policy for hepatitis B and C with local partners including secondary care services, that provide treatment, the PHE Centre (PHEC), and commissioners of prison and immigration removal healthcare services (NICE, December 2012). The PHPQI also state that the prison should have a hepatitis C policy agreed by the PCT/Prison Partnership Board, including as a minimum, health promotion, criteria for offering testing and a care pathway with clear criteria for referral to specialist treatment where this is indicated. |
| Audit Questions | 3.1 Is there a written documentation used by the prison on hepatitis C e.g. policy, Standard Operating Procedure (SOP), algorithm etc?<br>3.2 Please tick the areas that this policy covers:<br>• Testing criteria;<br>• Guidance on providing results;<br>• Post-test discussion information for positive results;<br>• Post-test discussion information for negative results;<br>• Guidance on managing positive results;<br>• Guidance on managing negative results.<br>3.3 Who has signed off the current policy?<br>3.4 How often is this policy reviewed? |
| **Criterion 5** | **Data on number of prisoners tested and treated** |
| Best practice guidance | Prisons should have a record of all hepatitis C tests performed as this is part of the PHPQI for hepatitis C. They should have a record of prisoner results and those undergoing treatment to inform service development and care of the patient. |
| Audit Questions | 3.5 During the period, January 2011 to December 2011, please state the number of prisoners who:<br>• Were tested for hepatitis C;<br>• Tested positive for hepatitis C antibodies,<br>- and of these, the number that tested positive for hepatitis C PCR;<br>• Were referred to the local treatment provider e.g. acute hospital trust for treatment;<br>• Commenced treatment; |

| | |
|---|---|
| | • Completed treatment,<br>- and of these, the number of individuals achieving a sustained virological response (SVR). |
| **Criterion 6** | **Health promotion materials** |
| Best practice guidance | The National AIDS Trust (NAT) and DH joint guidance on BBVs recommend that the induction period is a useful time to inform prisoners about hepatitis C and other BBVs (NAT & DH, 2011). Access to information on harm minimisation should be provided through both healthcare and education programmes (PHPQI, 2012). |
| Audit Questions | 4.1 What health promotion materials are available?<br>4.2 Is information on BBVs included in the induction programme for new receptions?<br>4.3 Is information on BBVs including hepatitis C available in:<br>- An easy read format for people with learning disabilities or people with language problems?<br>- Any language other than English?<br>- In Braille?<br>- DVD material with sign language?<br>4.3.1 If any of the above is not available is there a need for it in this prison population? |
| **Criterion 7** | **Disinfectant tablets** |
| Best practice guidance | The PHPQIs state that access to disinfectant tablets for cleaning drug using paraphernalia should be available to all prisoners (DH, 2012). |
| Audit questions | 4.4 Are disinfectant tablets available in the prison?<br>4.4.1 If yes, how are they accessed?<br>4.4.2 Who is responsible for replenishing stocks? |
| **Criterion 8** | **Testing** |
| Best practice guidance | NICE Public Health Guidance (NICE, December 2012) state that all prisoners should be offered access to confidential testing when entering prison and during their detention. Current best practice guidelines suggest that between two and six months after entering prison may be the best time to offer testing although testing should be available at any point during the prisoner's sentence (NAT&DH, 2011).<br><br>Venous blood test is the preferable way to test for hepatitis C as it has the highest specificity and sensitivity; however DBST is recommended as an alternative if venous blood testing is not appropriate (HPA, March 2012). Both have the advantage that all BBVs can be tested simultaneously by PCR. The recent NICE Public Health Guidance (NICE, December 2012) recommend that prison services should have access to DBST for hepatitis B and C for people whom venous access is difficult. |

| | |
|---|---|
| Audit questions | 5.1 Please tick all those in the prison who currently offer testing:<br>• GUM services;<br>• IDTS/CARAT teams;<br>• Prison primary care team;<br>• Other, please specify.<br>5.2 When are prisoners offered testing in the prison regime?<br>5.4 Please tick what type of test you currently provide (venous blood sample, DBST, oral fluid).<br>5.4.1 From the list above which is the most common type of test you perform?<br>5.4.2 For blood samples, are antibody positive tests automatically tested for PCR? |
| **Criterion 9** | **Pre-test and Post-test discussion** |
| Best practice guidance | All prisoners should be offered access to confidential testing for hepatitis C and should receive their result, regardless of their location (NICE, December 2012). Furthermore, healthcare professionals should be competent to carry out pre and post-test discussions (Royal College of General Practitioners, 2007). |
| Audit Questions | 5.3 Do prisoners have a documented pre-test discussion before the test is undertaken?<br>5.5 Do prisoners have a documented post-test discussion after they have had a positive result? |
| **Criterion 10** | **Service delivery model** |
| Best practice guidance | NICE Public Health Guidance (NICE, December 2012) state that for people diagnosed with hepatitis C in prison, prisons should:<br>• Ensure prisoners are referred to and managed by local hepatitis treatment services in liaison with prison healthcare;<br>• Carry out investigations and follow up for hepatitis C in the prison;<br>• Ensure prisoners and immigration detainees with hepatitis B and C are treated in the prison or immigration removal centre, using in-reach services involving local specialist secondary care providers or the prison or immigration removal centre healthcare team. |
| Audit Questions | 6.1 What was the average waiting time from referral to appointment with a specialist in 2011?<br>6.2 What is the service delivery model/s?<br>6.2.1 If more than one model applies which one is used most frequently?<br>6.4 Are any other further investigations provided in the prison e.g. do you have access to a Fibroscan in-house?<br>6.5 If treatment for hepatitis C is provided in house, does the prisoner have to access hospital outpatient department for any reason e.g. biopsy, ultrasound, Fibroscan? |

| **Criterion 11** | **Psychosocial support** |
|---|---|
| Best practice guidance | Living with hepatitis C can cause stress or other mental health problems. The side-effects of the medication also include depression. This means that ongoing support including referral to counselling, psychotherapy and/or psychiatry is key (RCGP, 2007). |
| Audit question | 6.3 Is there any psychological or social support for prisoners with hepatitis C? |
| **Criterion 12** | **Continuity of care** |
| Best practice guidance | The current NICE Public Health Guidance (NICE, December 2012) state that:<br>„The NHS lead for hepatitis treatment in prisons should ensure continuity of hepatitis treatment through contingency, liaison and handover arrangements before the prisoner release date, or before any prisoner or immigration detainee receiving hepatitis treatment is transferred between prisons or removal centres. Once a prisoner has started treatment, it may be helpful to put them on medical hold to ensure continuity of care (which might be compromised by transfer between prisons). Planning should involve NHS, prison and immigration removal centre healthcare services and other agencies working with prisoners or detainees.' |
| Audit questions | 7.1 Are prisoners placed on medical hold during hepatitis C treatment in your prison?<br>7.2 If the prisoner with hepatitis C is released into the community how does the prison ensure that he/she is referred onto the appropriate service?<br>7.3 If the prisoner with hepatitis C is transferred to another prison how does the prison ensure that healthcare services in the receiving prison are informed? |
| **Criterion 13** | **Training staff** |
| Best practice guidance | NICE recommends that all prison (and immigration removal centre staff) are trained to promote hepatitis B and C testing and treatment and hepatitis B vaccination (recommendation 3, NICE, December 2012). |
| Audit questions | 8.1 Please select which groups receive training about BBVs (prison officers, healthcare staff, drug workers or others – please specify) and the frequency of this training?<br>8.2 Please tick the topics below that the training for healthcare staff covers:<br>• testing<br>• monitoring<br>• treatment |

# 4 Methodology and data used

## 4.1 Sampling strategy

The working group agreed that the sampling frame used to select prisons for audit would be those adult prisons covered by the HPA's sentinel surveillance study for hepatitis. Whilst this frame is not statistically representative, it broadly reflects prisons nationally. The HPA's sentinel surveillance study of hepatitis testing in England provides information on trends in testing, individual risk exposures and clinical symptoms. It collects information on hepatitis A, B and C testing carried out in participating sentinel centres. The prisons included in sentinel surveillance were identified as a suitable sampling frame as this would allow triangulation of reported data from audited prison with sentinel surveillance data. 31 adult prisons have been included in the sentinel surveillance system since 2009 and 20 of these were selected in order to obtain a sample representative of the type of adult prison by category, type and size, with a geographical distribution in England as wide as possible. The sampling strategy is presented in **Table 1** below. The working group also decided that a Foreign National Prison (FNP) and 2 private prisons should be included to make the sample representative of the adult prison estate.

**Table 1: Sampling strategy used in the national audit of hepatitis C services in prisons in England, 2013**

| Prison security category and population size requirements | Total number |
|---|---|
| **Category B (at least 1 of each size)** | 4 |
| **Category C/D (at least 2 of each size)** | 7 |
| **Female (any size)** | 1 |
| **High Security (any size)** | 1 |
| **Local (only large and medium in sample frame)** | 7 |
| **Total number of prisons in sample** | 20 |

The prisons were categorised according to size based on their population on 27 July 2012 (National Offender Management Service, [NOMS] 2012).

**Table 2: Size categorisation based on actual prison population[9] on 27 July 2012**

| Size category | Population |
|---|---|
| **Small** | <500 |
| **Medium** | 500-999 |
| **Large** | 1000+ |

[9] 'Population' includes prisoners on authorised absence.

## 4.2 Sentinel surveillance data

Data has been collected and analysed from the HPA's sentinel surveillance of hepatitis testing which shows testing activity within the sample prisons. Two prisons were included in the sample which are not currently covered by the sentinel surveillance laboratories: HMP Forest Bank and HMP Hull. For HMP Hull, data were available from their local HPU on testing and whilst HMP Forest Bank's testing activity is reflected in the sentinel study, data was not submitted during 2011.

## 4.3 Other information resources: HPZone and PIP team reports

HPZone is a web based case management and surveillance tool designed by the HPA to support their health protection work. Reports of infectious diseases made to the HPA are recorded on HPZone along with all associated actions undertaken and information received by the responding HPU. In addition, the PIP team receive reports directly from HPUs of infectious diseases throughout the prison estate in England. This is another valuable source of information when analysing the incidence of hepatitis C in prisons.

## 4.4 Audit rollout

The audit was sent out electronically by the NOMS with a covering letter (**Annex C**) signed by Richard Bradshaw, Director of OH, DH and Michael Spurr, Chief Executive Officer, NOMS on 21st November 2012 to the healthcare managers and governing governors of the 20 prisons selected for the audit. Participants were given the option of either emailing or posting the completed audit to the PIP team. Evidence of auditable information was requested along with information provided in the audit tool including:

- Written hepatitis C documentation used such as care pathway(s), SOP etc.
- Induction programme: i.e. a list of activities carried out during the prisoner's first week in the prison.
- Pre and post-test checklists.
- Health promotion material used (both locally and nationally produced).

The deadline for returning the completed audit tool and associated documentary evidence was 20th December, 2012 initially but this was then extended to 3rd January, 2013. During the audit period, prisons were followed up via email or telephone by the OH and PIP team to encourage completion of the audit.

## 4.5 Audit analysis

The audit analysis was carried out by OH and the PIP team. The results from the audit were analysed using an Excel spreadsheet programme. Thematic analysis was carried out on free text questions. The full results of the audit are available in **Annex E.** They have been summarised in the results section below.

In addition to the 20 sample prisons, the data provided by the pilot prison was included in the audit making the total sample 21[10].

### 4.6 Limitations

There are several limitations to this audit. Firstly, it is based on self-reporting from the prison and is therefore reliant on the responses being accurate. Although the audit was piloted to make sure it was clear and covered all the relevant points, some of the questions are open to interpretation, particularly as different prisons have different names for groups and so on. To try and overcome this, documents were requested as evidence, but not all prisons were able to provide this supplementary information or did not have it. The audits were checked to ensure they were filled in correctly and any answer that looked inconsistent was verified with a follow up call where possible.

Unfortunately due to time constraints and not wanting to place a burden on the whole prison estate only a sample of 21 adult prisons were included in the audit which represents 17% of the total number of adult prisons in England. They were chosen to achieve a representative sample of the prison estate in terms of size of prison and category.

To validate the prison treatment and testing data, data were requested from the sentinel surveillance scheme, PIP team and HPUs. However there were found to be flaws with this data which is discussed later in the report. In addition the data requested were for 2011 in order to have a complete year and so it does not capture recent changes to testing arrangements in the prison post 2011.

[10] One out of the original sample did not respond to the audit request; however an additional prison submitted an audit which is of the same category, in the same region and is also included in the sentinel surveillance scheme so this prison was used to replace the non-responding prison included in the original sample.

# 5 Results

## 5.1 Sentinel Surveillance Data

Data from the sentinel surveillance of hepatitis testing laboratories show that during 2011, for those prisons in this sample, 2,524 prisoners were tested for hepatitis C antibodies of which 222 (9%) were positive. Of these, only 154 (69%) prisoners were subsequently tested for hepatitis C PCR and of these, only 107 (69%) were positive.

## 5.2 Response Rates

The response rate for the audit was 95% with 19/20 prisons completing it. The non responding prison was replaced with a prison not originally invited to participate but completed the audit. This prison is from the same region and of the same category as one that did not respond. Also, the results from the pilot prison are included in the analysis. This means that in total 21 prisons completed the audit. The participating prisons are displayed below. They followed the distribution of sizes and categories set out in **Table 1** except one prison had been re-categorised from B to C and a medium sized category C prison that did not respond was replaced with a small category C prison from the same region.

**Table 3: Participating prisons**

| Prison Name | Category | Size Category | Population on 27.7.12[11] | Total number of receptions[12] | Region |
|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | 1173 | 4250 | North West |
| HMP Whitemoor | High security | Small | 457 | 85 | East of England |
| HMP Altcourse | B local private | Large | 1143 | 4620 | North West |
| HMP Forest Bank | B local private | Large | 1299 | 3911 | North West |
| HMP Leeds | B local | Large | 1088 | 5026 | Yorkshire and the Humber |
| HMP Nottingham | B local | Large | 1033 | 5281 | East Midlands |
| HMP Swaleside | B training | Large | 1088 | 558 | South East |
| HMP Wormwood | B local | Large | 1194 | 5088 | London |
| HMP Durham | B local | Medium | 898 | 4222 | North East |
| HMP Hull | B local | Medium | 885 | 4276 | Yorkshire and the Humber |
| HMP Lincoln | B local | Medium | 646 | 2295 | East Midlands |
| HMP and YOI Littlehey | C and YOI | Large | 1148 | 1181 | East of England |
| HMP Wymott | C | Large | 1158 | 1020 | North West |
| HMP Brixton | C | Medium | 574 | 3478 | London |
| HMP Haverigg | C and D | Medium | 618 | 1058 | North West |
| HMP Stocken | C and training | Medium | 948 | 1683 | East Midlands |
| HMP Canterbury | C and FNP | Small | 280 | 972 | South East |
| HMP Erlestoke | C | Small | 482 | 637 | South West |
| HMP Kingston | C | Small | 203 | NA | South East |
| HMP Shepton Mallet | C | Small | 188 | 73 | South West |
| HMP & YOI Low Newton | Female | Small | 269 | 949 | North East |

[11] NOMS Monthly Bulletin July 2012
[12] Source: 2011/12 PHPQI

## 5.3 Prison hepatitis C leads and steering groups

The section below describes the leadership and oversight of hepatitis C services in prison.

**Table 4: Summary of whether responding prisons had hepatitis C leads and steering groups**

| Prison Name | Category | Size Category | Steering group | Frequency steering group meets | Nominated clinical lead | Job title of clinical lead | Clinical team |
|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | N | | Y | Nurse | Y |
| HMP Whitemoor | High security | Small | Y | Annually | Y | Nurse | N |
| HMP Altcourse | B local private | Large | N | | Y | Nurse | Y |
| HMP Forest Bank | B private | Large | Y | Monthly | Y | Nurse | Y |
| HMP Leeds | B local | Large | Y | Annually | Y | GP | Y |
| HMP Nottingham | B local | Large | Y | Quarterly | Y | Nurse | Y |
| HMP Wormwood | B local | Large | N | | N | | N |
| HMP Swaleside | B training | Large | N | | N | | N |
| HMP Durham | B local | Medium | N | | Y | Nurse | Y |
| HMP Hull | B local | Medium | N | | Y | Nurse | N |
| HMP Lincoln | B local | Medium | Y | Quarterly | Y | Nurse | Y |
| HMP and YOI Littlehey | C and YOI | Large | N | | Y | Nurse | N |
| HMP Wymott | C | Large | Y | Biannually | Y | Nurse | N |
| HMP Brixton | C | Medium | N | | Y | Nurse | N |
| HMP Haverigg | C and D | Medium | N | | Y | Nurse | N |
| HMP Stocken | C and training | Medium | N | | Y | Nurse | Y |
| HMP Canterbury | C and FNP | Small | N | | N | | N |
| HMP Erlestoke | C | Small | N[13] | Quarterly | Y | Healthcare manager/hep C nurse | N |
| HMP Kingston | C | Small | N | | N | | N |
| HMP Shepton Mallet | C | Small | N | | Y | Nurse | Y |
| HMP & YOI Low Newton | Female | Small | N | | Y | Nurse | Y |
| **Total positive responses** | | | **6** | | **17** | | **10** |
| **Percentage out of 21 prisons** | | | **29%** | | **81%** | | **48%** |

### 5.3.1 Steering group

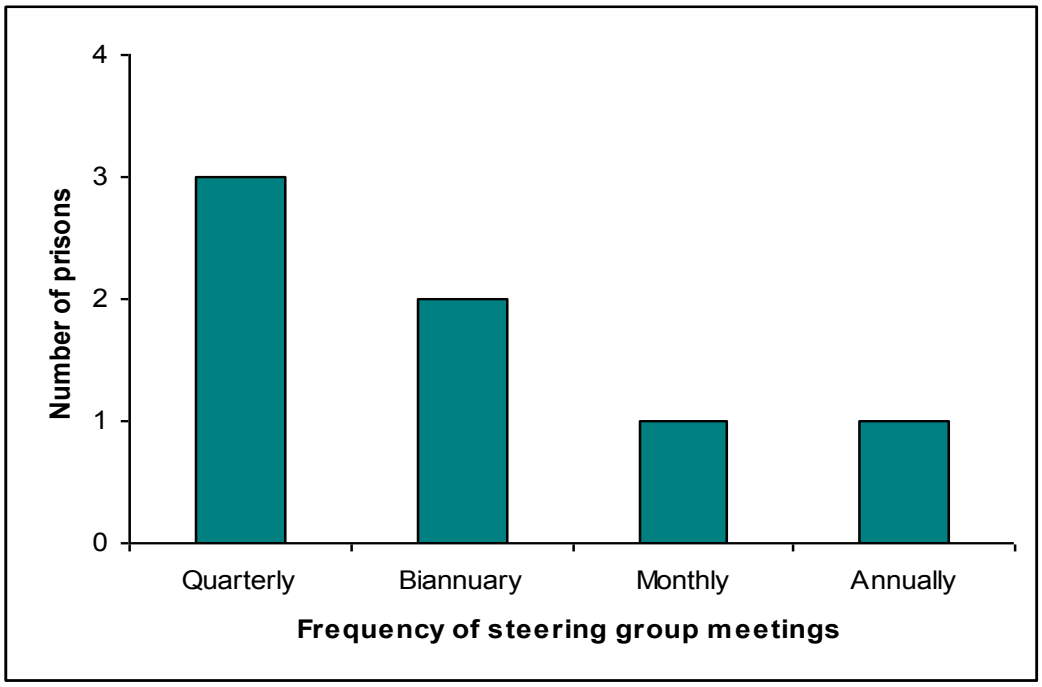
Only 29% (6/21) of respondents had a steering group. All these steering groups included a prison nurse and most also a Local Acute NHS Trust nurse specialist (**Table 5**). 2/21 prisons were in the process of developing steering groups at the time of audit. The frequency of steering group meetings ranged from monthly to biannually (**Figure 2**).

[13] Although HMP Erlestoke does not have a formal steering group it has a communicable disease group that cover hepatitis C.

**Table 5: Steering group membership by professional affiliation (n=6, number of prisons featured in table)**

| Job role of member of the steering group | Number of prisons with named member | Percentage of prisons with steering group including the named member |
|---|---|---|
| Prison nurse(s) including healthcare managers | 6 | 100% |
| Hospital nurse | 4 | 67% |
| Prison drugs team | 3 | 50% |
| Prison pharmacist/ NHS pharmacy lead | 2 | 33% |
| Hospital consultant | 2 | 33% |
| Community drugs team (doctor and/or nurse) | 2 | 33% |
| Prison doctor | 1 | 17% |
| PCT commissioner | 1 | 17% |
| Health protection | 1 | 17% |
| Healthcare assistant | 1 | 17% |

**Figure 2: Frequency of steering group meetings in those prisons where a steering group is established (n = 7 Includes HMP Erlestoke)**




### 5.3.2 Clinical Lead

81% (17/21) of responding prisons had a nominated hepatitis C lead. The majority of the leads were nurses (94%). In one case, the lead was a GP.

### 5.3.3 Clinical Team

The clinical team is the group of individuals in the prison and hospital responsible for the management of the patient. 48% (10/21) of responding prisons had a clinical team and a further 3/21 prisons stated that they had an informal arrangement with the hospital. The median size of the clinical team was 4. The members of these clinical teams are listed in

**Table 6**; the most common members of a clinical team are the prison nurse, followed by prison doctor[14], hospital nurse and hospital doctor.

**Table 6: Clinical team membership by professional affiliation (n=10)**

| | Number of prisons with named member in their clinical team | Percentage of prisons with named member out of those with a clinical team |
|---|---|---|
| Prison nurse(s) including healthcare managers | 10 | 100% |
| Prison doctor | 8 | 80% |
| Hospital nurse | 7 | 70% |
| Hospital consultant | 4 | 40% |
| Healthcare assistant | 3 | 30% |
| Community drugs team (doctor and/or nurse) | 2 | 20% |
| Mental health lead/nurse | 2 | 20% |
| Prison drugs team | 1 | 10% |
| Administrative | 1 | 10% |

## 5.4 Policy and governance

Almost two thirds (62%, 13/21 prisons) of those audited had written hepatitis C documentation in place which is a lower proportion than the survey published in July 2012 which was 74% (82/110). All prisons with a written policy document also had a steering group (**Table 7**). 54% (7/13) of these policy documents were submitted to the audit team.

Most written testing and treatment/policy documents claimed to cover at least one of the key areas of:

- Testing criteria (12/13 prisons);
- Guidance on providing results (9/13 prisons);
- Post-test discussion information for positive results (7/13 prisons);
- Post-test discussion information for negative results (6/13 prisons);
- Guidance on managing positive results (9/13 prisons);
- Guidance on managing negative results (9/13 prisons).

[14] The term prison doctor refers to the doctor overseeing the primary healthcare needs of prisoners in prison.

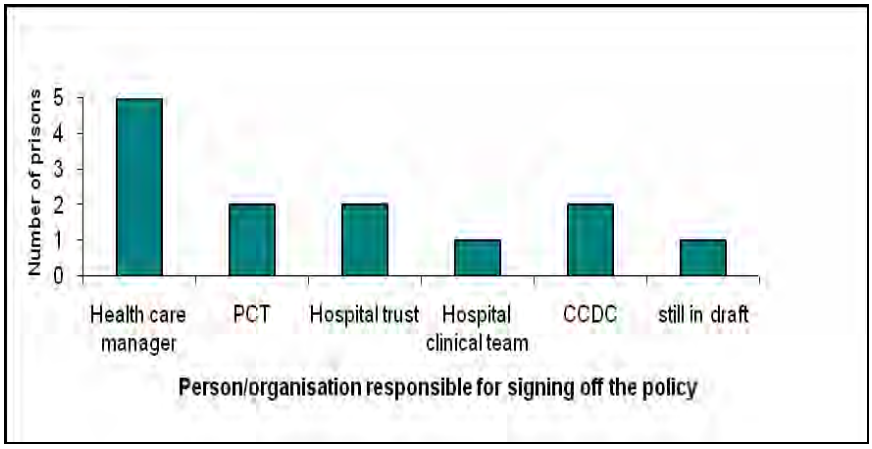
**Table 7: Summary of whether a written hepatitis C policy or equivalent is available in the prison, the professionals responsible for it and its contents**

| Prison Name | Category | Size Category | Written documentation on hep C | Policy content: Testing criteria | Guidance on providing results | Policy content: Post test discussion info for positive results | Policy content: Post test discussion info for negative results | Policy content: Guidance on managing positive results | Policy content: Guidance on managing prisoners with negative results | Who has signed off the current policy? | How often is the policy reviewed? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Whitemoor | High security | Small | Y | Y | Y | Y | N | Y | Y | PCT | Annually |
| HMP Altcourse | B local private | Large | Y | Y | Y | N | N | Y | Y | Hospital Trust | NK |
| HMP Forest Bank | B local private | Large | Y | Y | Y | Y | Y | Y | Y | HC manager | Annually |
| HMP Leeds | B local | Large | Y | NK | NK | NK | NK | NK | NK | PCT | Annually |
| HMP Nottingham | B local | Large | N | N | N | N | N | N | N | NP | NP |
| HMP Wormwood | B local | Large | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Swaleside | B training | Large | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Durham | B local | Medium | Y | Y | Y | Y | Y | Y | Y | CCDC | Under discussion |
| HMP Hull | B local | Medium | Y | Y | Y | N | N | Y | Y | HC manager | Biannually |
| HMP Lincoln | B local | Medium | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP and YOI Littlehey | C and YOI | Large | Y | Y | N | N | N | N | N | HC manager | Annually |
| HMP Wymott | C | Large | Y | Y | N | N | N | Y | Y | Hospital clinical team | NK |
| HMP Brixton | C | Medium | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Haverigg | C and D | Medium | Y | Y | N | N | N | N | Y | still in draft | NK |
| HMP Stocken | C and training | Medium | Y | Y | Y | Y | Y | Y | N | Hospital Trust | Biannually |
| HMP Canterbury | C and FNP | Small | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Erlestoke | C | Small | Y | Y | Y | Y | Y | N | N | HC manager | Annually |
| HMP Kingston | C | Small | N | NP | NP | NP | NP | NP | NP | NP | NP |
| HMP Shepton Mallet | C | Small | Y | Y | Y | Y | Y | Y | Y | HC manager | Every 3 years |
| HMP & YOI Low Newton | Female | Small | Y | Y | Y | Y | Y | Y | Y | CCDC | Under discussion |
| **Total positive responses** | | | **13** | **12** | **9** | **7** | **6** | **9** | **9** | | |
| **Percentage out of 21 prisons / 13 prisons with a policy*** | | | **62%** | **92%*** | **69%*** | **54%*** | **46%*** | **69%*** | **69%*** | | |

NP: No policy, NK: Not known, HC manager: Prison healthcare manager, CCDC: Consultant in communicable disease control, PCT: Primary Care Trust.

The hepatitis C documentation is signed off by a range of people as shown in **Figure 3**.

**Figure 3: Responsible body/manager for approving the prison hepatitis C testing and treatment documentation**




## 5.5 Testing and treatment data

**Table 8** shows data from five different sources on the numbers of prisoners tested and treated in 2011, with the exception of the PHPQI data which is for 2011/12. Nearly a third (29%) of responding prisons had no data on testing, results and treatment and some prisons (48%) only had partial data available. Only 24% (4/21 prisons) had all the data requested.

According to the prisons' data, the number of prisoners tested in 2011 ranges from 0 to 465 per prison. Where the data were available, the positivity rate (the proportion of those that are tested that are positive) for hepatitis C antibodies ranged from 0 to 73%. HMP Littlehey reported that out of 158 prisoners tested none tested positive for antibodies. Only a small number of prisons had data on both hepatitis C antibody and PCR status. Of those that had this data, the majority of prisoners testing positive for hepatitis C antibodies also tested positive for PCR, although this ranged from 0 to 100%. However the prison that recorded 0% testing positive for PCR, HMP Whitemoor, only had one prisoner testing positive for hepatitis antibodies. In HMP Hull only 32% of those who test positive for antibodies were PCR positive, which is perhaps lower than expected. However, caution should be taken when interpreting small numbers.

It is expected that most of those who test positive would be referred to a local treatment provider for treatment, but in some cases, such as HMP Leeds, the service is delivered through a prison GP led model, in which case prisoners may not be referred to local providers unless there are complications such as co-morbidities.

The number commencing treatment whilst in prison in 2011 according to the prison data varied from 0 to 22 per prison. In **Table 8** the proportion of those who commenced treatment in 2011 out of all those who tested PCR positive is displayed, this ranged from 14% to 110%[15], although in the majority of cases this could not be calculated. It is not expected that all prisoners with confirmed hepatitis C will start treatment straight away. This would depend on a number of factors including co-morbidities, cost benefit of the treatment if the patient has a

[15] HMP Durham recorded 110% as a prisoner was initiated on treatment in another prison but completed treatment with them.

very short sentence and crucially the prisoner's willingness to commence treatment. Some people commencing treatment in 2011 could have been tested in the previous year.

The number of prisoners completing treatment in 2011 ranged from 0 to 11 per prison. Given that the treatment takes 48 weeks for genotype 1 and 24 weeks for the other genotypes it is not expected that all those prisoners who commence treatment will complete treatment within the same calendar year. Some of those who complete treatment would have commenced it in a previous year.

Of those prisons that had data, the number of prisoners who commenced treatment in 2011 and achieved SVR ranged from 1 to 11.

The data available from the prisons does not correspond with the sentinel surveillance data, the number reported to the PIP team or those captured on HPZone in most cases (**Table 8**). Sentinel surveillance data were available for 19 out of the 21 prisons however according to the available data the numbers tested varied from 1 to 416 per prison. Of those prisons that were included in the sentinel surveillance, the average proportion that were antibody positive was 9%. Over two thirds (69%) of those who were antibody positive were also tested by PCR.

Only HMP Lincoln and HMP Erlestoke have good correspondence between the number tested according to the prison and the number tested according to the sentinel surveillance data. HMP Stocken, HMP Durham, HMP Littlehey and HMP Nottingham have a considerably higher number of people tested according to the sentinel surveillance system compared to the number recorded by the prison. However, at HMP Leeds and HMP Manchester this feature is reversed. Reasons for this are discussed in the next section. In addition Health Protection Units (HPUs) have different policies for reporting hepatitis C and in some cases only acute cases are recorded on HPZone or cases which require public health action. The PIP team encourage all HPUs to report on confirmed cases of hepatitis C (both acute and chronic ones); however this does not appear to occur consistently.

**Table 8: Testing and treatment monitoring data from the prison and sentinel surveillance system, 2011**

| | | | Prison reported data on testing and treatment for prisoners (numbers refer to 2011) | | | | | | | HPU 2011 | HPA 2011 | Sentinel Surveillance data 2011 | | | | PHPQI 2011/12 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Prison Name** | **Category** | **Size** | **Number tested for hep C Ab** | **Number tested positive for antibody (Ab) hep C (% of total tested)** | **Number tested positive for hep C PCR (% of those testing positive for Ab hep C** | **Number referred to the local treatment provider (% of those PCR positive)** | **Number who commenced treatment (% commencing on treatment after testing PCR positive)** | **Number who completed treatment** | **Of the numbers completing treatment the number achieving SVR (% of those completing treatment in 2011)** | **PIP log** | **HPZone** | **Hep C Ab tested** | **Hep C Ab positive (% of those tested)** | **Hep C PCR tested (% PCR tested out of those Ab pos)** | **Hep C PCR pos** | **Number tested** | **% hep C tests performed out of total number of receptions in that year** |
| HMP Manchester | High security, local | Large | 162 | 22 (14%) | 22 (100%) | 22 (100%) | 22 (100%) | 8 | N/A | 0 | 0 | 1 | 0 (0%) | 0 (-) | 0 | 149 | *4%* |
| HMP Whitemoor | High security | Small | 5 | 1 (20%) | 0 (0%) | 0 | 0 | 0 | 0 | 0 | 4 | 13 | 1 (7%) | 0 (0%) | 0 | 6 | *7%* |
| HMP Altcourse | B local private | Large | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 168 | 29 (17%) | 27 (93%) | 22 | 83 | *2%* |
| HMP Forest Bank | B local private | Large | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0 | ** | ** | ** | ** | 72 | *2%* |
| HMP Leeds | B local | Large | 465 | 93 (20%) | 78 (84%) | 45 (58%) | 11 (14%) | 11 | 5 (45%) | 1 HCV PCR positive | 41 | 309 | 32 (11%) | 29 (91%) | 23 | 309 | *6%* |
| HMP Nottingham | B local | Large | 286 | 70 (24%) | N/A | 31 (N/A)) | 22 (N/A) | 8 | N/A | 29 HCV Ab positive 1 HCV PCR positive | 0 | 416 | 22 (5%) | 0 (0%) | 0 | 318 | *6%* |
| HMP Wormwood | B local | Large | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0 | 253 | 29 (11%) | 16 (55%) | 13 | 0 | *0%* |
| HMP Swaleside | B training | Large | N/A[16] | N/A | N/A | 13 (N/A) | 4 (N/A) | 3 | 2 (67%) | 0 | 1 | 103 | 7 (7%) | 5 (71%) | 3 | 0 | *0%* |
| HMP Durham | B local | Medium | 62 | 33 (53%) | 28 (85%) | 21 (75%) | 16 (57%) | 10 | 11[17] (110%) | 0 | 0 | 144 | 9 (6%) | 8 (89%) | 6 | 141 | *3%* |
| HMP Hull | B local | Medium | 384 | 74 (19%) | 24 (32%) | 23 (96%) | 5 (21%) | 4 | 4 (100%) | 0 | 1 | ** | ** | ** | ** | 370 | *9%* |
| HMP Lincoln | B local | Medium | 104 | NA | NA | NA | NA | NA | NA | 16 HCV Ab positive | 21 | 97 | 19 (20%) | 15 (79%) | 7 | 23 | *1%* |
| HMP and YOI Littlehey | C and YOI | Large | 158 | 0 (0%) | NA | NA | NA | NA | NA | 0 | 4 | 204 | 6 (3%) | 0 (0%) | 0 (-) | 99 | *8%* |

[16] The sexual health service previously carried out the testing at HMP Swaleside but funding was withdrawn in 2011.
[17] One patient's treatment was not initiated but completed at HMP Durham.

| | | | **Prison reported data on testing and treatment for prisoners (numbers refer to 2011)** | | | | | | | **HPU 2011** | **HPA 2011** | **Sentinel Surveillance data 2011** | | | | **PHPQI 2011/12** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prison name | Category | Size | **Number tested for hep C** | **Number tested positive for antibody (Ab) hep C (% of total tested)** | **Number tested positive for hep C PCR (% of those testing positive for Ab hep C** | **Number referred to the local treatment provider (% of those PCR positive)** | **Number who commenced treatment (% commencing on treatment after testing PCR positive)** | **Number who completed treatment** | **Of the numbers completing treatment the number achieving SVR (% of those completing treatment in 2011)** | **PIP log** | **HPZone** | **Hep C Ab tested** | **Hep C Ab positive (% of those tested)** | **Hep C PCR tested (% PCR tested out of those Ab pos)** | **Hep C PCR pos** | **Number tested** | **% hep C tests performed out of total number of receptions in that year** |
| HMP Wymott | C | Large | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 2 HCV Ab positive & 2 HCV PCR positive | 7 | 67 | 11 (16%) | 11 (100%) | 6 | 0 | *0%* |
| HMP Brixton | C | Medium | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 2 HCV Ab positive | 0 | 173 | 11 (6%) | 11 (100%) | 10 | 52 | *1%* |
| HMP Haverigg | C and D | Medium | 113 | N/A | N/A | N/A | N/A | N/A | N/A | 3 HCV PCR positive & 1 Ab positive | 3 | 5 | 4 (80%) | 3 (75%) | 2 | 22 | *2%* |
| HMP Stocken | C and training | Medium | 81 | 5 (6%) | N/A | 5 (N/A) | 3 (N/A) | 3 | 3 (100%) | 14 HCV Ab positive | 34 | 273 | 15 (5%) | 9 (60%) | 0 | 217 | *13%* |
| HMP Canterbury | C and FNP | Small | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 2 | 115 | 9 (8%) | 8 (89%) | 5 | 107 | *11%* |
| HMP Erlestoke | C | Small | 85 | N/A | N/A | N/A | N/A | N/A | N/A | 0 | Not on HPZone | 83 | 5 (6%) | 5 (100%) | 5 | 97 | *15%* |
| HMP Kingston | C | Small | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 22 | 1 (5%) | 1 (100%) | 1 | *** | *** |
| HMP Shepton Mallet | C | Small | 11 | 2 (18%) | 1 (50%) | 0 (0%) | 1 (100%) | 1 | 2 (200%) | 0 | Not on HPZone | 6 | 0 (0%) | 0 (0%) | 0 | 2 | *3%* |
| HMP & YOI Low Newton | Female | Small | 90 | * | * | 12 *(N/A)* | 6 *(N/A)* | N/A | N/A | 15 HCV Ab positive & 1 HCV PCR | Not on HPZone | 72 | 12 *(17%)* | 6 *(50%)* | 4 | 206 | *22%* |
| ***Total*** | | | ***2006*** | ***300*** | ***153*** | ***172*** | ***90*** | ***48*** | ***27*** | | | ***2524*** | ***222 (9%)*** | ***154 (69%)*** | ***107*** | ***2273*** | |

* Data inaccurate due to change in readcode ** not part of the sentinel surveillance system N/A not available/known *** not submitted.
* Ab: Antibody, HCV: Hepatitis C virus, PCR: Polymerase chain reaction, SVR: Sustained virological response.

## 5.6 Prevention

The table below summaries the health promotion material available in the prison as well as other hepatitis C prevention tools.

**Table 9: A summary of health promotion information available in the prison**

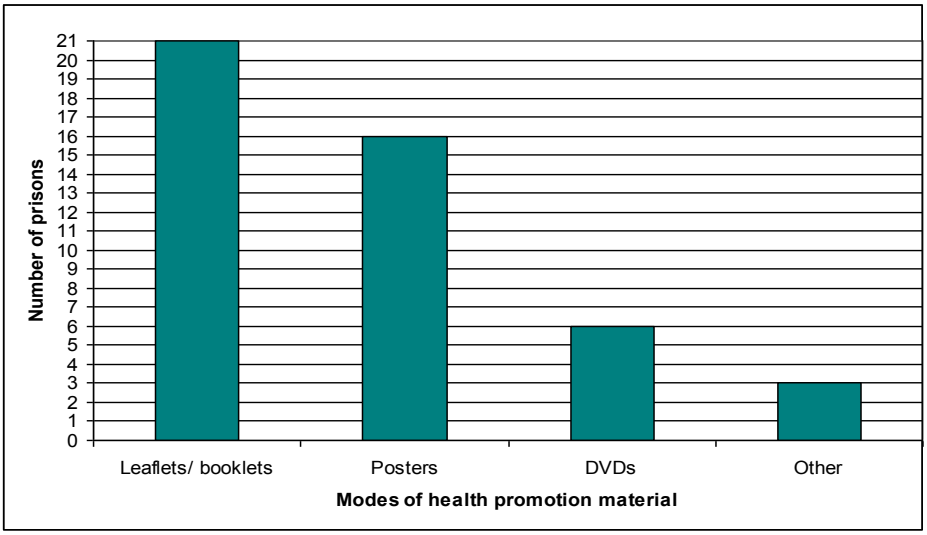
| Prison Name | Category | Size Category | Health promotion material - Leaflets/booklets | Health promotion materials -DVDs | Health Promotion Materials- posters | BBV materials available in induction period | Disinfectant tablets available? | How are they accessed? (dispensers, HC staff, prison staff)* | Who is responsible for stock replenishment?* |
|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Y | N | Y | Y | Y | D | PO |
| HMP Whitemoor | High security | Small | Y | Y | Y | Y | Y | PO | CS |
| HMP Altcourse | B local private | Large | Y | N | Y | N | Y | D | NR |
| HMP Forest Bank | B local private | Large | Y | N | Y | Y | Y | D | PO |
| HMP Leeds | B local | Large | Y | N | Y | N | Y | PO | NK |
| HMP Nottingham | B local | Large | Y | N | Y | Y | N | NA | NA |
| HMP Wormwood | B local | Large | Y | N | N | N | N | NA | NA |
| HMP Swaleside | B training | Large | Y | N | N | N | Y | PO | PO |
| HMP Durham | B local | Medium | Y | Y | Y | N | N | NA | NA |
| HMP Hull | B local | Medium | Y | N | N | N | N | NA | NA |
| HMP Lincoln | B local | Medium | Y | Y | Y | Y | Y | PO | PO |
| HMP and YOI Littlehey | C and YOI | Large | Y | N | Y | Y | Y | PO | PO |
| HMP Wymott | C | Large | Y | N | Y | N | Y | PO | PO |
| HMP Brixton | C | Medium | Y | N | Y | Y | Y | HC | HC |
| HMP Haverigg | C and D | Medium | Y | N | Y | | Y | PO | PO |
| HMP Stocken | C and training | Medium | Y | N | Y | N | Y | D | PO |
| HMP Canterbury | C and FNP | Small | Y | N | Y | Y | Y | D & HC | HC |
| HMP Erlestoke | C | Small | Y | Y | Y | N | Y | D | H&S |
| HMP Kingston | C | Small | Y | Y | N | Y | Y | D | HC |
| HMP Shepton Mallet | C | Small | Y | N | Y | Y | Y | D | PO |
| HMP & YOI Low Newton | Female | Small | Y | Y | N | Y | Y | D | HC |
| **Total positive responses** | | | **21** | **6** | **16** | **11** | **17** | | |
| **Percentage out of 21 prisons** | | | **100%** | **29%** | **76%** | **52%** | **81%** | | |

D: staff Dispensers, HC: Healthcare, PO: Prison officers, H&S: Prison health and safety, NK: Not known, NR: No response, NA: Not applicable, CS: Prison central stores.

### 5.6.1 Health Promotion Material

All prisons who responded had hepatitis C health promotion leaflets and most (76%, 16/21 prisons) had posters. About one third (29%, 6/21 prisons) had the OH produced hepatitis C DVD[18] (**Figure 4**). Other examples of health promotion materials and interventions mentioned were the OH commissioned BBV materials[19], health information playing cards, The Hepatitis C Trust talks with prisoners and Life Channel[20]. Over half (52%) of prisons audited had health promotion hepatitis C material available during the induction period. The induction period is generally defined as the first seven days in the prison during which time prisoners have general orientation and introduction sessions to different aspects of prison life, including health and wellbeing. They would usually have the second health screen during this period. A list of materials available in the sample of prisons is detailed in Annex D.

**Figure 4: Nature of health promotion material on hepatitis C diagnosis, prevention and management available in responding prisons (not mutually exclusive)**



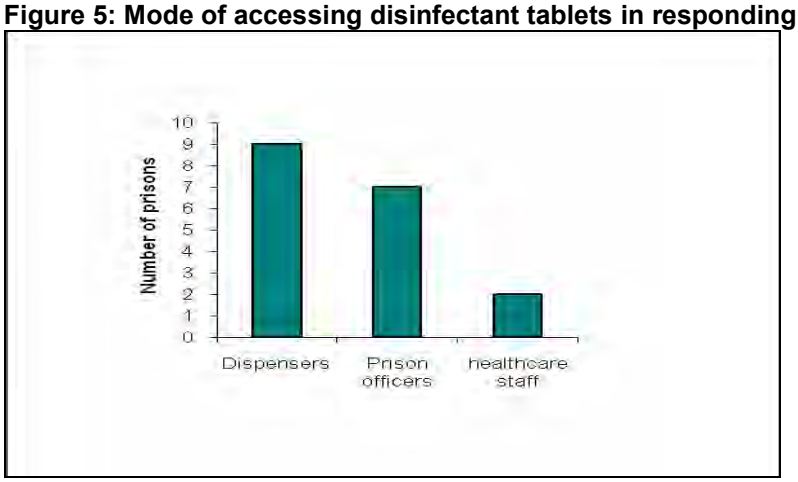

7/21 prisons claimed to have access to information on hepatitis C in different languages either through written material or the use of interpreting services when necessary. 6/21 prisons requested additional material for prisoners with learning disabilities or where English is not the prisoner's first language. The FNP mentioned the need for material in multiple languages, in Braille as well as the need to adapt materials for people with learning disabilities. 1 prison requested to have a DVD to be used in the healthcare waiting room whilst people are waiting for their appointment.

### 5.6.2 Disinfectant tablets

17/21 (81%) prisons reported having disinfectant tablets available. One prison was planning to reintroduce disinfectant tablets as the dispenser had previously been vandalised. In prisons where disinfectant tablets are available, just over half use dispensers (9/17, 53%), but in some cases the prisoner has to request disinfectant tablets from healthcare staff (2/17, 12%) or prison officers (7/17, 41%). In one prison, tablets were available in dispensers and from prison staff.

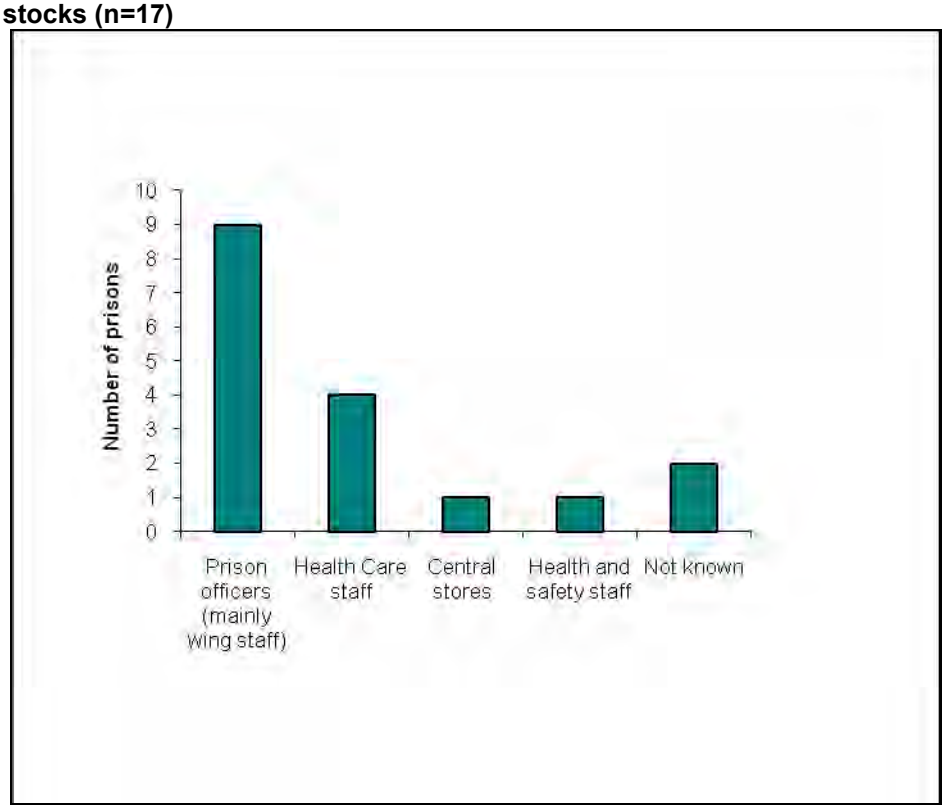
[18] The „Bleach Works' DVD is a short engaging animated film, made by Lifeline and Exchange Supplies for prison health and the NTA as part of the Harm Reduction Works campaign materials.
[19] The British Liver Trust developed a „blood-borne virus awareness' series of leaflets and posters aimed at prisoners.
[20] Life channel is a prison-based TV service provided by a private company in a significant number of prisons in England.

**Figure 5: Mode of accessing disinfectant tablets in responding prisons (n=17) (not mutually exclusive)**




In over half of these prisons, prison officers (9) were responsible for replenishing stock, followed by health care staff (4). In one prison, the stores department routinely ordered the same monthly stock.

**Figure 6: The person responsible for monitoring and replenishing disinfectant tablet stocks (n=17)**



## 5.7 Testing

The table below details who offers testing in the prison, the type of test and the time in the prison regime the test is offered.

**Table 10: Summary table on health and care services providing testing in prisons**

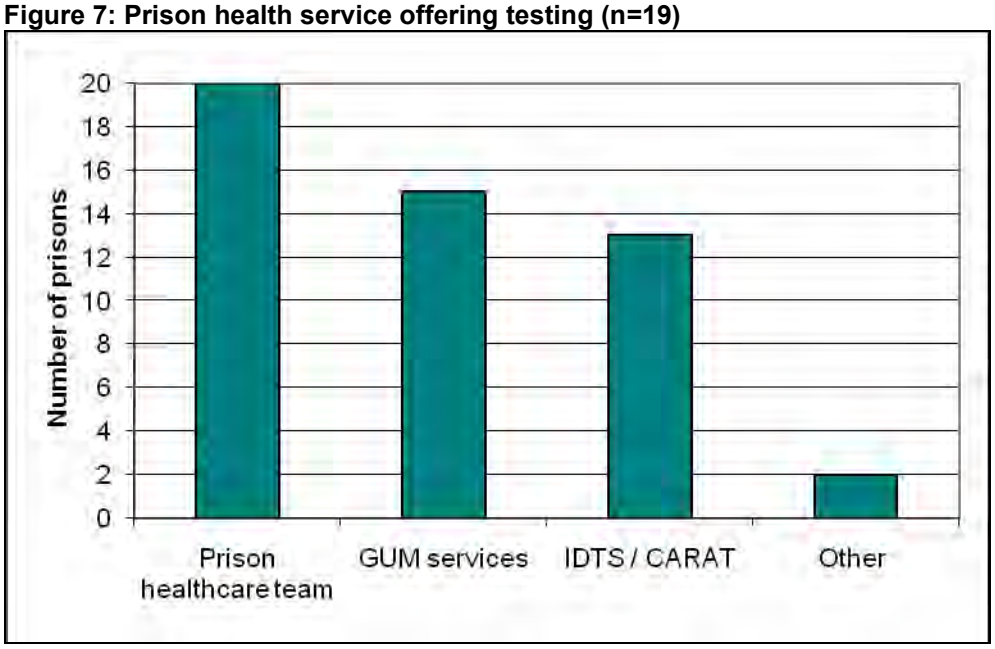
| Prison Name | Category | Size Category | GUM services offer testing? | IDTS / CARAT offer testing | Prison healthcare team - offer testing | Documented pre-test discussion | Type of test available - Venous Blood Sample (VBS) | Type of test available - Dried blood spot test (DBST) | Type of test available Oral fluid | Most common test performed | Are blood samples tested automatically for PCR? | Documented post-test discussion? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Y | Y | Y | Y | Y | Y | N | DBST | Y | Y |
| HMP Whitemoor | High security | Small | Y | Y | Y | Y | Y | N | N | VBS | N | Y |
| HMP Altcourse | B local private | Large | Y | N | Y | N | Y | N | N | VBS | Y | N |
| HMP Forest Bank | B local private | Large | Y | N | Y | Y | Y | N | N | VBS | N | Y |
| HMP Leeds | B local | Large | N | N | Y | N | Y | Y | N | VBS | Y | N |
| HMP Nottingham | B local | Large | Y | Y | Y | Y | Y | N | N | VBS | Y | Y |
| HMP Wormwood | B local | Large | Y | N | Y | N | Y | N | N | VBS | N | N |
| HMP Swaleside | B training | Large | N | N | N | N | Y | N | N | VBS | N | N |
| HMP Durham | B local | Medium | Y | Y | Y | Y | Y | Y | N | VBS | Y | Y |
| HMP Hull | B local | Medium | Y | Y | Y | Y | Y | Y | Y | VBS | Y | Y |
| HMP Lincoln | B local | Medium | Y | Y | Y | Y | Y | N | N | VBS | Y | Y |
| HMP and YOI Littlehey | C and YOI | Large | Y | Y | Y | Y | Y | N | N | VBS | NA | NA |
| HMP Wymott | C | Large | Y | Y | Y | Y | Y | N | N | VBS | Y | Y |
| HMP Brixton | C | Medium | Y | N | Y | Y | Y | N | N | VBS | Y | Y |
| HMP Haverigg | C and D | Medium | N | Y | Y | N | Y | Y | N | VBS | Y | Y |
| HMP Stocken | C and training | Medium | Y | Y | Y | Y | Y | N | N | VBS | N | Y |
| HMP Canterbury | C and FNP | Small | Y | Y | Y | Y | Y | N | N | VBS | N | N |
| HMP Erlestoke | C | Small | N | Y | Y | Y | Y | Y | N | VBS | N | Y |
| HMP Kingston | C | Small | N | N | Y | Y | Y | N | N | VBS | Y | Y |
| HMP Shepton Mallet | C | Small | N | N | Y | Y | Y | N | N | VBS | Y | Y |
| HMP & YOI Low Newton | Female | Small | Y | Y | Y | Y | Y | Y | N | VBS | Y | Y |
| **Total** | | | **15** | **13** | **20** | **16** | **21** | **7** | **1** | | **13** | **15** |
| **Percentage out of 21 prisons** | | | **71%** | **62%** | **95%** | **76%** | **100%** | **33%** | **5%** | | **62%** | **71%** |

VBS: Venous blood sample, DBST: Dried blood spot test

### 5.7.1 Testing logistics

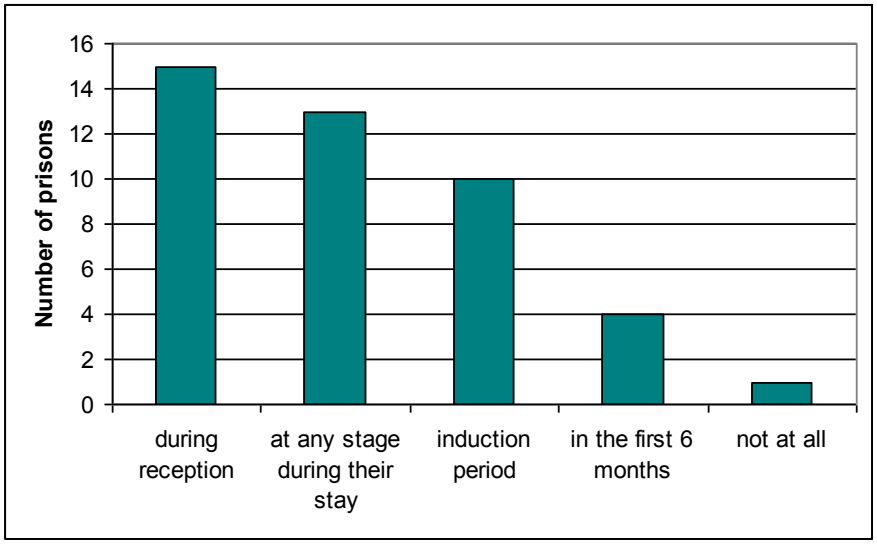
In all bar one prison, the prison healthcare team offered testing (20/21). Most prisons audited however had more than one team offering testing in addition to the healthcare team. 15/21 used Genitourinary Medicine (GUM) services and 13/21 used IDTS/CARAT teams. 2/21 prisons also offered testing through the prison GP / medical officer. One prison (HMP Swaleside) reported that they currently do not offer testing at all, (in 2011 testing was provided by sexual health services which is reflected in the sentinel surveillance data but this arrangement has now ceased). In this prison if the prisoner requests to be tested or the GP advises a test a nurse comes into the prison from the community to carry out the testing.

**Figure 7: Prison health service offering testing (n=19)**




In the majority of prisons offering testing, 75% (15/20) did so during the prisoner's reception period; although most of these commented that they would also offer testing at any stage of their stay (13/20) (**Figure 8**). Several prisons offered testing in the induction period (10/20) and 4/20 offered testing in the first six months specifically.

**Figure 8: Time into sentence when prisoners are offered testing (n = 20) (not mutually exclusive)**



### 5.7.2 Pre-test and post-test discussion

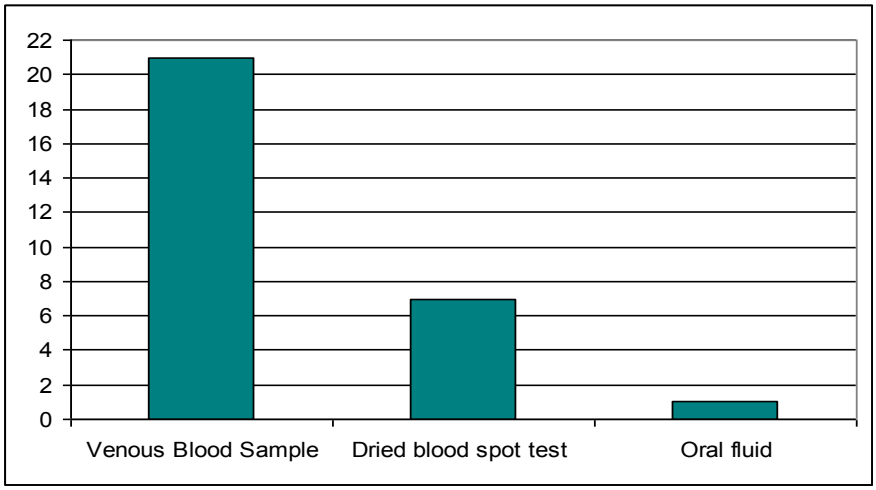
The majority of prisons in the audit (76%, 16/21) stated that they have a documented pre-test discussion with the prisoner. Slightly less (71%), stated that they have a documented post-test discussion. 41% (7) of these prisons provided pre-test and post-test discussion documentation to the audit team. 2 prisons stated that these discussions were documented on SystmOne so they were not able to provide a copy of the documentation.

### 5.7.3 Type of test

All prisons used venous blood sampling to test for hepatitis C, 7/21 prisons also used DBST and one prison also used oral fluid testing. For the majority of prisons, venous blood sample testing (20) was the most common mode of testing and in one prison DBST was the most common.

62% of prisons said their antibody positive samples were tested automatically for HCV PCR. This was an improvement in three prisons from their position in the survey which took place between September and November 2011 (HPA, July 2012).

**Figure 9: Type of test performed in prison (n=21) (not mutually exclusive)**




## 5.8 Service delivery model and other support

Most prisons in the audit only have one service delivery model; 3/21 prisons have two models and one prison has three models. The most common service delivery model is hospital outpatient (52%, 11/21), followed by hospital in-reach (43%, 9/21) (**Figure 10**). One prison had a GP led service. These are slightly different proportions than were observed in the survey carried out in 2011 (HPA, July 2012) which showed 45/110 prisons (41%) refer prisoners to outpatient hospital appointments, 59/110 prisons (54%) have an in-reach service provided by the local hospital and 22/110 (20%)[21] of prisons provide treatment in-house overseen by a prison doctor (although it is likely that many of these prisons misinterpreted the question and were in fact referring to the prison doctor being involved in the patients treatment rather than being the person overseeing it).

[21] Percentage total is in excess of 100% as some prisons reported more than one model.

**Figure 10: Most common service delivery model**

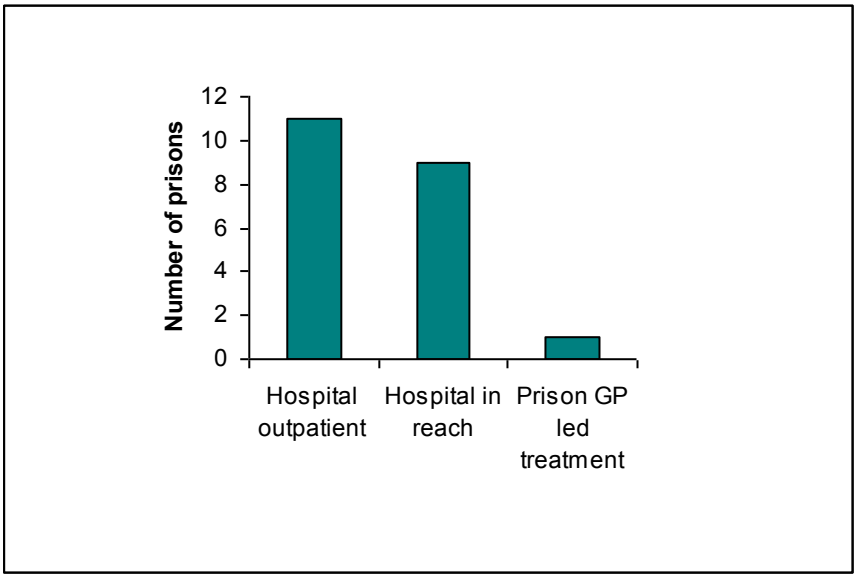


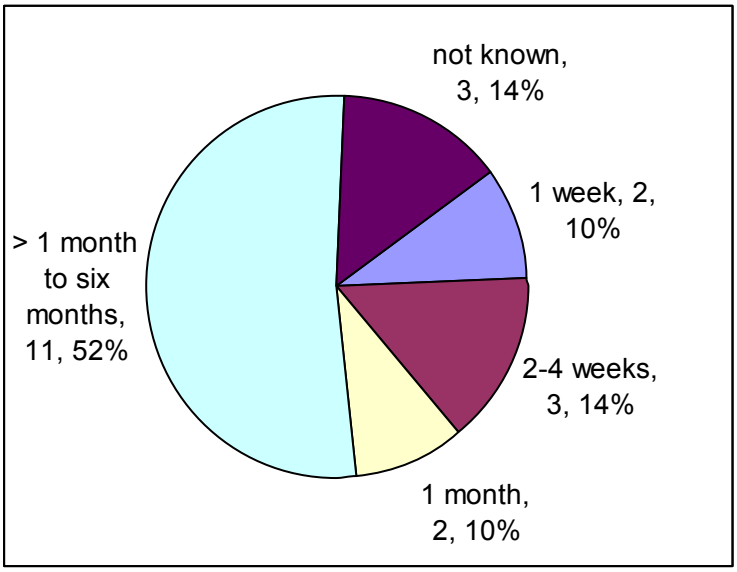
**Table 11: Service delivery model in prisons and details of other support available**

| Prison Name | Category | Size Category | What is the most common service? | Details of additional support available in the prison | Psychological / social support |
|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | HIR | Fibroscan | Y |
| HMP Whitemoor | High security | Small | HO** | Ultrasound | Y |
| HMP Altcourse | B local private | Large | HIR | Fibroscan | N |
| HMP Forest Bank | B local private | Large | HIR | | Y |
| HMP Leeds | B local | Large | GP | | N |
| HMP Nottingham | B local | Large | HIR | | Y |
| HMP Wormwood | B local | Large | HO | | N |
| HMP Swaleside | B training | Large | HO | | N |
| HMP Durham | B local | Medium | HIR | Ultrasound | Y |
| HMP Hull | B local | Medium | HIR | | Y |
| HMP Lincoln | B local | Medium | HO | | Y |
| HMP and YOI Littlehey | C and YOI | Large | HO | Monitoring liver function tests for tolerance | Y |
| HMP Wymott | C | Large | HO | | Y |
| HMP Brixton | C | Medium | HO | | N |
| HMP Haverigg | C and D | Medium | HO | | Y |
| HMP Stocken | C and training | Medium | HIR | | N |
| HMP Canterbury | C and FNP | Small | HO | | N |
| HMP Erlestoke | C | Small | HIR | | N |
| HMP Kingston | C | Small | HO | | Y |
| HMP Shepton Mallet | C | Small | HO | | Y |
| HMP & YOI Low Newton | Female | Small | HIR | Ultrasound | Y |
| **Total** | | | | **6** | **13** |
| **Percentage out of 21 prisons** | | | | **28%** | **62%** |

HO: Hospital outpatients, HIR: Hospital in-reach, GP: Prison GP led, ** will be moving to HIR in the future.

The average waiting time from referral to an appointment with a specialist varied considerably. About one third (34%, 7/21) of these prisons audited had a waiting time of one month or less, and 52% (11/21) had a waiting time above this but less than six months. Prisoners have the same rights to care as people in the community and therefore, under the NHS Operating Framework 2011/2012, prisoners have the right to start consultant-led treatment within a maximum of 18 weeks from referral (just over four months), unless they choose to wait longer, or it is clinically appropriate to wait longer. However, out of the 11 prisons reporting a waiting time of between 1- 6 months it is not possible to see from this data collection in which prisons the waiting time was over four months.

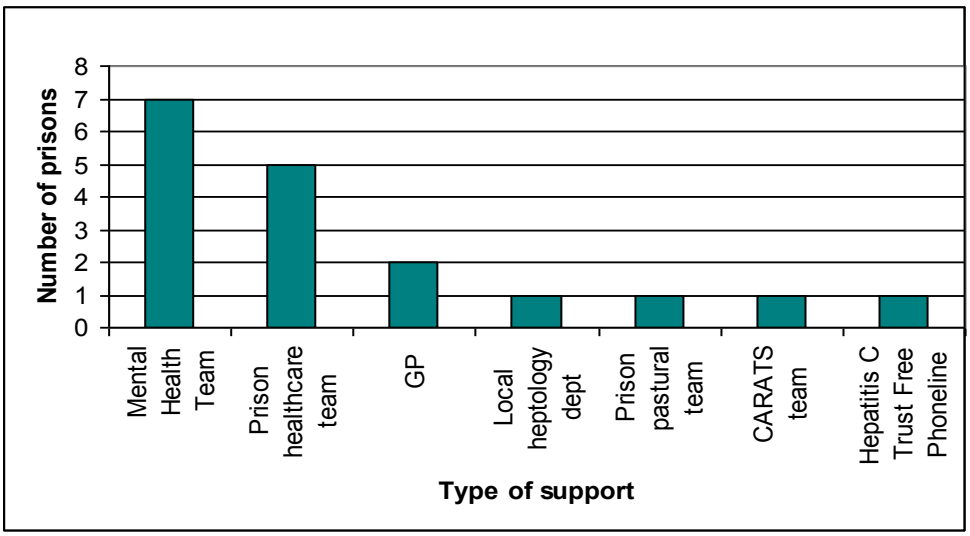
**Figure 11: Average waiting time from referral to appointment with a specialist**




### 5.8.1 Psychosocial support

Some form of psychosocial support was available in 62% (13/21) of the prisons audited and some had a combination of organisations providing this (Figure 12). The most common service is the mental health team in prison, followed by the prison healthcare team. One prison made use of a free telephone helpline provided by The Hepatitis C Trust.

**Figure 12: Number of prisons who use a particular service for psychosocial support for prisoners with hepatitis C**



### 5.8.2 Capacity to undertake further investigations in prison

Two prisons had access to a Fibroscan, 3 to ultrasounds and 3 out of these 5 reported that prisoners would only access hospital outpatient appointments when there are complications. However, the majority of prisons in the sample (76%) reported not having the resources to undertake further investigations in-house meaning that most prisoners have to access further investigations via hospital outpatient appointments.

### 5.8.3 If treatment for hepatitis C is provided in-house does the prisoner have to access hospital outpatients for any other reason?

Of the 10 prisons which provide an in-house treatment service 6/10 (60%) reported that prisoners need to access a hospital outpatient appointment for further investigations such as a Fibroscan or ultrasound. A further 2/10 reported prisoners having to access hospital outpatients to see a consultant. Only 2/10 (20%) prisons reported prisoners not usually having to access hospital outpatients (unless there are complications) as they are able to do routine tests in house through access to a Fibroscan.

## 5.9 Continuity of Care

This section refers to factors that aid continuity of care including medical hold and the type of communication between the community and prisons when prisoners on treatment for hepatitis C are transferred or released from prison.

**Table 12: Summary of the medical hold policy and continuity of care in prison**

| Prison Name | Category | Size Category | Are prisoners placed on medical hold during treatment? | If the prisoner with hepatitis C is released into the community how does the prison ensure that he/she is referred onto the appropriate service? | If the prisoner with hepatitis C is transferred to another prison how does the prison ensure that healthcare services in the receiving prison are informed? |
|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Y | LS | SO |
| HMP Whitemoor | High security | Small | Sometimes | NK | HC |
| HMP Altcourse | B local private | Large | Sometimes | LS/GP | HC |
| HMP Forest Bank | B local private | Large | Y | LS&GP | HC |
| HMP Leeds | B local | Large | Y | LS | HC |
| HMP Nottingham | B local | Large | Y | LS | HC |
| HMP Wormwood | B local | Large | N | LS | SO |
| HMP Swaleside | B training | Large | Y | LS | HC |
| HMP Durham | B local | Medium | Y | LS&GP | HC |
| HMP Hull | B local | Medium | Y | LS | SO |
| HMP Lincoln | B local | Medium | Sometimes | LS&GP | HC |
| HMP and YOI Littlehey | C and YOI | Large | Sometimes | LS | HC |
| HMP Wymott | C | Large | Y | GP | SO |
| HMP Brixton | C | Medium | Sometimes | LS&GP | SO |
| HMP Haverigg | C and D | Medium | Sometimes | LS | HC&HOSP |
| HMP Stocken | C and training | Medium | Sometimes | LS | HC&HOSP |
| HMP Canterbury | C and FNP | Small | N | GP | HC |
| HMP Erlestoke | C | Small | N | LS&GP | HC |
| HMP Kingston | C | Small | Y | GP | SO |
| HMP Shepton Mallet | C | Small | Sometimes | LS | HC |
| HMP & YOI Low Newton | Female | Small | Y | LS | HC |

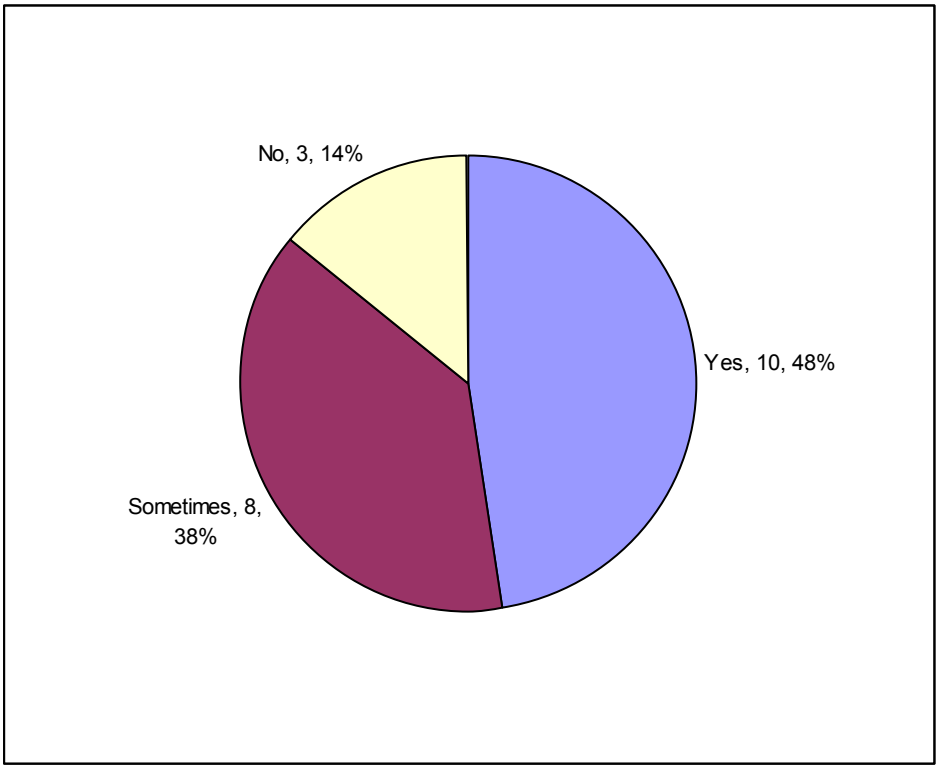
NK: Not known as situation has not arisen, LS: Local hospital services, LS / GP: Local hospital services or GP, LS & GP Local: hospital services & GP, GP: GP only, SO: SystmOne only, HC: SystmOne direct contact with healthcare, HC & hosp: SystmOne and direct contact with healthcare and hospital.

### 5.9.1 Medical hold

48% (10/21) prisons said they kept prisoners on medical hold if they had started treatment and 38% (8/21) prisons said they sometimes did. Reasons given for not always being able to place a prisoner on medical hold could be categorised into three groups:

- Prison service restrictions: 1 prison stated they were no longer allowed to place prisoners on medical hold and another prison stated that due to security or prisoner protection issues the prisoner had to be moved around the estate.
- Prisoner choice: 1 prison mentioned that it was sometimes the prisoner's choice to transfer, but they were encouraged not to do so if they lived locally to maintain continuity of care in that area.
- Receiving prison: 1 prison suggested that it was acceptable to transfer within the region but not outside; 1 prison suggested that they tried to refer care to the next prison rather than delaying a move; and, another stated that it was dependent on whether the receiving prison was able to offer treatment.

**Figure 13: Breakdown of prisons able to place prisoners on medical hold during treatment for hepatitis C**

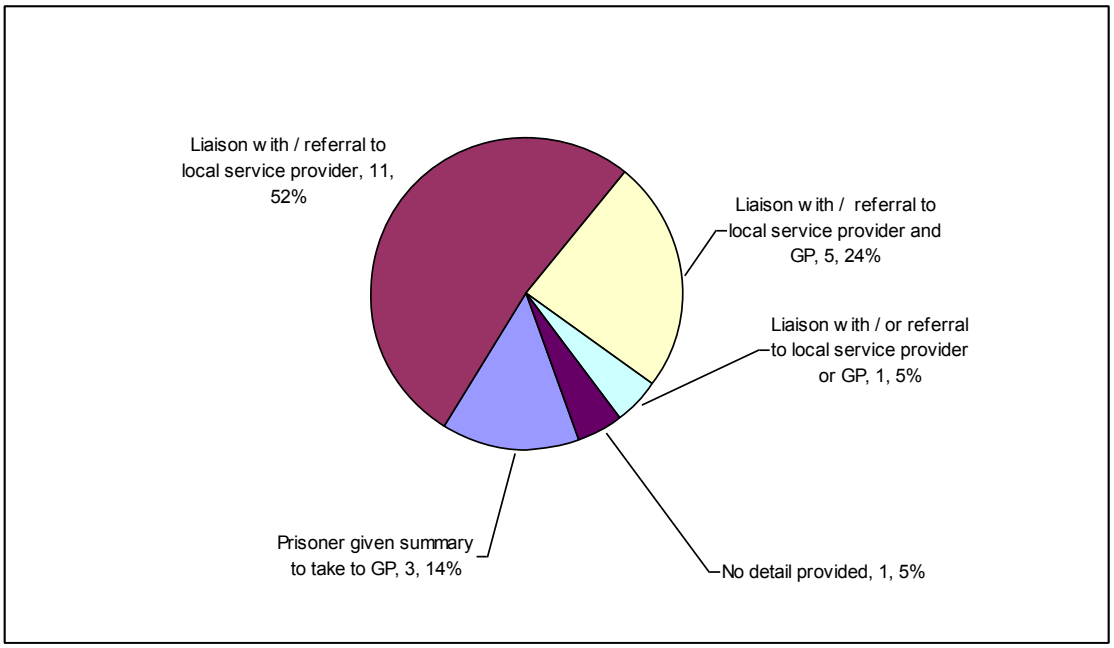


### 5.9.2 Release from prison

Prisons were asked to state how they ensure that a prisoner is referred onto the appropriate service if he/she is released into the community (**Figure 14**). The responses were quite variable and may also be influenced by the mode of service delivery. In most cases the prison would liaise with the local treatment provider if the prisoner is due to be released (17/21), this may involve a new referral in some cases if the prisoner is not already under treatment with this service. This sometimes also includes the GP being informed, although how they are contacted varies considerably. Some prisons contact the GP directly; others give the summary of care to the prisoner to give to the GP. 2/21 prisons commented that it was difficult to contact GPs as prisoners are not always registered with a GP. In one prison, prisoners were just issued with a summary of care from SystmOne and are encouraged to give this summary to their GP who can then request the full record from the prison (in the case of this prison – this was the standard procedure for all discharges which only amounted to two per year so they may not have had experience of releasing prisoners who have had hepatitis C treatment). Three prisons also issued the prisoner with hepatitis C medications on release: in one case this was a one week supply and another 2-4 weeks. Some prisons seemed well set up to ensure continuity of care on release for example one prison commented that on release:

> *'The specialist hepatitis nurse from the local hospital arranges appointments for the patients with the local provider. Adequate medication supply is given to the patient on release. The link nurse within the prison signposts the patient to the relevant support network and external services available.'*

**Figure 14: Actions by prisons to ensure that prisoners are referred onto an appropriate service following discharge back into the community**

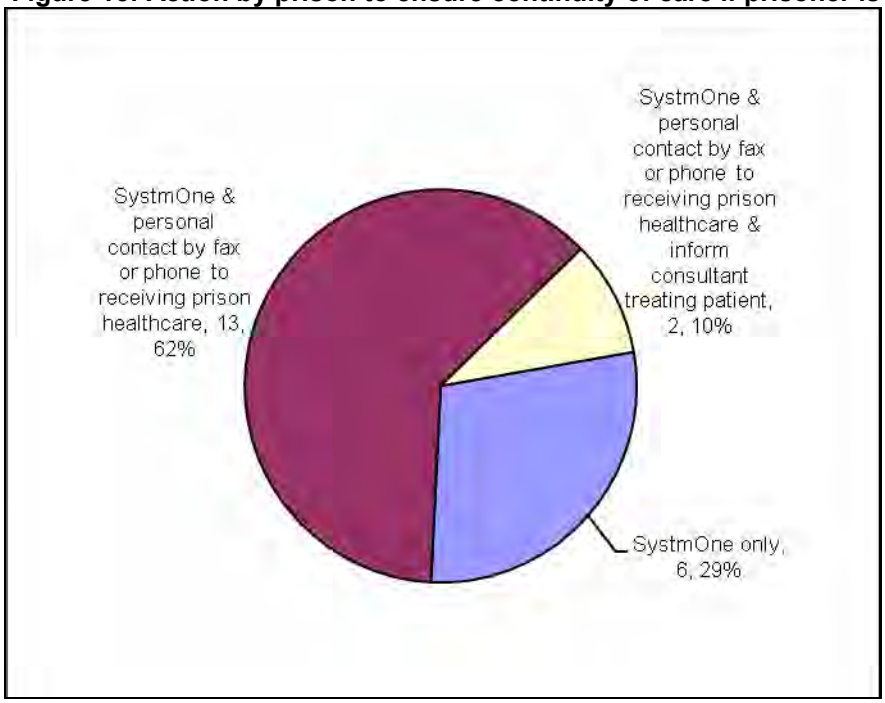



### 5.9.3 Prisoner transfer

**Figure 15** below shows the action the prison takes when transferring prisoners with hepatitis C to another prison to ensure that healthcare in the receiving prison are informed. All prisons have SystmOne, the electronic healthcare record used by GPs. Some prisons (29%, 6/21) rely on this solely to inform the prison healthcare team in the receiving prison. However whilst one

prison commented that there is a BBV flag on SystmOne which is used to alert healthcare that the prisoner has a BBV, some prisons did not seem to be aware of this alert and instead are reliant on either the prisoner telling staff about their condition on transfer or the staff reading the electronic record in full. The majority of prisons (61%, 13/21) also followed this up with personal contact with the healthcare team usually by telephone – some prisons did this when they deemed it was necessary. A further 2/21 prisons also contacted the consultant or clinical team treating the patient. 3/21 prisons mentioned that they would ensure that the prisoner also had a supply of medications on transfer so his treatment would not be disrupted. A further 3/21prisons stated that they would not transfer prisoners undergoing treatment.

**Figure 15: Action by prison to ensure continuity of care if prisoner is transferred to another prison**



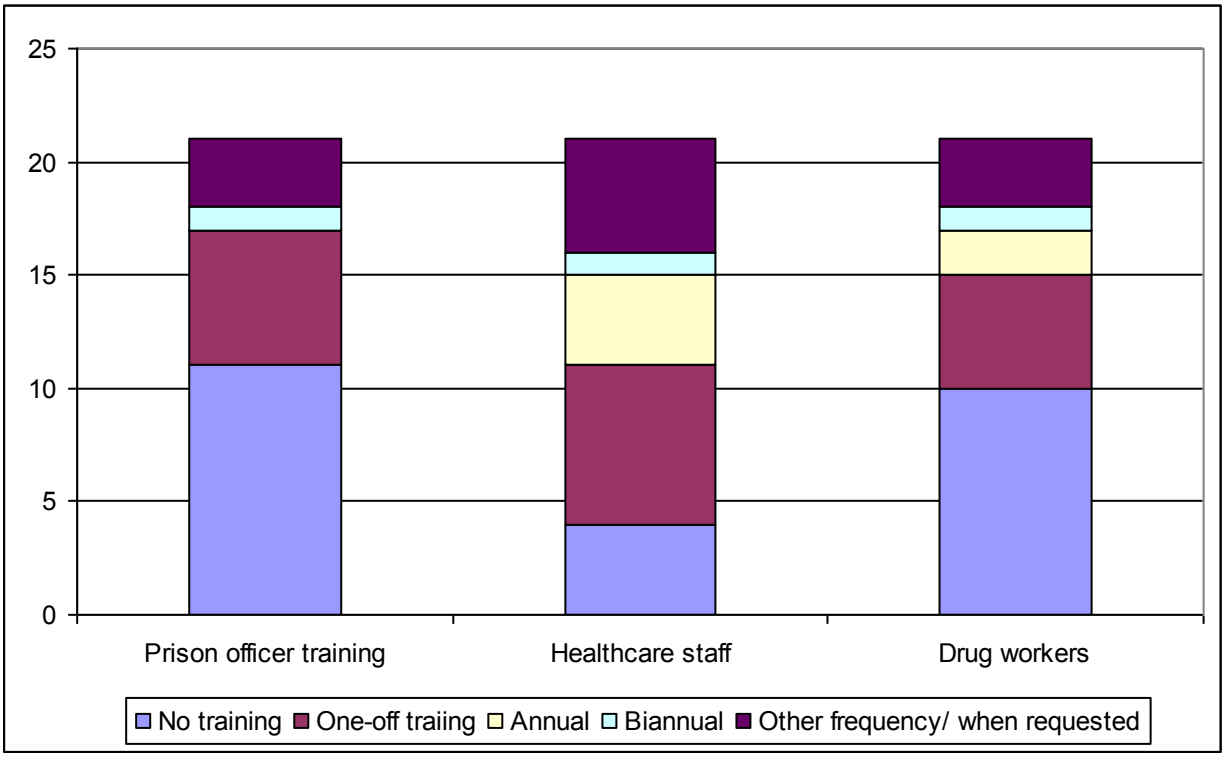

## 5.10 Training

Most prisons 81% (17/21) provided training for healthcare staff. For the majority of prisons this was either one-off training for healthcare staff or arranged on an ad hoc basis when it was needed. Just over half of prisons do not have any BBV training for prison officers (48%, 10/21 prisons) and almost half did not have training for drug workers. Given the variation in responses to the audit, the quality of the material submitted as evidence, and some of the practices reflected in the figures, on-going training and continuing professional development in this area would appear to be required.

**Table 13: Summary of staff training information**

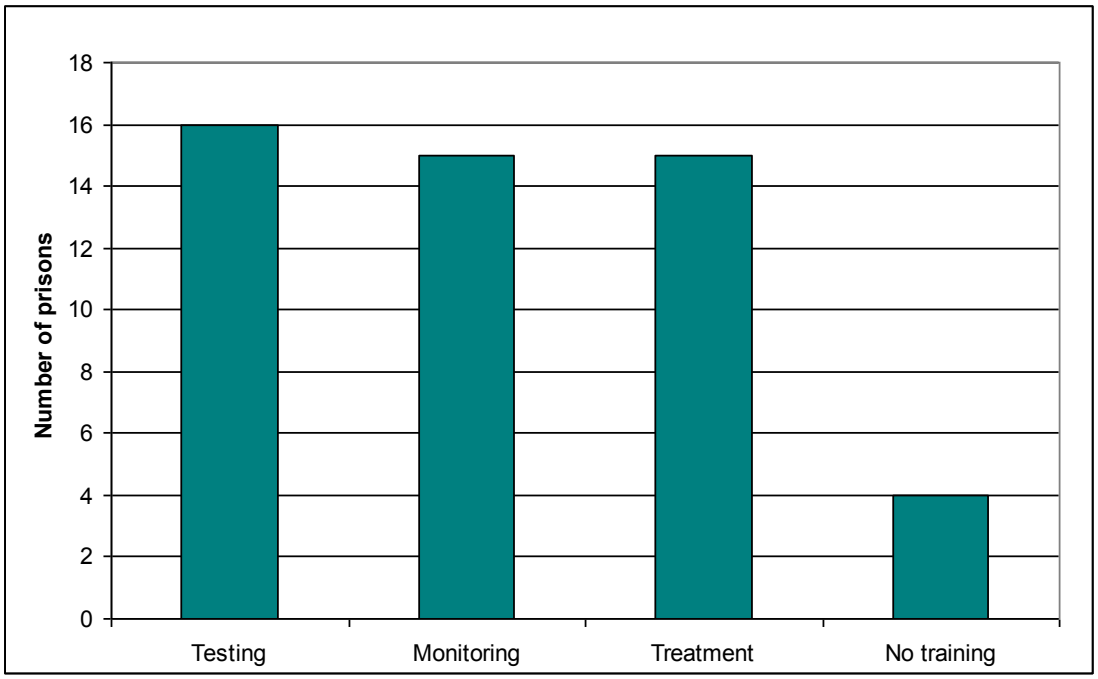
| Prison Name | Category | Size Category | Prison officer training frequency | Drug worker staff training frequency | Healthcare staff training frequency | HC staff training content: Testing | HC staff training content: Monitoring | HC staff training content: Treatment |
|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | None | Other frequency | Annual | Y | Y | Y |
| HMP Whitemoor | High security | Small | Other frequency | Annual | Annual | Y | Y | Y |
| HMP Altcourse | B local private | Large | None | None | None | N | N | N |
| HMP Forest Bank | B local private | Large | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Leeds | B local | Large | One-off training | One-off training | One-off training | Y | N | N |
| HMP Nottingham | B local | Large | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Wormwood | B local | Large | None | When requested | None | N | N | N |
| HMP Swaleside | B local training | Large | None | None | One-off training | N | Y | Y |
| HMP Durham | B local | Medium | Other frequency | When requested | When requested | Y | Y | Y |
| HMP Hull | B local | Medium | None | Biannual | Initial & when requested | Y | N | N |
| HMP Lincoln | B local | Medium | None | When requested | When requested | Y | Y | Y |
| HMP and YOI Littlehey | C and YOI | Large | None | None | None | N | N | N |
| HMP Wymott | C | Large | One-off training | None | One-off training | Y | Y | Y |
| HMP Brixton | C | Medium | One-off training | One-off training | Annual | Y | Y | Y |
| HMP Haverigg | C and D | Medium | None | None | When requested | Y | Y | Y |
| HMP Stocken | C and training | Medium | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Canterbury | C and FNP | Small | None | None | None | N | N | N |
| HMP Erlestoke | C | Small | None | Annual | Biannual | Y | Y | Y |
| HMP Kingston | C | Small | None | None | One-off training | Y | Y | Y |
| HMP Shepton Mallet | C | Small | Biannual | None | Annual | Y | Y | Y |
| HMP & YOI Low Newton | Female | Small | When requested | None | When requested | Y | Y | Y |
| **Total (some training undertaken)** | | | **10** | **12** | **17** | **16** | **15** | **15** |
| **Percentage out of 21 prisons** | | | **48%** | **57%** | **81%** | **76%** | **71%** | **71%** |

**Figure 16: Frequency of training for prison staff by professional group**




All prisons should have training available for healthcare workers that covers testing, monitoring and treatment. Out of the 17 prisons that offered training for healthcare workers most covered these three domains (**Figure 17**).

**Figure 17: The number of prisons covering testing, care and treatment in their training for healthcare workers**



## 5.11 Other Feedback

The majority of prisons provided additional information in the „feedback' section of the audit which asked for further details on possible changes or improvements in the service/process. However, some prisons simply used this section to provide additional information about their audit answers, although 12/21 (57%) provided details about how they would like to improve the service. The table below provides a summary of the issues raised:

**Table 14: A summary of improvements / changes prisons would like to see in relation to hepatitis C service provision**

| Issue | Number of prisons commenting |
|---|---|
| More training for staff | 1 |
| Improve monitoring and data collection | 3 |
| Have a hospital in reach treatment service | 1 |
| Better joint working with teams in prison | 2 |
| Introduction of DBST | 2 |
| Develop better guidance for staff around hepatitis C | 2 |
| Have shorter waiting times from diagnosis to treatment | 1 |

Over half (7/12) of those completing the feedback question said that more training is required amongst prison staff. Furthermore, 7/12 of the prisons responding only have access to hospital outpatient services for treatment and 3 out of these 7 (43%) said that they would like to see a hospital in-reach treatment service developed. Other prisons also commented on the need to introduce DBST to enable more prisoners to be tested for hepatitis C and also that they need to develop better written documentation to guide staff on hepatitis C.

# 6 Discussion and conclusions

The audit has been successful in achieving its original objectives in that:

- National best practice standards relating to hepatitis C services in prisons in England have been identified;
- A comparison of hepatitis C services in a sample broadly representative of English prisons against these national best practice standards has been achieved;
- The audit results provide objective evidence and intelligence for national and local commissioners, prisons and local service providers to assist in the development and delivery of high quality hepatitis C services in prisons.

In highlighting areas of good practice as well as areas of concern, it is intended that the audit will contribute positively to improving the care of people in prison and the quality of clinical services provided and act as a useful resource for professionals in developing hepatitis C services for prisoners. The audit is intended to inform the work of NHSE who have taken over responsibility for the commissioning of offender health services across England. It is crucial that the new commissioning structures are well linked to ensure a seamless pathway for prisoners affected by hepatitis C both in prison and the community. It is hoped that the good practice identified can be shared across the prison estate through developing a network of stakeholders interested in hepatitis C services in prisons.

## 6.1 Hepatitis C leads and steering groups

Most prisons have a clinical lead for hepatitis C but not all. Best practice guidance suggests that every prison should have a clinical lead to promote prevention, testing and treatment. Having someone „champion' improvements in hepatitis C services is valuable in achieving progress. This role may be combined with other BBVs. Most prisons did not have a hepatitis C steering group. This may indicate a lack of strategic oversight or the fact that it is managed by another group such as a BBV or infectious disease group.

## 6.2 Hepatitis C documentation

Only 13/21 (62%) of prisons stated that they had a written hepatitis C policy or equivalent documentation, but those submitted varied in quality and detail. The PHPQIs request that all prisons have a hepatitis C policy which should include:

- Outline of testing criteria;
- Guidance on providing results;
- Post-test discussion information for positive results;
- Post-test discussion information for negative results;
- Guidance on managing positive and negative results.

Treatment for hepatitis C is becoming more complex and it would appear to be an urgent priority to address policy, documentation and oversight (clinical governance) at a local level to ensure safe practice in this area.

### 6.3 Disinfectant tablets

It is a PHPQI that that prisoners in England have access to disinfectant tablets. However, 81% (17/21) of the prisons in the audit provide them. Out of these, only 9/17 (53%) of prisons make the tablets available via a dispenser. Offering tablets via a dispenser was intended to encourage the use of disinfectant tablets by prisoners as they can maintain their anonymity. One prison had problems with the dispenser being vandalised, despite it being designed to be vandal proof. The company which manufactures these dispensers has also gone into administration and therefore they are currently not available. One prison in the audit stated that having to ask prison staff for disinfectant tablets was not a barrier to use, as they have normalised the use of disinfectant tablets and they are not just used to disinfect drug paraphernalia. A more important barrier to accessing tablets was the fact that demand often outstripped supply. There is some uncertainty in a few cases about who should fund disinfectant tablets. This should come from the prison's general healthcare budget.

### 6.4 Data quality

Not all prisons were able to provide testing and treatment data for the audit. Although all but one submitted data on testing for the PHPQIs, most were only able to provide partial data. Data sources have been shown to be inconsistent. The sentinel surveillance data does not match with the prison data. In addition, there were inconsistencies in how different HPUs recorded hepatitis C cases and how they are reported to the PIP team.

In the cases where the sentinel surveillance numbers are greater than the prison-reported testing numbers, it may be because prisoners are also tested by the GUM services whose tests may not necessarily be recorded by the prison. This may be why HMP Swalesdale's numbers being tested for hepatitis C were considerably lower than the sentinel surveillance results as all testing in 2011 was undertaken by the sexual health service (this service no longer provides testing in this prison). In addition, some prisons may have problems extracting data from SystmOne, and therefore the numbers being tested or on treatment may be underreported. The HPA are currently working on a template to help ensure consistent data recording.

In the cases where the sentinel surveillance data is lower than the prison testing numbers, this could be because the laboratories are not correctly identifying all samples that are sent to them through the prison, however, following discussion with the sentinel surveillance team this seems unlikely. Another possible source of variation may arise as a result of individuals undertaking multiple hepatitis C tests within a prison service under different identifiers, which would result in an over ascertainment. Conversely, for those individuals who were first known to sentinel surveillance in a previous year, repeat testing with the same person identifiers, would result in an under-ascertainment.

There is also inconsistency in HPU reporting as not all Units record cases of hepatitis C on HPZone nor do they report all cases to the PIP team. Some HPUs only record acute cases of hepatitis C on HPZone, however it is rare to identify an acute case of hepatitis C as the symptoms are not particularly distinctive. The PIP team encourage the prisons to report all confirmed cases of hepatitis C, but this is best practice and is not mandatory.

As part of the PHPQI, prisons are requested to submit data on the number of prisoners tested for hepatitis C every financial year. It is expected that the submission for 2011/2012 is similar

to the numbers tested recorded by the prison for 2011, although as the time period is slightly different the numbers are unlikely to be identical. In some cases they were similar, but in others there was a marked difference indicating that either one source of data is inaccurate or there is something notable in the amount of testing carried out in the first three months of 2011 or 2012 (when the time periods for the two sources do not overlap).

It is difficult to ascertain which data source, if any, is most accurate which is why further work needs to be done to address these inconsistencies across the prison estate and in the recording by laboratories and HPA.

### 6.5 Testing

The different positivity rates suggest different testing strategies are in place across different prisons. It is a concern that one prison does not feel able to offer testing at all due to lack of resources. For example, HMP Durham has an antibody positivity rate of 53% of all those tested which is high, suggesting a very targeted approach to testing. Literature suggests that between 20-80% of IDUs are hepatitis C positive (Taylor et al, 2000, Goldberg et al 2001, Hag et al 2001, Roy et al, 2001) and around 4% of the non-IDU prisoner population are positive (Gore et al, 1999).

Whilst there has been some improvement in three prisons from their position in the survey which took place between September and November 2011 (HPA, July 2012) there are still only 62% of prisons reporting that their samples are tested automatically for hepatitis C PCR. The laboratory should routinely test for hepatitis C PCR after a positive antibody result (NICE, 2012). According to the sentinel surveillance results for 2011, the percentage antibody positive samples tested for PCR varies from 0 to 100% suggesting that some laboratories are not routinely testing antibody positive results by PCR (**Table 8**). However there may have been an improvement in practice after this time as indicated by some of the prisons responses (**Table 10**).

Testing was generally offered by prison healthcare staff but was also offered by GUM services, drug teams and by GPs in 2 prisons. It is recommended that a wide range of staff feel comfortable in encouraging prisoners to undertake testing, to optimise the opportunities to target high risk individuals.

### 6.6 Service delivery and treatment

The extent of hepatitis C services in prison is very varied. Some prisons appear to be much better equipped to test, treat and support prisoners with hepatitis C. Some prisons are much more reliant on services from outside. For example, one prison was not even able to offer testing but could only respond to prisoner request or GP referral using an in-reach nurse.

### 6.7 Psychosocial support

It is well documented that patients can suffer from psychological problems whilst undergoing treatment for hepatitis C and it is therefore important that they are able to access psychosocial support for this (SIGN, 2006). Worryingly, almost half of prisons did not state that any psychosocial support was available for prisoners with hepatitis C. Some form of psychosocial support was available in 52% (13/21) prisons but only 7/13 were able to access mental health teams.

## 6.8 Training

NICE recommends that all prison (and immigration removal centre) staff are trained to promote hepatitis B and C testing and treatment and hepatitis B vaccination (recommendation 3, NICE, December 2012). This seems quite an aspirational recommendation considering that not all prisons offered training for healthcare staff (81% of prisons audited offered training for healthcare staff) whilst around half offered training for prison officer staff and drug workers. Whilst some prisons offer annual training, the majority of prisons offering training just have a one off session rather than including it in an ongoing programme.

The level of training required obviously varies depending upon the person's role in the prison. Healthcare staff should have regular training on testing, treatment and monitoring, but all staff should be aware of BBVs, the risk factors and benefits of testing and treatment. Non-healthcare staff, such as prison wing officers, spend a lot of time with prisoners and can play an important role in promoting good health and risk avoidance as well as being key to monitoring any changes in prisoner behaviour. The Royal College of Nursing (RCN) and DH have recently published a competency framework for nursing relating to liver disease (February 2013) which provides details on the professional standards expected of practitioners when caring for people with liver disease. It is evident from this audit that a national resource for prison staff to access training would be beneficial in improving the care being provided to prisoners regarding hepatitis C.

## 6.9 Continuity of care

3/21 prisons reported that prisoners are not put on medical hold during treatment for hepatitis C. The majority (18/21) reported that prisoners are put on medical hold during treatment either in all cases or some of the time. Whilst it would be difficult to implement a blanket policy to put all prisoners on hepatitis C treatment on medical hold, it is certainly something that should be attempted to prevent disruption in the treatment. NICE suggests that it may be helpful to put them on medical hold to ensure continuity of care (NICE, December 2012). It is acknowledged that whilst this is best practice the ultimate decision lies with the prison service which considers prisoner and public safety of paramount importance.

The degree of support given to a prisoner when they are hepatitis C positive and are being transferred or released seems to vary widely. The transfer of care arrangements with healthcare in the community when the prisoner is released and healthcare in other prisons vary. Some prisons make direct contact, whilst others rely on SystmOne to inform the receiving prison of the details of any treatment a prisoner may be receiving. Contact with hospital services seems to vary widely too. This may depend on the experience the prison has in dealing with the hospital in hepatitis C care. Some prisons have relatively few prisoners who have been diagnosed with hepatitis C and seem to have less robust plans. In a small number of cases on releasing a prisoner from prison, the prison relies on the prisoner taking their SystmOne summary to their GPs. This may be common practice for prisoners released, but it is a concern that the prisoner may not make contact with the GP, particularly if they are not registered with one and therefore hepatitis C treatment would be disrupted. HMP Leeds provides an example of a model that works well, whereby the hospital, prison and drug service all form a multi-disciplinary team (MDT) and have a clear pathway in place for prisoners being released into the community. Here there is an agreed pathway in place to ensure that anyone started on treatment in HMP Leeds who is then released into the community is then picked up by the community drug service and they will continue their treatment for hepatitis C. This works

well as it allows HMP Leeds to not be so restricted on who they start on treatment if the prisoner is on a relatively short sentence. Furthermore by providing the substance misuse service alongside treatment for hepatitis C in the community, it is more likely that the patient will attend appointments, particularly if they are receiving substitute medication for heroin use.

# 7 Recommendations

1. PHE should work closely with NHSE and other key stakeholders to co-produce a high level service specification in relation to hepatitis C testing, treatment, care and health promotion in prison.

2. The new commissioning structures should work together to ensure clear care pathways are in place between prisons and between the prison and community with regards to hepatitis C.

3. PHE should further explore data inconsistencies in relation to hepatitis C testing and treatment in prisons and should work in partnership with NHSE to improve its accuracy.

4. PHE should work in partnership with NHSE to address the training needs of prison staff with regards to hepatitis C.

5. PHE should liaise with NHSE to look at how better links can be made between prisons and good practice be shared in relation to hepatitis C.

6. Hepatitis C testing should be offered in all prisons and should be available at any stage during the prisoner's stay, not just at reception or immediately afterwards and there should be better co-ordination and partnership between the multiple agencies carrying out BBV testing to improve effectiveness and generate efficiencies.

7. PHE need to ensure that laboratories automatically undertake PCR testing of all positive hepatitis C antibody tests.

8. All prisons should have a hepatitis C policy in place which covers the areas detailed in the PHPQI 2012 guidance.

9. There should be a prison steering group to oversee the delivery of hepatitis C services. Leadership is crucial and the steering group needs to meet regularly to examine the quality of services provided, including the training of healthcare staff.

10. Prisons should ensure that treatment for hepatitis C is available in-house. However it is recognised that there are a minority of prisons in England where the need is not sufficient to warrant such a service, for these prisons there should be a clear and accessible pathway for outpatient based treatment.

11. Prisons should ensure, where possible that prisoners are put on medical hold whilst receiving treatment for hepatitis C.

12. All prisons should ensure that disinfectant tablets are made available to prisoners. These should be made available through the specially designed dispensers previously provided to prisons by OH.

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# 8 Annex A: Hepatitis C working group membership

**Cathie Railton (nee Gillies)**, PIP team Scientist, Public Health England (previously Health Protection Agency)

**Clare Humphreys**, Public Health Specialty Registrar, Offender Health, Department of Health

**Dr Autilia Newton**, Chair of Health Protection Services Prison Network and Local Director for Health Protection, Public Health England (previously Health Protection Agency)

**Dr Éamonn O'Moore**, Director, Public Health England (previously Offender Health, Department of Health)

**Emma Dapaah**, Health Protection Nurse Specialist, Public Health England (previously Health Protection Agency)

**Gary Hemphill**, Peer to Peer Educator, The Hepatitis C Trust

**Joanne Noble**, Nurse, HMP Manchester

**Professor Martin Lombard**, Clinical Director for Liver Disease, Department of Health

**Robert Downs**, Deputy Healthcare Manager, HMP Manchester

**Susanne Howes**, Health Protection Nurse Specialist, Public Health England (previously Health Protection Agency)

# 9 Annex B: Audit tool

## Audit tool for Hepatitis C services in prison

Offender Health, NOMS and Department of Health and Health Protection Agency are undertaking an audit in a sample of prisons to ascertain the current level of hepatitis C service provision in the prison estate and how it compares to best practice. The information gathered through this audit aims to:

- Provide objective information for use by commissioners and service providers in designing and delivering high quality hepatitis C services in prisons;
- Allow further refinement of the „best practice guidance' which can be fed into the next audit cycle;
- Contribute positively towards improving standards of care for people in prison;
- Contribute positively towards improving practice of clinical governance in prisons.

This audit tool in the form of a questionnaire is intended to be filled in by the healthcare manager of the prison or appropriate alternative colleague. Please fill the questionnaire in by selecting the appropriate boxes and providing information and return via email or post to the address at the end of the questionnaire.

If you are completing these forms on the computer: to select a box ☐ click inside the box and write text by selecting and writing in the grey boxes: .

The results of this audit shared with you in Spring 2013. Thank you for your contribution to this work.

## 1. Contact details

**1.1.** Prison name:
**1.2.** Prison category:
**1.3.** Name of person completing the audit:
**1.4.** Contact phone number:
**1.5.** Contact email:

## 2. Steering group and leadership

**2.1. Is there a nominated lead for the hepatitis C service in prison?**

☐ No
☐ Yes Please state job title (e.g. nurse grade, consultant, GP):

**2.2. Is there a steering group for the hepatitis C service in prison?**

☐ No (please go to question 2.3)
☐ Yes Please state the job title and roles of the members of this group
Job title:

**2.2.1. How often does this steering group meet? Please select one box below**

☐ Monthly
☐ Quarterly
☐ Annually
☐ Biannually

**2.3. Is there clinical team that meets regularly to discuss all prisoners on treatment for hepatitis C?**

☐ No
☐ Yes, please state the membership of this team.
Job title:

## 3. Policy and governance

**3.1. Is there a written documentation* used by the prison on hepatitis C?**

- ☐ No (please go to question 3.5)
- ☐ Yes PLEASE SUBMIT A COPY OF THE DOCUMENTATION WHEN RETURNING THE QUESTIONNAIRE

*e.g. Policy, SOP, algorithm

**3.2. Please tick the areas that this policy covers:**

- ☐ Criteria for offering testing
- ☐ Guidance on providing results to prisoners
- ☐ Information on what to cover in a post-test discussion for positive results
- ☐ Information on what to cover in a post-test discussion for negative results
- ☐ Guidance on managing positive results
- ☐ Guidance on managing prisoners with negative results who undertake risky behaviour

**3.3. Who has signed off the current policy? Please state job title:**

| |
|---|
| |

**3.4. How often is the policy reviewed? Please select one box below**

- ☐ Six monthly
- ☐ Annually
- ☐ Biannually
- ☐ Every 5 years
- ☐ Other please specify:

**3.5. During the period, January 2011 to December 2011, please state the <u>number</u> of prisoners who :**
**(state "NA" if the information is not available in your prison)** tested positive for HCV antibodies:

- **3.5.1.1.** and of these, the number that tested positive for HCV RNA:
- **3.5.1.2.** were referred to the local treatment provider e.g. acute hospital trust for treatment:
- **3.5.1.3.** commenced treatment:
- **3.5.1.4.** completed treatment:
- **3.5.1.5.** and of these, the number of individuals achieving a Sustained Virological Response (SVR):

## 4. Prevention

**4.1. What health promotion materials are available?**

- ☐ Leaflets
- ☐ DVDs
- ☐ Posters
- ☐ Other, please specify:
- ☐ No materials are currently available

PLEASE SUBMIT A LIST OF THE MATERIAL WITH THE ORGANISATION WHO PRODUCES THEM E.G. BRITISH LIVER TRUST, HEPATITIS C TRUST, HEALTH PROTECTION AGENCY, LOCAL PCT, PRISON AND SO ON.
IF YOU HAVE ANY LOCALLY PRODUCED MATERIAL PLEASE SUBMIT A COPY OF THEM WHEN RETURNING THE QUESTIONNAIRE.

**4.2. Is information on blood-borne viruses included in the induction programme for new receptions?**

- ☐ No
- ☐ Yes

PLEASE SUBMIT A COPY OF THE INDUCTION PROGRAMME WHEN RETURNING THE QUESTIONNAIRE

**4.3. Is information on blood-borne viruses including hepatitis C available in: (Please select all that apply)**

- ☐ An easy read format for people with Learning Disabilities or people with language problems
- ☐ Any language other than English? Please state which language:
- ☐ In Braille?
- ☐ DVD material with sign language?

**4.3.1. If any of the above is not available is there a need for it in this prison population?**

- ☐ No
- ☐ Yes, please state where there is a need:

**4.4. Are disinfectant tablets available in the prison?**

- ☐ No, please go to question 5.1
- ☐ Yes

**4.4.1. If yes, how are they accessed?**

- ☐ Dispensers
- ☐ From healthcare
- ☐ Other please specify:

**4.4.2. Who is responsible for ensuring stocks of disinfectant tablets are replenished?**

| |
|---|
| |

## 5. Testing

**5.1. Please tick all those in the prison who currently offer testing:**

- ☐ GUM services
- ☐ IDTS / CARAT teams
- ☐ Prison primary care team
- ☐ Other, please specify:

**5.2. When are prisoners offered testing in the prison regime? Please tick all that apply:**

- ☐ During reception
- ☐ In the induction period
- ☐ In the first six months of their stay
- ☐ At any stage during their stay
- ☐ Prisoners are not currently offered the test unless under specific circumstances. Please specify:

**5.3. Do prisoners have a documented pre-test discussion before the test is undertaken?**

- ☐ No
- ☐ Yes, PLEASE INCLUDE THE CHECKLIST WHEN RETURNING THE FORM

**5.4. Please tick what type of tests you currently provide**

- ☐ Venous blood sample
- ☐ Dried blood spot test
- ☐ Oral fluid

**5.4.1. From the list above which is the most common type of test you perform?**

| |
|---|
| |

**5.4.2 For blood samples are antibody positive tests automatically tested for PCR?**

- ☐ No
- ☐ Yes

**5.5. Do prisoners have a documented post-test discussion after they have had a positive result?**

- ☐ No
- ☐ Yes, PLEASE INCLUDE THE CHECKLIST WHEN RETURNING THE FORM

## 6. Service Delivery

**6.1. What is the average waiting time from referral to appointment with a specialist in 2011? Please select one box.**

- ☐ 1 week
- ☐ 2-4 weeks
- ☐ 1 month
- ☐ > 1 month to six months
- ☐ > six months
- ☐ not known

**6.2. What is the service delivery model? If there is more than one service delivery model, please tick all that apply:**

- ☐ Hospital in-reach
- ☐ Hospital outpatient
- ☐ Prison GP led treatment

**6.2.1. If more than one model applies please write here the one that is used most frequently.**

| |
|---|
| |

**6.3. Is there any psychological or social support for prisoners with hepatitis C?**

- ☐ No
- ☐ Yes, please state who provides this support:

**6.4. Are any other further investigations provided in the prison, e.g. do you have access to a Fibroscan in house?**

- ☐ No
- ☐ Yes, please provide details:

**6.5. If treatment for hepatitis C is provided in-house, does the prisoner have to access hospital outpatient department for any reason, e.g. biopsy, ultrasound, Fibroscan?**

- ☐ No
- ☐ Yes, please provide details:

## 7. Continuity of care

**7.1. Are prisoners placed on medical hold during hepatitis C treatment in your prison?**

- ☐ No
- ☐ Yes
- ☐ Sometimes, please state when:

**7.2. If the prisoner with hepatitis C is released into the community how does the prison ensure that he/she is referred onto the appropriate service?**

| |
|---|
| |

**7.3. If the prisoner with hepatitis C is transferred to another prison how does the prison ensure that healthcare services in the receiving prison are informed?**

| |
|---|
| |

## 8. Training

**8.1. Please select which groups receive training about blood-borne viruses and the frequency of this training (please only select one box per row):**

| | No training | One off training | Annual | Biannual | Other, please state |
|---|---|---|---|---|---|
| Prison officers | ☐ | ☐ | ☐ | ☐ | ☐ |
| Healthcare staff | ☐ | ☐ | ☐ | ☐ | ☐ |
| Drug workers | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other, please specify | ☐ | ☐ | ☐ | ☐ | ☐ |

**8.2. Please tick the topics below that the training for healthcare staff covers.**

- ☐ testing
- ☐ monitoring
- ☐ treatment

## 9. Feedback

**If there is anything you would like to change or improve in the process / service please list here:**

### Survey Completion

Thank you very much for taking the time to complete the survey.

Please email or post the survey back to: prisonteam@hpa.org.uk
Prison Infection Prevention team
North Yorkshire and the Humber HPU
FERA
Sand Hutton
York
YO41 1LZ

If you have any queries about the questionnaire please email using the above address or phone 01904 468900

### Returned checklist

With the survey please include:

- the hepatitis C policy used in the prison;
- the induction programme;
- pre and post test checklists;
- a list of names of the health promotion material used with the name of the publisher e.g. HPA, Department of Health, The Hepatitis C Trust, British Liver Trust, PCT, Prison, locally printed/produced health promotion material for hepatitis C if used in the prison.

# 10 Annex C: Audit letter

**National Offender Management Service**
Clive House
70 Petty France
London
SW1H 9EX

21 November 2012

Dear Governing Governor and Healthcare Manager

Following on from the hepatitis C survey carried out last year by the Department of Health, NOMS and the Health Protection Agency, a more detailed audit of hepatitis C services is being conducted in a representative sample of 20 prisons in England. Your prison has been selected to take part in this audit. The audit tool is in the form of a questionnaire and is attached. This is to be completed by the healthcare manager or an appropriate colleague and sent back to Prison Infection Prevention Team by Thursday 20th December.

The results of the audit will be shared with you in Spring next year. It will help inform and shape the future commissioning of hepatitis C services in prison to positively contribute to improving practice and standards of care for prisoners affected by hepatitis C as well as informing the further refinement of best practice guidance.

Please email or post the survey back to:
prisonteam@hpa.org.uk
Prison Infection Prevention Team
North Yorkshire and the Humber HPU
FERA
Sand Hutton
York
YO41 1LZ I

If you have any queries about the questionnaire please email using the above address or phone 01904 468900 / 07785 950559 and ask to speak to the PIP (Prison Infection Prevention) team.

Thank you for completing this audit and contributing to the work to prevent and reduce the incidence of hepatitis C.

Yours faithfully

**Michael Spurr and Richard Bradshaw**

# 11 Annex D: Extra information from prisons

**Additional information submitted with audit:**

## 11.1 Health promotion information

| Prison | In-house materials provided | National materials provided | Other |
|---|---|---|---|
| HMP Altcourse | Materials available within prison but details not provided | | No |
| HMP Haverigg | Materials available within prison but details not provided | | No |
| HMP Wymott | Yes:<br>- Prison developed in house materials for prison staff<br>- Hepatitis C treatment poster for prisoners | Yes:<br>- HPA and DH | Yes:<br>- Condom distribution policy<br>- Leaflet on how to access condoms |
| HMP & YOI Forest Bank | Materials available within prison but details not provided | | No |
| HMP Manchester | Yes:<br>- Testing poster<br>- Playing cards and leaflets | Yes but details not provided | No |
| HMP Erlestoke | Materials available within prison but details not provided | | No |
| HMP Shepton Mallet | Yes but details not provided | Yes:<br>- British Liver Trust (BLT)<br>- The Hepatitis C Trust<br>- The Terrence Higgins Trust | No |
| Durham | No | Yes:<br>- Pharmaceutical company info<br>- NTA and DH<br>- Lifeline<br>- Mesmac North East | No |

| Prison | In-house materials provided | National materials provided | Other |
|---|---|---|---|
| HMP & YOI Low Newton | Yes:<br>- General hep C leaflet | Details not provided | No |
| HMP Hull | Yes:<br>- General information on testing | Yes:<br>- HPA<br>- DH<br>- BLT<br>- Hep C Trust<br>- NTA, Harm Reduction Works | No |
| HMP Leeds | Yes:<br>- Information for prisoners on treatment<br>- Compass hepatitis C testing and diagnosis leaflet<br>- St James Liver Unit patient diary of undergoing treatment<br>- Yorkshire Mesmac B leaflet | Yes:<br>- DH leaflets<br>- BLT BBV and prisoner leaflets<br>- Janssen leaflets<br>- Roche leaflets | No |
| HMP Littlehey | No | Yes:<br>- BLT<br>- NTA Harm Reduction Works | No |
| HMP Whitemoor | Materials available within prison but details not provided | | No |
| Stocken | No | Yes:<br>- The Hepatitis C Trust | No |
| Nottingham | No | Yes:<br>- DH<br>- Janssen<br>- The Hepatitis C Trust<br>- BLT<br>- On One Condition: hepatitis C, Ambermed publication | No |

| Prison | In-house materials provided | National materials provided | Other |
|---|---|---|---|
| Lincoln | No | Yes:<br>- Currently looking at appropriate materials | No |
| Wormwood Scrubs | Yes:<br>- Provided by GUM service | Details not provided | No |
| HMP Brixton | Materials available within prison but details not provided | | No |
| HMP Canterbury | Materials available within prison but details not provided | | No |
| HMP Swaleside | Materials available within prison but details not provided | | No |
| HMP Kingston | Materials available within prison but details not provided | | No |

## 11.2 Hepatitis C written documentation

| Prison | Hepatitis C written documentation submitted? | If nothing submitted do they report having documentation in place? | Pre and post-test checklist submitted? | Induction programme submitted? | Other information submitted |
|---|---|---|---|---|---|
| HMP Altcourse | No | Yes:<br>- Hepatitis C policy | No | No | No |
| HMP Haverigg | Yes:<br>- Draft testing pathway<br>- Other documentation currently been developed | | No | No | Templates (from SystmOne):<br>Hep C initial care plan which covers vaccination, testing, risks, substance misuse, mental health, sexual health, social information.<br>Continuity of care transfer health screen. |
| HMP Wymott | No | Yes:<br>- Referral guidelines for treatment<br>- Planning to develop SOP for hep C | No | No | No |

| Prison | Hepatitis C written documentation submitted? | If nothing submitted do they report having documentation in place? | Pre and post-test checklist submitted? | Induction programme submitted? | Other information submitted |
|---|---|---|---|---|---|
| HMP & YOI Forest Bank | No | Yes, no details provided | No | No | No |
| HMP Manchester | Yes:<br>- Testing pathway<br>- Treatment pathway which includes information on MDT, transfer details and checklist for assessment | | No | Yes | |
| HMP Erlestoke | No | Yes, no details provided | No | No | No |
| HMP Shepton Mallet | Yes:<br>- Comprehensive document details management of patients with BBV<br>- Hepatitis C pathway<br>- Staff guidance re hepatitis testing | | Yes | No | |
| HMP Leeds | Yes:<br>- BBV screening pathway at reception and in treatment room<br>- Hepatitis C patient treatment assessment<br>- Medical templates for treatment monitoring | | No | No | |

| Prison | Hepatitis C written documentation submitted? | If nothing submitted do they report having documentation in place? | Pre and post-test checklist submitted? | Induction programme submitted? | Other information submitted |
|---|---|---|---|---|---|
| Durham | Yes:<br>Hepatitis C care pathway draft business case:<br>• Care pathway<br>• Clinical management protocol<br>• Guidance re hepatitis C care<br>• Referral form<br>• Pre and post-test checklist | | Yes, comprehensive | No | |
| HMP & YOI Low Newton | Yes:<br>Hepatitis C care pathway draft business case:<br>• Care pathway<br>• Clinical management protocol<br>• Guidance re hepatitis C care<br>• Referral form<br>• Pre and post-test checklist | | Yes, comprehensive | No | |
| HMP Littlehey | Hepatitis C screening algorithm only | | No | No | |

| Prison | Hepatitis C written documentation submitted? | If nothing submitted do they report having documentation in place? | Pre and post-test checklist submitted? | Induction programme submitted? | Other information submitted |
|---|---|---|---|---|---|
| HMP Hull | Yes, comprehensive set of information:<br>• Referral pathway<br>• Patient letter following test<br>• Pre and post-test checklist<br>• Guidance information for staff | | Yes | No | |
| HMP Whitemoor | Yes:<br>- Comprehensive draft pathway for health promotion, testing and access to treatment<br>- Protocol for the assessment and management of patients with hepatitis C | | Pathway doesn't include checklist | Yes ,induction for the drug services | |
| Stocken | Yes, comprehensive policy:<br>- Pre and post-test discussion checklist<br>- Testing pathway<br>- Referral pathway for treatment<br>- Referral form for treatment | | Yes:<br>- Comprehensive | No | |

| Prison | Hepatitis C written documentation submitted? | If nothing submitted do they report having documentation in place? | Pre and post-test checklist submitted? | Induction programme submitted? | Other information submitted |
|---|---|---|---|---|---|
| Nottingham | No, no documents used | | No | Yes:<br>- CARATs induction | |
| Lincoln | No but under development | | No but under development | No | Draft SystmOne assessment templates for BBVs submitted |
| Wormwood Scrubs | No, no documents used | | No | No | |
| HMP Brixton | No, no documents used | | No | No | |
| HMP Canterbury | No, no documents used | | No | No | |
| HMP Swaleside | No, no documents used | | No | No | |
| HMP Kingston | No but hoping to adopt one from Isle of Wight prisons | | No | No | SystmOne templates for screening submitted |

# 12 Annex E: Full audit data

| Prison Name | Category | Size Category | Nominated clinical lead | Job title of clinical lead | Steering group | Frequency steering group meets | Clinical team | Written documentation hep C | Policy content: Testing criteria | Guidance on providing results | Policy :Post test discussion info for positive results | Policy: Post test discussion info for negative results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Y | Nurse | N | | Y | N | NP[22] | NP | NP | NP |
| HMP Whitemoor | High security | Small | Y | Nurse | Y | Annually | N | Y | Y | Y | Y | N |
| HMP Altcourse | B local | Large | Y | Nurse | N | | Y | Y | Y | Y | N | N |
| HMP Forest Bank | B private local | Large | Y | Nurse | Y | Monthly | Y | Y | Y | Y | Y | Y |
| HMP Leeds | B local | Large | Y | GP | Y | Annually | Y | Y | N/K | N/K | N/K | N/K |
| HMP Nottingham | B local | Large | Y | Nurse | Y | Quarterly | Y | N | N | N | N | N |
| HMP Wormwood | B local | Large | N | | N | | N | N | NP | NP | NP | NP |
| HMP Swaleside | B local training | Large | N | | N | | N | N | NP | NP | NP | NP |
| HMP Durham | B local | Medium | Y | Nurse | N | | Y | Y | Y | Y | Y | Y |
| HMP Hull | B local | Medium | Y | Nurse | N | | N | Y | Y | Y | N | N |
| HMP Lincoln | B local | Medium | Y | Nurse | Y | Quarterly | Y | N | NP | NP | NP | NP |
| HMP and YOI Littlehey | C and YOI | Large | Y | Nurse | N | | N | Y | Y | N | N | N |
| HMP Wymott | C | Large | Y | Nurse | Y | Biannually | N | Y | Y | N | N | N |
| HMP Brixton | C | Medium | Y | Nurse | N | | N | N | NP | N | N | N |
| HMP Haverigg | C and D | Medium | Y | Nurse | N | | N | Y | Y | N | N | N |
| HMP Stocken | C and training | Medium | Y | Nurse | N | | Y | Y | Y | Y | Y | Y |
| HMP Canterbury | C and FNP | Small | N | | N | | N | N | NP | NP | NP | NP |
| HMP Erlestoke | C | Small | Y | HC mgr/hep C nurse | N | Quarterly | N | Y | Y | Y | Y | Y |
| HMP Kingston | C | Small | N | | N | | N | N | NP | N | N | N |
| HMP Shepton Mallet | C | Small | Y | Nurse | N | | Y | Y | Y | Y | Y | Y |
| HMP & YOI Low Newton | Female | Small | Y | Nurse | N | | Y | Y | Y | Y | Y | Y |
| **Total** | | | **17** | | **6** | | **10** | **13** | **12** | **9** | **7** | **6** |
| **Percentage out of 21 prisons** | | | **81%** | | **29%** | | **48%** | **62%** | **92%** | **69%** | **54%** | **46%** |
| **Percentage highlighted, denominator is 13** | | | | | | | | | | | | |

[22] NP: No policy

| Prison Name | Category | Size Category | Policy content: Post test discussion info for negative results | Policy: Guidance on managing positive results | Policy: Guidance on managing prisoners with negative results | Who signed off the current policy? | How often is the policy reviewed? | Prison data available on numbers tested/treated in 2011* | Health promotion material - Leaflets/booklets | Health promotion materials - DVDs |
|---|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | NP | NP | NP | NP | NP | P | Y | N |
| HMP Whitemoor | High security | Small | N | Y | Y | PCT | Annually | P | Y | Y |
| HMP Altcourse | B local | Large | N | Y | Y | Hospital trust | Other | Y | Y | N |
| HMP Forest Bank | B private local | Large | Y | Y | Y | HC manager | Annually | N | Y | N |
| HMP Leeds | B local | Large | N/K | N/K | N/K | PCT | Annually | N | Y | N |
| HMP Nottingham | B local | Large | N | N | N | No policy | | Y | Y | N |
| HMP Wormwood | B local | Large | NP | NP | NP | NP | | P | Y | N |
| HMP Swaleside | B local training | Large | NP | NP | NP | NP | | N | Y | N |
| HMP Durham | B local | Medium | Y | Y | Y | CCDC | Under discussion | P | Y | Y |
| HMP Hull | B local | Medium | N | Y | Y | HC manager | Biannually | Y | Y | N |
| HMP Lincoln | B local | Medium | NP | NP | NP | NP | | P | Y | Y |
| HMP and YOI Littlehey | C and YOI | Large | N | N | N | HC manager | Annually | P | Y | N |
| HMP Wymott | C | Large | N | Y | Y | Hosp. clinical team | Other | N | Y | N |
| HMP Brixton | C | Medium | N | N | N | | | N | Y | N |
| HMP Haverigg | C and D | Medium | N | N | Y | Still in draft | | P | Y | N |
| HMP Stocken | C and training | Medium | Y | Y | N | Hospital trust | Biannually | P | Y | N |
| HMP Canterbury | C and FNP | Small | NP | NP | NP | NP | | N | Y | N |
| HMP Erlestoke | C | Small | Y | N | N | HC manager | Annually | P | Y | Y |
| HMP Kingston | C | Small | N | N | N | | | Y | Y | Y |
| HMP Shepton Mallet | C | Small | Y | Y | Y | HC manager | Other | Y | Y | N |
| HMP & YOI Low Newton | Female | Small | Y | Y | Y | CCDC | Under discussion | P | Y | Y |
| **Total** | | | **6** | **9** | **9** | | | **15** | **21** | **6** |
| **Percentage out of 21 prisons** | | | **46%** | **69%** | **69%** | | | **71%** | **100%** | **29%** |
| **Percentage highlighted, denominator is 13** | | | | | | | | | | |

| Prison Name | Category | Size Category | Health Promotion Materials- posters | BBV materials available in induction period | Disinfectant tablets available? | How are the accessed? (Dispensers, HC staff, Prison staff | Who is responsible for stock replenishment? | GUM services offer testing? | IDTS / CARAT offer testing | Prison healthcare team - offer testing | Documented pre test discussion | Type of test available – Venous Blood Sample (VBS) | Type of test available – Dried blood spot test (DBST) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Y | Y | Y | D | PO | Y | Y | Y | Y | Y | Y |
| HMP Whitemoor | High security | Small | Y | Y | Y | PS | CS | Y | Y | Y | Y | Y | N |
| HMP Altcourse | B local | Large | Y | N | Y | D | | Y | N | Y | N | Y | N |
| HMP Forest Bank | B private local | Large | Y | Y | Y | D | PO | Y | N | Y | Y | Y | N |
| HMP Leeds | B local | Large | Y | N | Y | PS | NK | N | N | Y | N | Y | Y |
| HMP Nottingham | B local | Large | Y | Y | N | | | Y | Y | Y | Y | Y | N |
| HMP Wormwood | B local | Large | N | N | N | | | Y | N | Y | N | Y | N |
| HMP Swaleside | B local training | Large | N | N | Y | PS | PO | N | N | N | N | Y | N |
| HMP Durham | B local | Medium | Y | N | N | | | Y | Y | Y | Y | Y | Y |
| HMP Hull | B local | Medium | N | N | N | | | Y | Y | Y | Y | Y | Y |
| HMP Lincoln | B local | Medium | Y | Y | Y | PS | PO | Y | Y | Y | Y | Y | N |
| HMP and YOI Littlehey | C and YOI | Large | Y | Y | Y | PS | PO | Y | Y | Y | Y | Y | N |
| HMP Wymott | C | Large | Y | N | Y | PS | PO | Y | Y | Y | Y | Y | N |
| HMP Brixton | C | Medium | Y | Y | Y | HC | HC | Y | N | Y | Y | Y | N |
| HMP Haverigg | C and D | Medium | Y | | Y | PS | PO | N | Y | Y | N | Y | Y |
| HMP Stocken | C and training | Medium | Y | N | Y | D | PO | Y | Y | Y | Y | Y | N |
| HMP Canterbury | C and FNP | Small | Y | Y | Y | D & HC | HC | Y | Y | Y | Y | Y | N |
| HMP Erlestoke | C | Small | Y | N | Y | D | H&S | N | Y | Y | Y | Y | Y |
| HMP Kingston | C | Small | N | Y | Y | D | HC | N | N | Y | Y | Y | N |
| HMP Shepton Mallet | C | Small | Y | Y | Y | D | PS | N | N | Y | Y | Y | N |
| HMP & YOI Low Newton | Female | Small | N | Y | Y | D | HC | Y | Y | Y | Y | Y | Y |
| **Total** | | | **16** | **11** | **17** | | | **15** | **13** | **20** | **16** | **21** | **7** |
| **Percentage out of 21 prisons** | | | **76%** | **52%** | **81%** | | | **71%** | **62%** | **95%** | **76%** | **100%** | **33%** |

| Prison Name | Category | Size Category | Type of test available oral fluid | Most common test performed | Are blood samples tested automatically by PCR? | Documented post test discussion? | What is the most common service? HIR (hospital in reach), HO (hospital outpatient), GP(prison GP led) | Details of additional support: | If treatment if provided in the prison does the prison have access to hospital outpatient department? |
|---|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | N | DBST | Y | Y | HIR | Fibroscan | Y |
| HMP Whitemoor | High security | Small | N | VBS | N | Y | HO | Ultrasound | |
| HMP Altcourse | B local | Large | N | VBS | Y | N | HIR | Fibroscan | Y |
| HMP Forest Bank | B private local | Large | N | VBS | N | Y | HIR | | Y |
| HMP Leeds | B local | Large | N | VBS | Y | N | GP | | Y |
| HMP Nottingham | B local | Large | N | VBS | Y | Y | HIR | | Y |
| HMP Wormwood | B local | Large | N | VBS | N | N | HO | | |
| HMP Swaleside | B local training | Large | N | VBS | N | N | HO | | |
| HMP Durham | B local | Medium | N | VBS | Y | Y | HIR | Ultrasound | Y |
| HMP Hull | B local | Medium | Y | VBS | Y | Y | HIR | | Y |
| HMP Lincoln | B local | Medium | N | VBS | Y | Y | HO | | |
| HMP and YOI Littlehey | C and YOI | Large | N | VBS | NA | NA | HO | Monitoring LFTs for tolerance | |
| HMP Wymott | C | Large | N | VBS | Y | Y | HO | | |
| HMP Brixton | C | Medium | N | VBS | Y | Y | HO | | |
| HMP Haverigg | C and D | Medium | N | VBS | Y | Y | HO | | |
| HMP Stocken | C and training | Medium | N | VBS | N | Y | HIR | | Y |
| HMP Canterbury | C and FNP | Small | N | VBS | N | N | HO | | |
| HMP Erlestoke | C | Small | N | VBS | N | Y | HIR | | Y |
| HMP Kingston | C | Small | N | VBS | Y | Y | HO | | |
| HMP Shepton Mallet | C | Small | N | VBS | Y | Y | HO | | |
| HMP & YOI Low Newton | Female | Small | N | VBS | Y | Y | HIR | Ultrasound | Y |
| **Total** | | | **1** | | **13** | **15** | | | |
| **Percentage out of 21 prisons** | | | **5%** | | **62%** | **71%** | | | |

| Prison Name | Category | Size Category | Details of additional support | Psychological / social support | Are any other further investigations provided in the prison? | Are prisoners placed on medical hold during treatment? | If the prisoner with hepatitis C is released into the community how does the prison ensure that he/she is referred onto the appropriate service? | If the prisoner with hepatitis C is transferred to another prison how does the prison ensure that healthcare services in the receiving prison are informed? |
|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | Generally don't access hospital outpatient unless complications | Y | Y | Y | LS | SO |
| HMP Whitemoor | High security | Small | Establishing in-reach, oupatients only used when necessary | Y | Y | Sometimes | N/K | HC |
| HMP Altcourse | B local | Large | As required but fibroscan done in house | N | Y | Sometimes | LS/GP | HC |
| HMP Forest Bank | B private local | Large | Prisoners have to access hospital appts | Y | N | Y | LS&GP | HC |
| HMP Leeds | B local | Large | Biopsy, ultrasound, fibroscan | N | N | Y | LS | HC |
| HMP Nottingham | B local | Large | | Y | N | Y | LS | HC |
| HMP Wormwood | B local | Large | | N | N | N | LS | SO |
| HMP Swaleside | B local training | Large | NHS appointment scheme | N | N | Y | LS | HC |
| HMP Durham | B local | Medium | Biopsy, ultrasound, fibroscan | Y | Y | Y | LS&GP | HC |
| HMP Hull | B local | Medium | Biopsy, ultrasound, fibroscan | Y | N | Y | LS | SO |
| HMP Lincoln | B local | Medium | Initial referral appointment / ultrasound /fibroscan | Y | N | Sometimes | LS&GP | HC |
| HMP and YOI Littlehey | C and YOI | Large | Hospital appt attended for biopsy and intermittent follow ups | Y | Y | Sometimes | LS | HC |
| HMP Wymott | C | Large | | Y | N | Y | GP | SO |
| HMP Brixton | C | Medium | | N | N | Sometimes | LS&GP | SO |
| HMP Haverigg | C and D | Medium | | Y | N | Sometimes | LS | HC & hosp |
| HMP Stocken | C and training | Medium | Ultrasound or biopsy if needed | N | N | Sometimes | LS | HC & hosp |
| HMP Canterbury | C and FNP | Small | Local hospital | N | N | N | GP | HC |
| HMP Erlestoke | C | Small | Ultrasound, biopsy, x-ray | N | N | N | LS&GP | HC |
| HMP Kingston | C | Small | All treatment provided in hospital outpatient dept | Y | N | Y | GP | SO |
| HMP Shepton Mallet | C | Small | Manage telephone consultations with team in the hospital | Y | N | Sometimes | LS | HC |
| HMP & YOI Low Newton | Female | Small | Consultant appointment | Y | Y | Y | LS | HC |
| **Total** | | | | **13** | **6** | | | |
| **Percentage out of 21 prisons** | | | | **62%** | **29%** | | | |

| Prison Name | Category | Size Category | Prison officer training frequency | Healthcare staff training frequency | Drug worker staff training frequency | HC staff training content: Testing | HC staff training content: Monitoring | HC staff training content: Treatment |
|---|---|---|---|---|---|---|---|---|
| HMP Manchester | High security local | Large | None | Annual | Other frequency | Y | Y | Y |
| HMP Whitemoor | High security | Small | Other frequency | Annual | Annual | Y | Y | Y |
| HMP Altcourse | B local | Large | None | None | None | N | N | N |
| HMP Forest Bank | B private local | Large | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Leeds | B local | Large | One-off training | One-off training | One-off training | Y | N | N |
| HMP Nottingham | B local | Large | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Wormwood | B local | Large | None | None | When requested | N | N | N |
| HMP Swaleside | B local training | Large | None | One-off training | None | N | Y | Y |
| HMP Durham | B local | Medium | Other frequency | When requested | When requested | Y | Y | Y |
| HMP Hull | B local | Medium | None | Initial and refresher training when requested | Biannual | Y | N | N |
| HMP Lincoln | B local | Medium | None | When requested | When requested | Y | Y | Y |
| HMP and YOI Littlehey | C and YOI | Large | None | None | None | N | N | N |
| HMP Wymott | C | Large | One-off training | One-off training | None | Y | Y | Y |
| HMP Brixton | C | Medium | One-off training | Annual | One-off training | Y | Y | Y |
| HMP Haverigg | C and D | Medium | None | When requested | None | Y | Y | Y |
| HMP Stocken | C and training | Medium | One-off training | One-off training | One-off training | Y | Y | Y |
| HMP Canterbury | C and FNP | Small | None | None | None | N | N | N |
| HMP Erlestoke | C | Small | None | Biannual | Annual | Y | Y | Y |
| HMP Kingston | C | Small | None | One-off training | None | Y | Y | Y |
| HMP Shepton Mallet | C | Small | Biannual | Annual | None | Y | Y | Y |
| HMP & YOI Low Newton | Female | Small | When requested | When requested | None | Y | Y | Y |
| **Total** | | | **10** | **17** | **12** | **16** | **15** | **15** |
| **Percentage out of 21 prisons** | | | **48%** | **81%** | **57%** | **76%** | **71%** | **71%** |