Public Health England

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Protecting and improving the nation's health

Public Health England Health & Justice report 2014

No health without justice, no justice without health

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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

For queries relating to this document, please contact: health&justice@phe.gov.uk

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Acknowledgements

Authors and contributors

Hilary Guite
Darren Kristiansen
Ailith Morrey
Autilia Newton
Éamonn O'Moore
Cathie Railton
David Sheehan
Sunita Sturup-Toft

Other contributors

Astrid Aldous
Rupert Bailie (National Offender Management Service)
Rachel Campbell
Max Courtney
Sam Cox
Abi Hamoodi
Susanne Howes
Andy Hunt (NHS England)
Dave Jones
Chris Kelly (NHS England)
Sam Lattimore
Andy Liggins
Kieran Lynch
Nino Maddalena
Simon Marshall (National Offender Management Service)
Magdalene Mbanefo
Anne Norton (National Offender Management Service)
Jenny Rees (National Offender Management Service)
Jackie Roberts
Sally Eapen Simon
Sandra White
Sue Wright
Zheng Yin

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Foreword

The opportunity of change for health and justice

Public Health England (PHE) was created on 1 April 2013 to bring together public health professionals from more than 70 organisations into a single public health service.

Our mission is to protect and improve the nation's health and to address inequalities.

PHE works in partnership with health and social care commissioners, criminal justice partners, service providers, academic and third sector organisations, international partners and prisoners/detainees to identify and meet the health and social care needs of people in prisons and other prescribed places of detention (PPDs), as well as those in contact with the criminal justice system (CJS) in the community.

PHE aims to reduce health inequalities, support people in living healthier lives, and ensure the continuity of care in the community.

Our Principles:

Equivalence: People in prison and other PPDs are entitled to care equivalent to that available to people in the wider community.

Evidence-based care: Care should be commissioned and provided according to needs, informed by rigorous health needs assessment approach, including collection and interpretation of data, and must be evidence-based.

Patient-focussed: People delivering care to people in PPDs are healthcare staff whose primary loyalty is to the health and wellbeing of their patients.

Quality: Healthcare staff should be appropriately trained and accredited, participate in continuing professional development programmes, and work within a clear clinical governance structure.

Patient voices: Prisoners and detainees and those in contact with the CJS should know their rights, should have their voices heard in designing and delivering healthcare services, and should know how to complain if unhappy with the level of service they receive.

Partnership: Working in partnership is essential; we advocate 'co-production' with partner organisations.

Continuity of Care: Our role does not stop at the prison gate – we must support care pathways beyond the prison walls.

Wider than prison impact: Prison health is everyone's business; addressing the needs of 'under-served' groups in prison has a 'ripple effect' into the wider community.

Health and justice: Health and healthcare is part of the problem and part of the solution – no health without justice, no justice without health.

The Health and Social Care Act 2012 led to major changes within the NHS generally as well as local public health systems. Since April 2013, NHS England assumed responsibility for commissioning health services for persons who are detained in prison or in other secure accommodation. 'Securing excellence in commissioning for offender health[i]' was developed collaboratively with stakeholders with the ambition of supporting commissioners in a consistent, high quality approach to the delivery of services that secure the best outcomes for people in prisons and other secure settings. The development of a 'single operating model' provides the opportunity to implement nationally consistent evidence-based commissioning specifications and quality standards appropriate to the patient population and integrated in community-based services.

In addition to the changes within the NHS there have been developments within the justice system under the coalition government's 'Transforming Rehabilitation' reforms. From 1 May 2015, the nationwide 'Through the Gate' (TTG) resettlement service, under which offenders including those serving sentences of less than 12 months will be offered a range of support in custody and through the gate into the community went live.

Community Rehabilitation Companies (CRCs) are delivering this service to virtually all prisoners, including remand prisoners. There are 21 CRCs across England and Wales, each serving their own specific region. The National Probation Service continue to oversee the rehabilitation and management of high-risk offenders.

As part of TTG, a network of 89 resettlement prisons has been set up to provide localised resettlement provision for prisoners returning to their home area. CRCs working in resettlement prisons create an individual resettlement plan for each prisoner to meet their immediate needs upon entering custody and work with them in the 12 weeks prior to their release to help deliver the resettlement plan and associated services. At a minimum, CRCs are delivering the following to prisoners prior to their release:

- help finding, or retaining, somewhere to live
- help finding, or retaining, a job
- advice on money and debt
- help and advice for sex workers and those who have been subjected to domestic violence and abuse

CRCs may also choose to offer additional services that they believe may assist offenders and reduce their reoffending.

The aim of these reforms is to reduce reoffending rates through changes in how prison and probation services are delivered. The creation of resettlement prisons will ensure that those over the age of 21 serving less than 12 months and those within the last 3 months of their sentence are released from a prison close to their home address. This can in turn support better integration between health providers, both in custody and in the community, and providers of resettlement services.

Work is also ongoing, led by the Youth Justice Board (YJB) to improve the resettlement outcomes of young offenders under the age of 18 years, following their release from young people specific secure settings.

These changes provide us with opportunities to better address the health needs of offenders, in custody or in the community, by improving local integration of the health and justice systems. Moreover, these changes allow us to address more effectively issues around health inequalities and health-related drivers of offending behaviour which will have positive impacts not only on people directly in contact with the CJS but also among much wider peer-groups and social networks often described as 'under-served'.

This report will be of interest to directors of public health (DsPH) and public health professionals at local and national level, local authorities, NHS England commissioners and specialised commissioners, clinical commissioning groups (CCGs), police and crime commissioners, police services, probation services, the Ministry of Justice (MoJ), the National Offender Management Service (NOMS), the Home Office, voluntary sector organisations and those representing the patient voice in the justice system. The report will also be of interest to international colleagues working in health and justice systems in the World Health Organization (WHO) European region and globally. The report captures a broad range of activity led by the national Health & Justice Team in PHE working both across our own organisation and with a broad range of partners internationally, nationally and locally across all the domains of public health practice.

Dr Éamonn O'Moore FFPH,
National Lead for Health & Justice, PHE and Director of the UK Collaborating Centre for WHO Health in Prisons Programme (European Region)

Executive Summary

This report provides details of key changes in the health and justice system and discusses the public health needs of people in prescribed places of detention (PPDs). In addition to demographic details of people in detained settings the report explores some of the key public health initiatives developed in partnership with NHS England, NOMS, the Home Office and the YJB.

People in the CJS often come from marginalised and underserved communities in the wider population and by tackling health inequalities in this population we can address wider health inequalities which benefits not only those in prisons but wider society. There is a co-dependency between partners to tackle inequalities and reduce re-offending and we have already seen the benefits of working in partnership to respond to these health inequalities.

Over the past 10 years investment in criminal justice based substance misuse interventions have made a marked contribution to reducing drug and alcohol related crime and improving health outcomes. During 2014 significant progress on tackling a range of health issues within the prescribed estate has been achieved. This includes improving the data and intelligence about people in PPDs through the introduction of health and justice indicators of performance (HJIPs) as well as improving the reporting of infectious diseases. Initiating workstreams with partners to directly confront health inequalities include the introduction of the opt-out testing for blood-borne viruses (BBVs) which aims to increase the diagnosis and treatment of people in prison for infection with a BBV. This is producing benefits with preliminary data indicating a near doubling of BBV testing following the introduction of the opt-out testing policy.

Progress in our international work has seen a number of developments since PHE took over the leadership function of the WHO Health in Prisons Programme (WHO HIPP) from 1 April 2014. The focus of this work is to support the development of a European network to share experiences and provide expertise and guidance to address the health issues facing people in prison in Europe. In October 2014 PHE in partnership with the WHO and Irish Prison Service hosted a 2 day international conference in Portlaoise, the Republic of Ireland which addressed two distinct themes: prisoner empowerment and improving lives in the community.

Finally, information on infectious diseases within prisons is detailed in appendix A. PHE provides data from a range of sources which facilitates a better understanding of the health protection issues facing this population as well as how to manage such need. This is a vital task as we attempt to measure the impact of new policies such as the introduction of opt-out testing for BBVs in all prisons in England.

It is the intention to produce a health and justice report every year to detail the public health needs of people in PPDs and discuss the initiatives being undertaken to address their needs.

1 Introduction

The scope of our work in health and justice covers all three dimensions of public health, ie health protection, health improvement and healthcare public health. PPDs[1] included in our remit are:

- prisons (public and privately managed) (116)
- immigration removal centres (IRCs) (9)
- children and young people's secure estate (CYPSE) (young offender institutions (4), secure training centres (3) and secure children's homes (14))
- police custody suites (40 separate police forces in England, 39 territorial forces and British Transport Police)
- liaison and diversion services which are designed to identify offenders who have mental health, learning disability or substance misuse vulnerabilities when they first come into contact with the CJS. Identified individuals are then either supported through the CJS pathway or they are diverted into a more appropriate service such as a treatment programme or a social care service which are designed to reduce re-offending and identify vulnerabilities earlier

Our remit also includes those in contact with the CJS in the wider community and therefore addresses much broader issues than custodial settings. The overwhelming majority of offenders will spend most of their time in the community and the average length of time served in prison in England and Wales, including time on remand, is 9.7 months for those released from determinate sentences[ii].

This report discusses the key health issues faced by people in contact with the CJS in custody or in the community and provides examples of how such issues can be addressed. It examines the current health and justice landscape and also looks at the imminent changes. We are faced with many new challenges but this report will help guide DsPH and other professionals working within the public health system locally and nationally with information about how to best meet the needs of this local population.

1.1 The national Health & Justice Team

The national Health & Justice Team is part of the Health and Wellbeing directorate within PHE which takes the lead in promoting healthier lifestyles, chronic disease prevention, national health marketing and health equity programmes. This saves lives, promotes wellbeing and helps create environments where individuals, families, and communities are better informed, more empowered, healthier and happier. The national team is part of the Population Healthcare division which aims to improve population health outcomes and reduce health inequalities through providing expertise and system leadership to improve the quality of healthcare delivered in a broad range of settings. The division also includes teams from Dental Public Health, Allied Health Professionals, Pharmacy & Health Care Public Health.

[1] Note: All data in the report refers to adults (18+) in England unless otherwise stated

The national Health & Justice Team works to deliver PHE's mission statement on health and justice. Our roles include:

- gathering and providing evidence and intelligence to inform and support the work of local and national commissioners and service providers
- providing expertise at local and national level on a broad range of health protection, health promotion and disease prevention activities working in close partnership with local commissioners and service providers
- supporting partners, including commissioners and providers of health and social care, in the development of care pathways which account for the movement of people around the detention estate and between prescribed detention settings and the community
- developing the evidence-base to support commissioning and service provision through primary research, audit, collection and analysis of data, publication and dissemination of information, reports and research studies
- identifying emerging health threats to detainees and staff working in PPDs and providing advice on their management or mitigation
- supporting both NOMS and NHS England in the performance of their statutory functions as appropriate
- supporting NHS England in relation to its Section 7a responsibilities in commissioning high quality health services in secure and detained settings
- supporting NOMS and NHS England to deliver on shared priorities in the National Partnership Agreement[iii] with PHE through the Prison Healthcare Board for England
- supporting the Home Office and NHS England in delivering on shared priorities for the health & wellbeing of detainees in the immigration removal estate as outlined in the National Partnership Agreement
- supporting YJB and NHS England to deliver on shared priorities as detailed in the document 'Improving Health and Well Being services for children placed in the Children and Young People's Secure Estate Agreement 2014-16'
- leading international engagement on prison health through its work as the UK Collaborating Centre to the WHO HIPP (Europe)
- supporting collaborative working for health across the devolved administrations of the UK and with the Republic of Ireland through the Five Nations' Health & Justice Collaboration

While PHE has a key role in providing expert public health advice guidance and support tools to NOMS and NHS England which supports commissioning in the context of this agreement, it does not have any direct responsibility for commissioning or performance management of healthcare services in secure and detained settings, nationally or locally.

1.2 Local and national partnership within PHE health and justice

PHE is structured into a national centre, 4 regions and 8 centres plus London, which is an integrated region-centre (see figure 1). The national Health & Justice Team works with health and justice public health specialists based in PHE centres who support implementation of the national business programme as well as meeting local needs in relation to health and justice including integration of this work with wider work programmes of their centres. PHE centres are the front door to the organisation, providing direct advice and support to the local public health system as well as supporting the implementation of nationally developed policies at a

local level. The national Health & Justice network is composed of representatives from the devolved administrations, the national team and the public health specialists in the PHE centres and works to gather intelligence, share good practice and provide opportunities for collaboration across England and with Scotland and Wales. The national team also leads international engagement on prison health through its work as the UK Collaborating Centre (UKCC) to the WHO HIPP (Europe).

Figure 1: PHE regions and centres

1.3 Policy context

Detention settings are a requirement of a functioning CJS. The health and wellbeing of people in PPDs is a particular responsibility of the state. There is great variety in both the nature of detained populations and the detention settings, which adds a level of complexity. Some detention settings are the responsibility of MoJ, others of the Home Office; some detention settings are publicly owned whereas others are privately managed under contract. NHS England is responsible for commissioning healthcare in PPDs but CCGs, local authorities and social care commissioners need to ensure health and care for vulnerable populations in contact with the CJS in the community as part of the services for the general population.

Section 15 of the Health and Social Care Act 2012 gives the Secretary of State the power to require NHS England to commission certain services outside of CCGs who are responsible for the commissioning of healthcare services in the community. These include ‘services or facilities for persons who are detained in a prison or other accommodation of a prescribed description’.

The 2014 Offender Rehabilitation Act made changes to the sentencing and release framework to extend supervision after release to offenders serving short sentences. It also created greater flexibility in the delivery of sentences served in the community. The Act provides a range of provisions that affect the local delivery landscape.

With the implementation of the Care Act (DH 2014) from April 2015, local authorities are now required to assess and meet the eligible social care and support needs of prisoners as well as residents in approved premises and those in bail accomodation, and there are opportunities to work with local authorities to broaden the scope of a joint health needs assessment to include the social care needs of prisoners and offenders in these settings.

The Care Act 2014 clarifies that local authorities are responsible for assessing and meeting the eligible social care needs of people in prison or resident in bail accommodation or approved premises.

There have been a number of recent policy drivers in England that relate to the needs of people within the health and justice system. The NHS Outcomes Framework 2014 to 2015 and the Public Health Outcomes Framework 2013 to 2016 have led to a change in the way we work together to improve public health within the youth and adult justice system.

The NHS Outcomes Framework 2014 to 2015 sets out the outcomes and corresponding indicators that are used to hold NHS England to account for improvements in health outcomes, as part of the government's mandate to NHS England. It acts as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

The Public Health Outcomes Framework 2013 to 2016 has a number of relevant indicators related to people in contact with the CJS:

- self-harm (2.10)
- smoking prevalence – adults (over 18s, 2.14)
- successful completion of drug treatment (2.15)
- people entering prison with substance dependence issues who are not previously known to community treatment (2.16)
- alcohol related admissions to hospital (2.18)
- self-reported wellbeing (2.23)
- people presenting with HIV at a late stage of infection (3.4)
- treatment completion for tuberculosis (TB, 3.5)
- mortality rate from causes considered preventable (4.3)
- under 75 mortality rate from liver disease (4.6)
- under 75 mortality rate from respiratory diseases (4.7)
- mortality rate from infectious and parasitic diseases (4.8)
- excess under 75 mortality rate in adults with serious mental illness (4.9)
- suicide rate (4.10)

1.4 Partnership working and governance arrangements

National partners

Effective working at both national and local level is essential to address the health needs of people in contact with the CJS. At a national level there are a number of strategic groups established to oversee health provision for people in contact with the CJS including:

- Cross Government Health & Justice Partnership Board, a multi-agency board chaired by the Department of Health (DH) and comprising representation from PHE, MoJ, NOMS, the Home Office, the police, NHS England, YJB and a range of non-statutory organisations which is responsible for overseeing health service provision for people in contact with the CJS
- the Prison Healthcare Board (England) co-chaired by NOMS and NHS England includes representatives from PHE and is responsible for overseeing the National Partnership Agreement between the NOMS, NHS England and PHE for the co-commissioning and delivery of healthcare services in prisons in England. The agreement sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities for NOMS, NHS England and PHE in relation to commissioning and delivering healthcare services in adult prisons in England during 2015 to 2016.
- the Children and Young Peoples Secure Estate Assurance Group co-chaired by YJB and NHS England is responsible for overseeing the National Partnership Agreement 'Improving Health and Wellbeing services for children placed in the Children and Young People's Secure Estate 2015 to 2016' and includes representatives from the YJB, PHE and NHS England
- the Immigration Removal Centre Assurance Group supports the Home Office and NHS England in delivering on shared priorities for the health and wellbeing of detainees in the immigration removal estate outlined in the National Partnership Agreement

Such partnership working facilitates national agreements, stimulates joint action and allows for the co-ordination of priorities, while clearly defining roles and responsibilities of relevant bodies.

Local partners

At a local level slightly more than a third of top-tier local authorities in England have prisons within their boundaries. However all local authorities have a responsibility for people living in the community who are in contact with the CJS. The key partnerships and agencies that should have an interest in the health needs of those held in the CJS include:

- CCGs
- health and wellbeing boards (HWBs)
- PHE centres
- DsPH
- directors of children's services
- directors of adult services
- directors of social services

- National Probation Service
- CRCs
- youth offending teams
- prison healthcare providers
- health providers in the children and young people secure estate (CYPSE)
- other healthcare providers in prisons who often provide in-reach services such as substance misuse teams and mental health services
- local healthwatch
- police and crime commissioners

2 The health of people in detention and in contact with the criminal justice system

2.1 Why address the health needs of people in the criminal justice system?

Poor health is often interlinked with offending and reoffending behaviour. Offenders suffer from multiple and complex health issues which are often exacerbated by the difficulties they experience in accessing the full range of health and social care services available in the local community. It is recognised that this leads to high usage of costly emergency services by this group[iv].

People in PPDs often experience higher mortality rates[v], a higher burden of disease (including infectious diseases, chronic illnesses and mental health problems), poorer access to treatment and prevention programmes, and problems with substance misuse (including drugs, alcohol and cigarette smoking) than their peers in the community. (Singleton, Meltzer, Gatward, Coid & Deasy 1998)[vi]. Health issues affecting this population are varied; some of the more prevalent ones are further explored below.

Addressing the health needs of people in contact with the CJS plays a key element of delivering the government ambitions for cutting crime, reducing reoffending and tackling health inequalities.

People in prison and other detainees often come from marginalised and underserved communities in the wider community. These prison-contact wider social networks and peer groups contribute disproportionately to wider health inequalities. Addressing health inequalities among detained populations may therefore address wider health inequalities and benefit not only those in prisons but wider society, we described this as the ‘community dividend’. Therefore, issues relating to health and justice directly affect all local authorities, all CCGs, all NHS and social care commissioners and all communities.

2.2 People in detention and in contact with the CJS are an ‘under-served’ populations

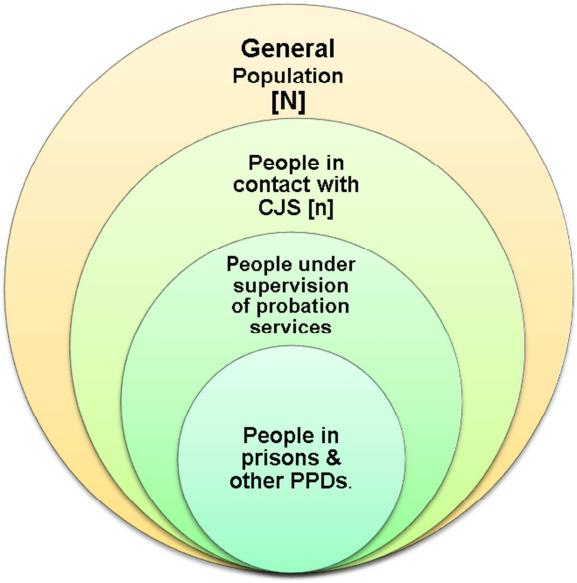
People in prescribed detention are often depicted as belonging to ‘hard-to-reach’ populations which is misleading. They are more accurately described as ‘under-served’ both in detention and in the community as health services often fail to map well to their needs.[vii] The community dividend model suggests that by addressing needs of those in contact with the CJS we can have an impact on the wider population and different segments of this population are different in size, ease of identification and access. The current standing prison population in England and Wales is around 85,000 with about 100,000 unique admissions per year; a further 220,000 are currently under supervision of probation services in the community (and this number may rise in 2015 with the implementation of the Offender Rehabilitation Act 2014 which means offenders leaving prisons will be supervised by CRCs or the NPS), and between 1-2 million people per year are captured by the police national computer system following contact with the police. This provides a large network of people defined in some

way as being in contact with the CJS. These same people are often members of the same communities and social networks who are disproportionately affected by health inequalities. Therefore, working with these people is a way to engage effectively with wider parts of the community often described as 'hard-to-reach' or marginalised populations.

The health inequalities experienced by people in prison are not only evident when in prison but also continue to have an effect beyond the prison walls; people in prison and 'at or near prison social networks and communities' contribute disproportionately to wider societal health and social inequalities.

People entering prisons have often experience a 'care deficit' which prison healthcare systems have to strive to address. There is evidence that people in prisons are higher consumers of healthcare services than peers in the community, particulary older prisoners[viii]. So prisons can and do impact positively on healthcare needs of people they manage but this effect is often contingent on being in prison: a return to the community often results in 'flipping' of previous health gains including access to health services especially preventive health services like screening and immunisation and chronic care.

Figure 2: Community dividend for public health interventions in prison populations



Developing and delivering health interventions in prisons not only benefits prisoners but it also delivers a 'community dividend' in addressing issues in under-served populations by having beneficial impacts on wider health and offending behaviour. Delivering effective healthcare to people in prison is not only the right thing to do but also the wise thing to do.

Figure 3: Public health model for health and justice

Offenders are likely to reside in areas of multiple deprivation and often live chaotic and disordered lives. A study[ix] into the background and circumstances of 200 sentenced young people within the secure estate found that 51% come from deprived or unsuitable accommodation. In addition, the surveying prison crime reduction (SPCR) survey provided an analysis of the pre-custody employment, training and education status of 1,435 newly sentenced prisoners (in 2005 and 2006). It stated that that 15% of prisoners reported being homeless before custody, including 9% who were sleeping rough. If the beneficial effects of detention are not to be reversed the future accommodation needs and other wrap-around services like employment need to be strengthened. Many adult offenders have a lack of basic level education, with 47% of prisoners sampled by the Prison Reform Trust holding no academic qualifications. The SPCR survey also showed that only one-third of prisoners reported being in paid employment in the 4 weeks before custody and 13% of prisoners surveyed reported never being in paid employment.

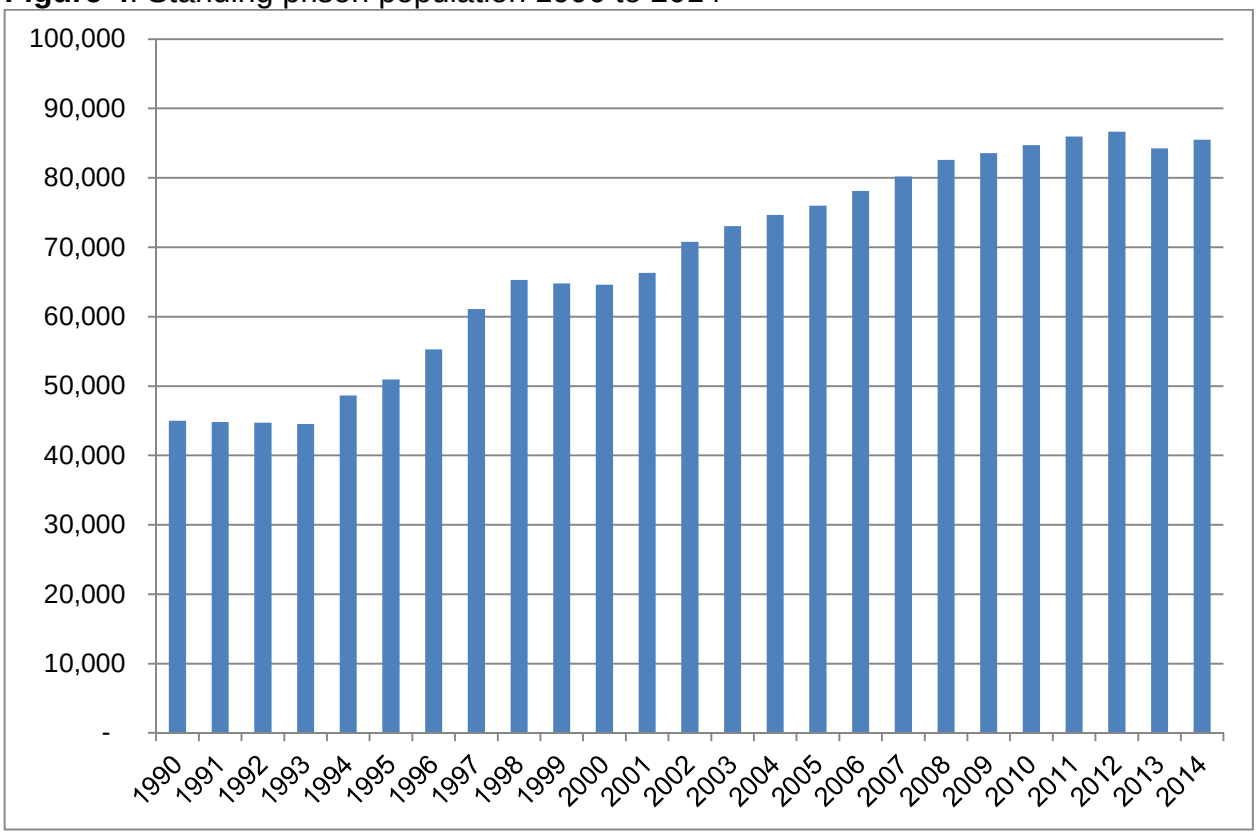
Figure 3 suggests a public health model for health and justice that looks downstream to the healthcare challenges and upstream to better prevention efforts to begin to address some of the health drivers of criminogenic behaviour. Research indicates that 59% of prisoners reported regularly playing truant, 63% had been temporarily excluded from school, and 42% permanently excluded[x]. This has implications for managing behaviour at an earlier age and the role that school has in addressing conduct that we know can influence the life chances of children.

2.3 Population demographics

Adult prisons

While the prison population has grown during most years since World War II, between 1993 and 2008 the growth rate increased from an average of 2.5% to 4% per year[xi]. Between 2008 and 2012 the MoJ reports that the total population remained relatively stable, however the public disorder of 6 to 9 August 2011 had an immediate impact on the prison population.

Figure 4: Standing prison population 1990 to 2014



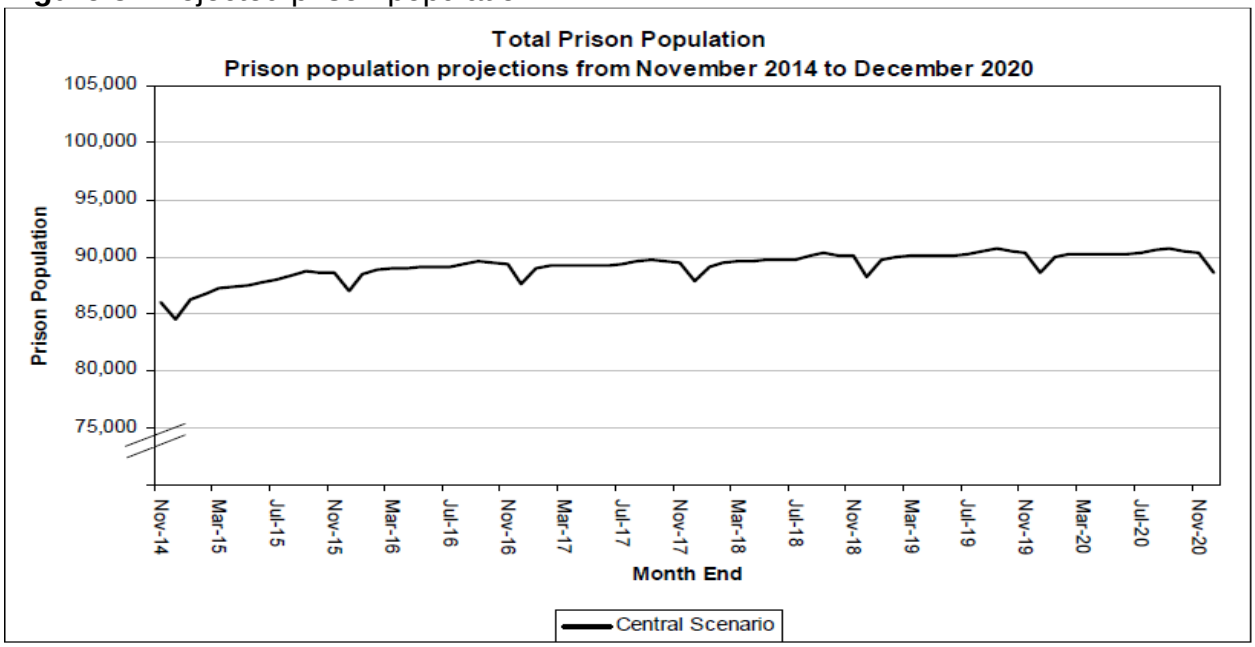
Source: Ministry of Justice statistics in England and Wales, all age groups https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2014

Two factors caused the increase in the prison population of England and Wales from 1993 to 2012: increasing use of custodial sentences in sentencing guidelines provided to courts, and a more serious mix of offence groups coming before the courts.

As of 31 March 2015 the prison population in England and Wales was 85,664. In terms of annual comparison, in England and Wales in March 2015, the adult prison population stood at 85,265, an increase of under 1%. The relative size of the female prison population has remained stable, at just under 5% of the total.

The MoJ published ‘Prison Population Projections 2014– 2020 England and Wales’ which usefully presents projections of the prison population in England and Wales from November 2014 to December 2020. The ‘central scenario’ estimates that the prison population will increase from the current position to 87,700 by June 2015. By the end of June 2020 the prison population is projected to be 90,200.

Figure 5: Projected prison population

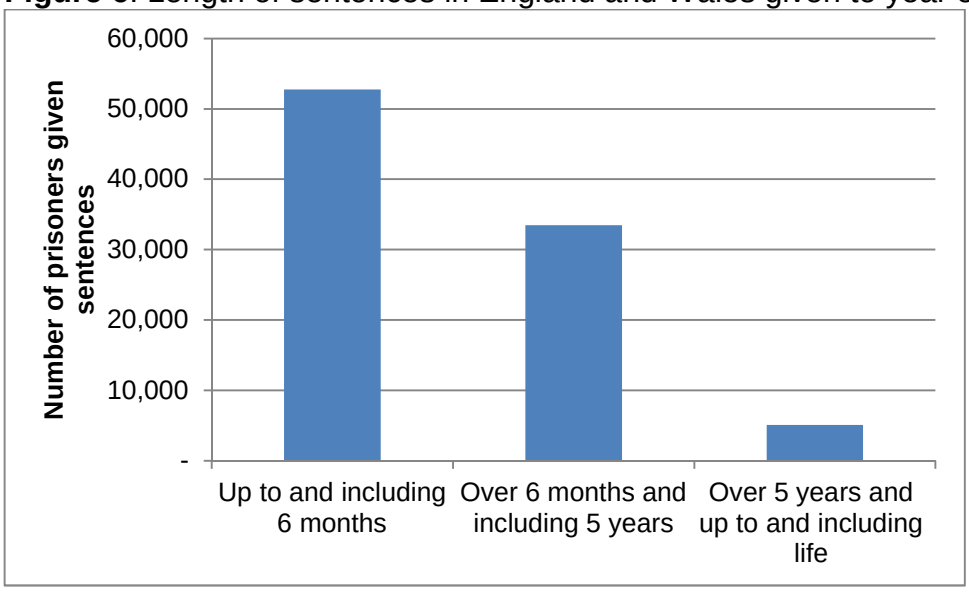


Source: Ministry of Justice https://www.gov.uk/government/statistics/prison-population-projections-ns

In terms of proportions, the vast majority of offenders sentenced at court receive a non-custodial sentence, (8% of those sentenced in 2014 were sentenced to custody) meaning there are a far greater proportion of people (over 90%) of offenders in the community compared to being in custody. This shows the need to address the health of all people in contact with the CJS and not just those in prison.

For those in custody, figure 6 shows the majority of individuals will only serve a sentence of 6 months or less which means that prisoner's healthcare needs must be met in a short space of time and effective continuity of care set up before their release.

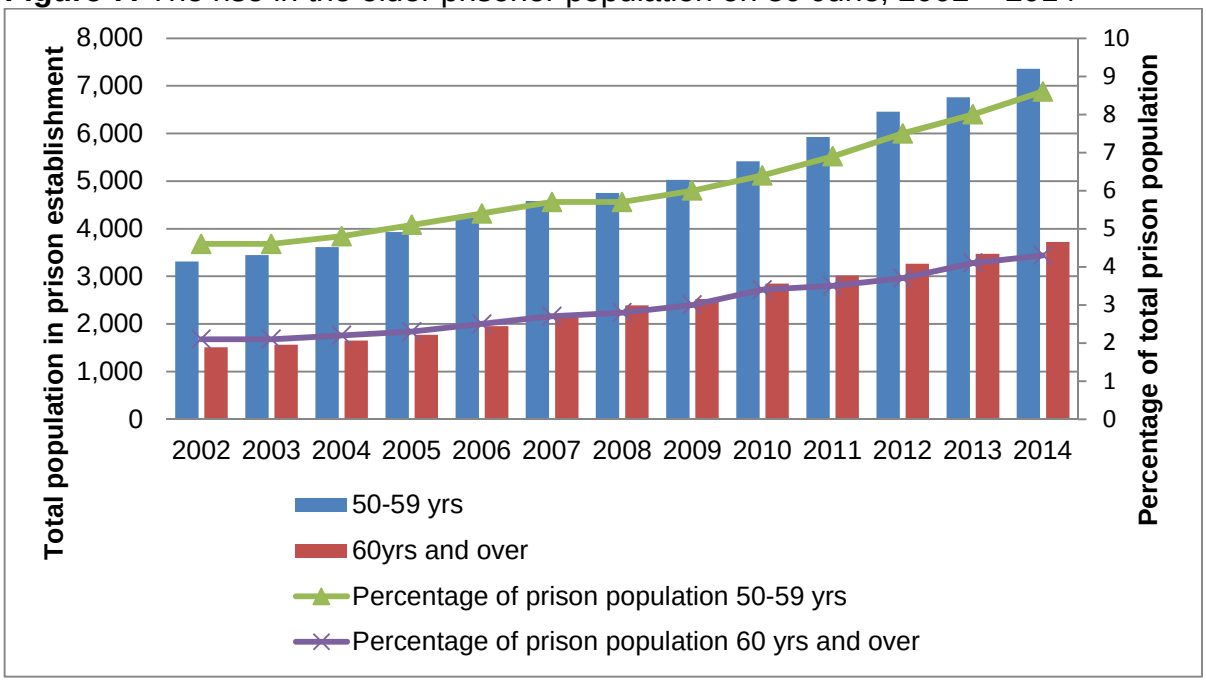
Figure 6: Length of sentences in England and Wales given to year ending June 2014



Source: Ministry of Justice statistics for England and Wales Criminal justice system statistics quarterly: December 2014

Understanding the demographics of people in prisons is important if we wish to appreciate their health needs. A report from the House of Commons Justice committee into the needs of older prisoners found that older prisoners are the fastest growing group within the prison population. The latest statistics show the number of those aged over 60 and those aged 50 to 59 have grown significantly between 2002 and 2014.

Figure 7: The rise in the older prisoner population on 30 June, 2002 – 2014



Source: MoJ Annual Prison Population Statistics
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339036/prison-population-2014.xls

This has led to a developing awareness among prison staff and prisoners of the difficulties faced by older people and a greater understanding that the response is often inadequate, and prisons ill-equipped, to meet their needs[xii]. Now that local social services are responsible for commissioning care and support services for prisoners, there are opportunities to develop improved responses to the needs of this growing and vulnerable population.

The children and young people's secure estate (CYPSE)

Data from YJB shows that from April 2013 to March 2014 in England and Wales the average population in custody (under 18) was 1,216, down by 21% from an average of 1,544 in the previous 12 months. From April 2013 to March 2014, most (68%) young people (under 18) held in custody were in young offenders institutions, 22% were in secure training centres and the remaining 11% in secure children's homes.

The average length of time spent in custody was 90 days which limits the opportunities to fully address any identified health need. This means continuity of care is crucial in addressing this population's needs. Such issues require both attention in any local joint strategic needs assessment (JSNA) and integration into any health and wellbeing strategy.

The health and wellbeing needs of children and young people tend to be particularly severe by the time they are at risk of receiving a community sentence, and even more so when they receive a custodial sentence. This presents particular challenges to those addressing their health and social care needs. Although fewer than 1% of all children in England are in care[xiii], looked-after children make up 33% of boys and 61% of girls in custody[xiv]. Research carried out for YJB among children and young people in the secure estate (age 12 to 18) found that their rates of smoking, drinking and use of illegal drugs before entering custody were substantially higher than among young people who do not offend[xv].

The Healthy Children, Safer Communities strategy states that over three-quarters of individuals in the CYPSE have serious difficulties with literacy and numeracy and over half have difficulties with speech, language and communication. Furthermore, over a third has a diagnosed mental health disorder.

For many children and young people their experience of a secure setting brings them into sustained and meaningful contact with health services for the first time. The placement provides opportunities for the routine identification and subsequent treatment of health (including mental health and wellbeing) or issues of disability through the provision of enhanced support and tailored responses.

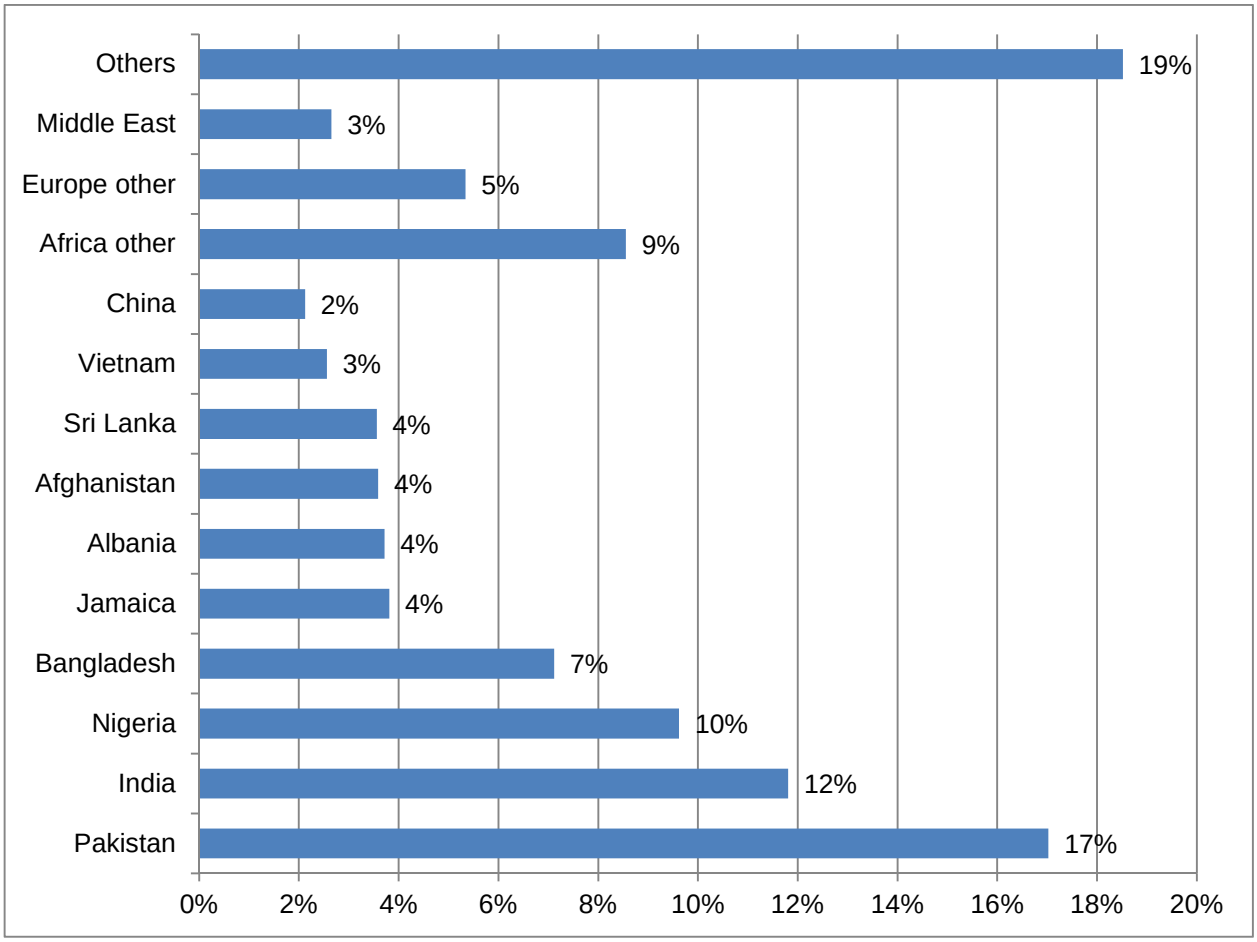
The National Partnership Agreement 'Improving health and wellbeing services for children placed in the children and young people's secure estate for the commissioning and delivery of healthcare services in the CYPSE in England between NHS England, the YJB and PHE 2015 to 2016 aims to ensure that through partnership working on operational and strategic issues to enable children and young people held in secure accommodation1 to access and receive the same quality and range of healthcare services as provided in the wider community.

Immigration removal centres (IRCs)

As of 30 September 2014 there were 3,202 individuals in detention in an IRC in England, a 10% increase compared with 12 months previously.

The majority of immigrants in detention on 30 September 2014 were from South Asia, making up 40% of the IRC population, closely followed by individuals from sub-Saharan Africa (22%). Understanding the makeup of the detainee population helps differentiate the health requirements of IRCs from prisons due to the specific health issues faced by both groups.

Figure 8: Proportion of people in detention on 30 September 2014 by place of birth



Source: Home Office https://www.gov.uk/government/statistics/immigration-statistics-july-to-september-2014-data-tables, all age groups

NHS England commissioned a Health and Wellbeing Health Needs Assessment Programme Immigration Removal Centres and Residential Short Term Holding Facilities during 2014. They found that there are no national data on the prevalence of long-term health conditions amongst detainees. However, some ethnic groups are known to have higher prevalence rates of certain chronic conditions eg diabetes is found twice as often amongst Caribbean and South Asian communities in the UK compared to the British population as a whole. The report states that whilst there are no known prevalence figures for mental health problems amongst detainee populations there are certain common mental health conditions, especially those that are related to stress and depression. These are likely to be high because of the factors affecting this population, for example experience of trauma, stress related to immigration status and a likely return to a home country where conditions and circumstances may be challenging.

This population is more likely to be susceptible to certain outbreaks of infectious diseases due to lack of immunisation in their home countries. Also, due to low prevalence of some infections outside the UK such as chickenpox, there is little chance of infection in childhood so they remain vulnerable as adults when they come to the UK and this makes infection more serious. Three out of the 4 chickenpox cases reported to PHIPS during 2014 were from IRCs and the chickenpox outbreak reported in Appendix 1 was at an IRC.

Police custody suites

There are 40 separate police forces in England, (39 territorial forces and British Transport Police) all of which are currently responsible for the healthcare of individuals whilst they are in police custody. From 1 April 2016 commissioning responsibilities for healthcare will transfer to NHS England.

Home Office data shows that there were nearly 1.1million arrests between 1 April 2012 and 31 March 2013 with men making up almost 85% of all arrests and over 75% of both male and female arrestees were aged 21 or over. Unlike with other detained settings we do not currently have a national system to monitor the health issues faced by this population, however we do know from health needs assessments recently carried out that the most common health issues affecting individuals that are arrested are substance misuse and mental health. With the transfer of commissioning over to NHS England from 2016 and the development of a health needs assessment (HNA) toolkit for police custody (due for publication during quarter 2 2015/16) we will soon be able to explore in more detail the public health issues affecting this population.

3 National and local partnership work

During 2014, the national Health & Justice Team have taken forward and supported a wide range of initiatives to improve health outcomes in detained populations to reduce reoffending and cut crime at both national and local levels working in partnership at local, national and international levels. Some of these initiatives are detailed in this chapter.

3.1 Health and justice indicators of performance (HJIPs)[xvi].

Up to March 2014, a broad set of indicators, known as the prison health performance quality indicators (PHPQIs) have been used to monitor the quality of healthcare in prisons and young offender institutions accommodating under 18s, as well as the performance of other contributing health and prison services. However, the PHPQIs were not outcome focused and were qualitative measures that largely relied on self-assessment by local healthcare teams. Given this, and the recent changes in the commissioning of healthcare services in places of detention, it was widely agreed that the PHPQIs needed reviewing and updating to:

- support effective commissioning of healthcare services in places of detention
- enable national and local monitoring of the quality and performance of healthcare in the secure estate
- provide a tool for providers to review their performance and identify areas that need improvement
- provide data for local HNAs
- provide assurance to commissioners and partners, including NOMS, that healthcare delivery in prisons is fit for purpose
- provide information for the Care Quality Commission and the HM Inspectorate of Prisons to support their inspection work

A new set of indicators were introduced in 2014 developed by PHE, NOMS and NHS England called HJIPs. Guidance was circulated to assist stakeholders and a series of workshops were held. The indicators are quantifiable where possible and cover a broad range of health themes. The focus during 2014 was the development of the indicators and the introduction of them to the system. NHS England have also been addressing data quality and supporting prisons to input their activity correctly.

A separate set of HJIPs are being developed for the CYPSE, the IRC estate and police custody suites.

3.2 Working with local government and local public health system

Since April 2015 local authorities are responsible for assessing and meeting the social care needs of adult prisoners (not just on discharge from prison but also while they are in custody). This change in legislation affects those local authorities in England which have prisons within their boundaries. All prisoners within those prisons will now be treated as if they are resident in that area for purposes of the Care Act for as long as they reside in that prison. In 2015 the Health & Justice network will work with NOMS, NHS England and the Local Government Association to support the implementation of this legislation.

Local authorities that do not have a prison within its boundaries also have a key role to play in delivering a 'community dividend' by addressing health issues in under-served populations. It is therefore important that JSNAs have clear references to health and justice.

During September 2014 health and justice public health specialists based in the centres surveyed electronically published JSNAs from 147 local authorities in England. The survey identified any references to the CJS in these documents. Findings indicated 73 (49%) had direct references to health and justice within their published JSNA documents and a further 71 (48%) had indirect references.

Given that the vast majority of people in contact with the CJS reside in the community and not in custodial settings, it is important that all JSNAs make clear and explicit reference to health and justice. These populations also tend to be dynamic: around 45,000 people in prison serve less than12 months and some 34% IRC detainees are returned to the community and not deported. Further work is required to improve the level of engagement by local authorities, HWBs and DsPH. This will build on the work of PHE and its partners (including non-government organisations) who published a resource for DsPH in October 2013 ('Balancing Act').

Promising practice:

Thames Valley: Working with local government

A year-long project has resulted in the needs of people in contact with the CJS to be considered in local commissioning plans and to raise their profile as a population with considerable health needs in the community. In doing so, commissioners can now give thought to supporting the health needs of people across the criminal justice pathway, thereby reducing health inequalities.

In March 2014, the Thames Valley Criminal Justice Board launched a document on the health needs of people in contact with the CJS. PHE supported the development of the document through the local health and justice public health specialist and provided the keynote speaker for the launch event. The event saw partners from the 8 local authorities across Thames Valley, CCGs, probation services and the police and as a result there is an agreed dataset shared annually from probation services to local authorities for inclusion in local JSNAs.

3.3 Health needs assessments (HNAs)

In order to meet the changing needs of the prison population, a toolkit has been produced by the Health & Justice PPDs HNA Working Group with representation from PHE, NHS England, NOMS, YJB and Public Health Wales. The Health & Justice HNA toolkit provides a consistent approach for producing a HNA, which can inform regional or national views of need across places of detention. It reflects the diverse health needs of different populations within PPDs for example women, older prisoners, young people, those with a learning disability and those with a physical disability.

We have published the parts 1 and 2 of the Health & Justice HNA Toolkit for PPDs which describes the template for HNA for adult prisons. The second template for police custody is due for publication during quarter 2 2015-16.

Templates supporting the creation of health and wellbeing needs assessments for CYPSE for ages 10 to 17 year olds are available on the Child and Maternal Health Intelligence Network (CHIMAT) website.

Promising practice:

West Midlands: Health needs of older prisoners, rapid health impact assessment, HMP Stafford

NOMS' redesign of the prison estate resulted in HMP Stafford (a victorian prison) being re-rolled to accommodate primarily sex offenders. This allowed the completion of a rapid health impact assessment to explore the impact of that decision, to review information, evidence and intelligence and to identify key issues that could be managed through local planning and engagement with work partners.

The work was undertaken as part of the health and justice programme for the west Midlands centre with partnership input from west Midlands stakeholders including NHS England NOMS and the Staffordshire local authority, as well as full engagement from HMP Stafford. The work took 4 months with the final report being published in July 2014.

The project resulted in 68 recommendations for the prison and other stakeholders. These recommendations support the change process, inform local planning and are used to open local discussions on what work is needed to improve health and social care.

3.4 Mental health

Mental health needs among those in contact with CJS are often complex, with comorbidity the norm among this group. In a survey of prisoners carried out in 1997 on behalf of the DH, 72% of male and 71% of female sentenced prisoners were found to suffer from 2 or more mental disorders (including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence)[xvii]. The provision of effective mental health services across the custodial estate is a vital element of rehabilitative support provided to individuals.

It is important to recognise that not all people who come into contact with CJS who require support with their mental health have committed a criminal offence. Police officers can be called to a scene where there are concerns for a person's safety. Sections 135 and 136 of the Mental Health Act (1983) empower the police to detain an individual in need of immediate care and control, and take them to a place of safety for an assessment under the Act. Figures published in 2014 by the Health and Social Care Information Centre on detentions under Section 136(3) of the Mental Health Act 1983 show that the reported number of place of safety orders made where an individual was taken to a police station has decreased by 24%, from 7,900 between April 2012 and March 2013 to 6,000 in the following 12 months. The government is keen to continue to address this issue and ensure that the most

vulnerable people in local communities are being supported by the most appropriate service and have asked local commissioners and providers to sign up to the Mental Health Crisis Care Concordat.

Liaison and diversion schemes

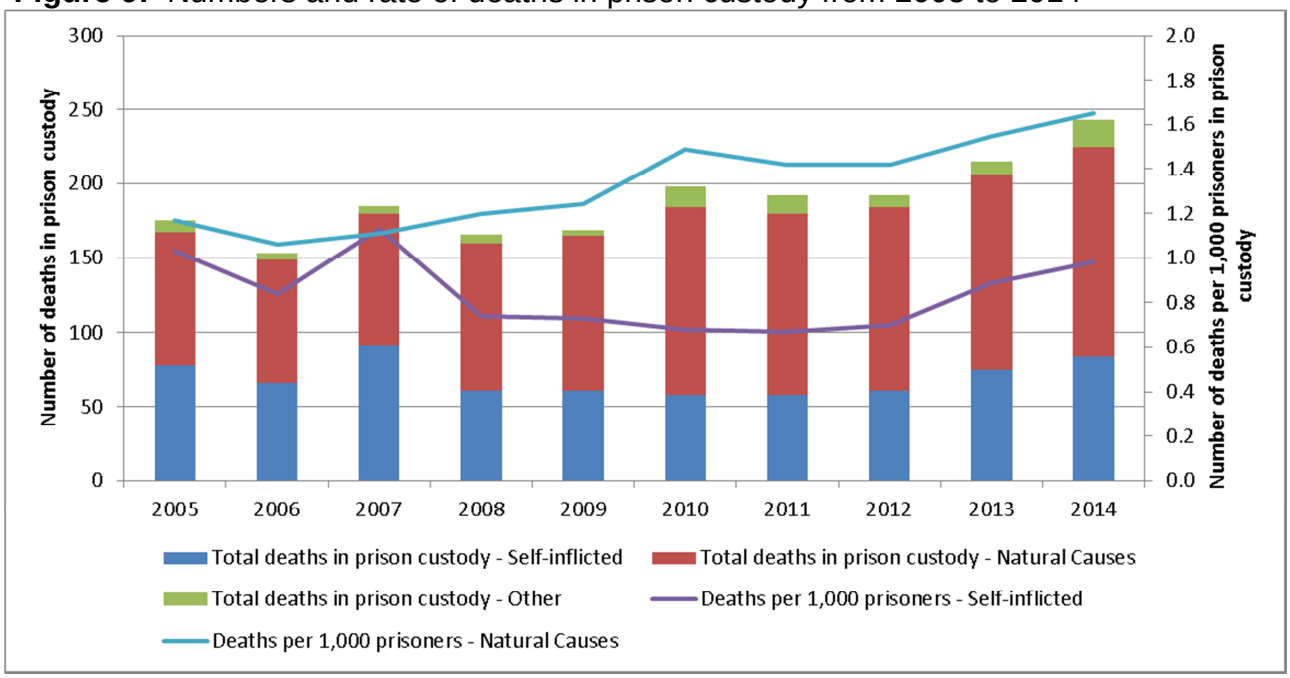
Liaison and diversion services are intended to improve the health and criminal justice outcomes for adults and children who come into contact with the criminal justice system where a range of complex needs are identified as factors in their offending behaviour. Ten liaison and diversion trial schemes set up across England in 2014 which are delivering an all age approach. A new wave of implementation was started in April 2015 for a further 13 sites, giving a total population coverage of 53%[xviii]. The initial trial schemes show that of those people entering liaison and diversion schemes, 58% of cases were identified by the police, 65% of adults were already known to mental health services and 45% of children were known to children's services. At least 50% of adults in the schemes had comorbid conditions.

The DH is funding street triage pilot schemes, managed by 9 police forces, in partnership with local NHS organisations. In these street triage schemes mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. Further information on street triage will be made available as the pilot schemes roll out.

Deaths in custody

MoJ statistics in figure 9 indicate an increase in the number of self-inflicted deaths in prisons over the last 3 years. A better understanding of these cases and a broader approach to tackling mental health in prisons is required.

Figure 9: Numbers and rate of deaths in prison custody from 2005 to 2014



Source: Ministry of Justice England and Wales, all age groups, https://www.gov.uk/government/collections/safety-in-custody-statistics

More recent data shows that in the 12 months to March 2015 there were 239 deaths in prison custody[xix] – an increase of 14 deaths compared to the 12 months ending March 2014. Of the 239 deaths, 76 were self-inflicted (a reduction from 88 deaths in the same period in 2014), 144 from natural causes, 4 homicides and 15 categorised as ''awaiting further information'' (including accidental and other difficult to classify deaths). A small proportion of the most recent figures from the last two years is expected to be reclassified as natural causes. In 2014 there were 25,775 reported incidents of self-harm, an increase of 2,545 incidents (11%) from 2013.

In attempting to reduce self-inflicted deaths, the mental health of those in prison needs to be reflected on in context. People are often entering prison with certain vulnerabilities, into a stressful environment and without their usual social and family supports. Therefore, best practice for treatment of mental ill-health needs to be applied as well as consideration of broader environmental factors such as increased awareness of staff of mental health and creating facilitative and enabling environments to increase overall positive wellbeing.

To this end, PHE has been supporting the MoJ on a review of mental health service provision in prisons and the development of a potential model of mental health services that could take these issues into account. PHE is also working with NHS England around unclassified deaths to improve practise and reduce the incidence of these going forward.

3.5 Continuity of care

As with all health issues, the concept of continuity of care is vital to ensure continual improvement of health and the potential to reduce future reoffending. The offender management community cohort study (OMCCS) is a longitudinal cohort study of adult offenders who started community orders between October 2009 and December 2010. The OMCCS estimated that nearly one-third of offenders on community orders reported that they had mental health conditions (29%); these were particularly prevalent among women (46%) and older offenders (40% of those aged 40 and over).

PHE and NHS England are committed to ensuring continuity of care not only around the estate but also on release into the community. The prison primary care information system (SystmOne) enables information on health issues to be transferred with a prisoner when moved to another prison and generates a care summary record for their GP and other care providers on release into the community. The National Probation Services and CRCs can support healthcare providers and drug treatment providers in planning and providing continuity of care to ensure that social and healthcare needs are identified and addressed for prisoners prior to release. Drug and alcohol service providers will also work effectively with prisoners in preparation for release to ensure seamless transition of care from custody to community settings. Healthcare needs are also supported by ensuring prisoners leaving prison have access to appropriate medication through issuing of an FP10 prescription which can be used to access medication required immediately on release.

DsPH have an important role in raising the issue of continuity of care locally with their CCGs to consider the needs of people in contact with CJS in commissioning community services. There is also scope for the involvement of CRCs as new partners in the local stakeholder landscape. The transforming youth custody programme led by the MoJ and the YJB, has presented an opportunity to embed a consideration of health and substance misuse need in

all planning for improved resettlement and an associated reduction in the rate of reoffending of this cohort. CCGs play an important role in ensuring local pathways are in place to support timely access to a range of health services on release from secure settings.

3.6 Substance misuse

The economic burden that illicit drug use imposes on NHS England and the CJS is significant – see Table 1 below[xx]. Drug users are estimated to be responsible for between a third and a half of acquisitive crime and treatment can cut the level of crime they commit by about half.[xxi]

Table 1: The economic and social costs of Class A drug use

	£m	% of total cost
Drug-related crime		
Fraud	£4,866	32%
Burglary	£4,070	26%
Robbery	£2,467	16%
Shoplifting	£1,917	12%
Drug arrests	£535	3%
Health costs		
Inpatient care	£198	1.2%
Inpatient mental health	£88	0.6%
A&E	£81	0.5%
Community mental health	£61	0.4%
Primary care – GP visits	£32	0.2%
Neonatal effects	£3	0.1%
Infectious diseases	£25	0.1%
Drug-related deaths	£923	6.0%
Social care	£69	0.4%
Total	£15,337m	99%

Source: Home Office

There is also a strong link between alcohol, and crime, disorder and anti-social behaviour, with alcohol being a factor in an estimated 47% of violent crime.[xxii]

Young people in custody also have disproportionately high levels of substance use.[xxiii] In the audit commission's report 'Misspent Youth: Young People and Crime', 15% of young offenders had a drug problem of some kind. However, for persistent offenders this figure increased to 37%.[xxiv]

Over the past 10 years, targeted investment in criminal justice based substance misuse interventions, both in community and custodial settings have made a significant contribution in reducing drug and alcohol related crime and improving health outcomes and building safer more resilient communities. Since drug interventions programme began in 2003, recorded acquisitive crime – to which drug-related crime makes a substantial contribution – has fallen by 39% across England and Wales[xxv]. It is believed that the improved availability and quality of drug treatment during the same period has played a key part in this fall. To continue to build on this success, it is essential that we ensure that commissioners maintain appropriate levels of funding in drug treatment services.

Recognising the increasing pressure on local authority, public health and police and crime commissioners budgets, PHE has released a series of reports that show local estimates of the prevalence of opiate and/or crack cocaine use, key national data for comparison and in addition to data from the national drug treatment monitoring system (NDTMS), estimates on crimes prevented from PHE's local value for money analysis and conviction data produced through analysis of police national computer and NDTMS combined datasets. These reports will assist local commissioners by providing information that can inform local JSNAs and support the argument for continued investment in drug and alcohol treatment as an effective means of achieving better crime reduction and health improvement outcomes, as well as supporting interventions with drug misusing offenders that local authorities directly commission.

The reports also provide data identifying the numbers of prisoners with substance misuse needs returning to each local authority area and the main prisons that they are being released from. This information should not only assist with meeting the needs of this particularly vulnerable group but also encourage greater dialogue and joint planning between local authority, police and crime commissioners and NHS England health and justice commissioners. These reports are available via the local PHE centre alcohol and drug manager and local authority joint commissioning managers.

In terms of alcohol, NDTMS records that there were 15,123 primary alcohol new treatment entries across the adult prison estate in England between April 2013 and March 2014. Of these, 8,963 completed a clinical detoxification intervention having been assessed as alcohol dependent. It is acknowledged that the majority of alcohol related crimes are committed by individuals whose drinking patterns are assessed as harmful or hazardous but who are not alcohol dependent. These individuals are often not identified on entry to prisons either because they decide not to disclose their alcohol problems or because of ineffective assessment/screening processes. Even where problems are identified, the limited availability of psychosocial interventions and treatment programmes for alcohol users in prison will often mean that they are unable to access the help they need.

In preparation for the introduction of Through the Gate services in all prisons from May 2015, PHE has been working in partnership with NOMS, NHS England and prisons to test a new approach to working with alcohol misusing offenders in prisons and follow up in the community with offenders. The model is based on brief interventions (BI), an approach that has a robust evidence base in primary care and has been used successfully in community based criminal justice settings. The project has been testing whether BI reduces drinking levels among higher and increasing-risk drinkers (non-dependent) and assess the longer-term impact in terms of offending and health outcomes. The new licence conditions that will apply to all sentenced prisoners on release offers the opportunity to engage both prison based providers and the new CRCs who will be responsible for supervising these individuals.

The emergence of novel psychoactive substances (NPS) within detention settings in England is supported by much anecdotal and significant media comment. Since these substances are deigned to mimic existing illicit drugs, stimulating or depressing the central nervous system, and/or causing a state of dependence, they pose public health risks including fatalities. The Home Office expert panel's NPS review defines NPS as "psychoactive drugs, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions".

In response to these issues PHE published a new NPS toolkit. The toolkit has been produced in response to a demand from local authorities for a NPS resource, and it was developed in consultation with local substance misuse commissioners and other professionals working in the drug prevention and treatment sector, as well as the Home Office, NOMS and NHS England. The toolkit helps set the scene on NPS and covers key topics such as prevention, information sharing, responding to acute NPS problems, treatment, workforce and prisons.

3.7 Tobacco control

Approximately four times as many people in prisons smoke than in the general population, with similarly high levels of smoking found among those in police custody and probation[xxvi]. These extraordinarily high rates of smoking damage health, and, when compared with the general population, cause marked health inequalities for offenders. Given the high rates of smoking, exposure to second-hand smoke is extensive across CJS and damaging to health of smoking and non-smoking offenders, visitors and staff. Stop smoking service provision is variable across the whole of the prison estate and is not joined-up between CJS settings or between CJS and the community. In 2007 a comprehensive national smoke-free policy was introduced in England. Adult prisons were the only setting exempted allowing prisoners to smoke in their own cells and nowhere else in the prison.

The Health & Justice Team have supported PHE's tobacco control team in working alongside NHS England and NOMS to reduce the levels of smoking in adult prisons. We recognise that this is a difficult journey and one which must be made in partnership, balancing the tensions that exist in the system, with the need to ensure that people are protected from the damaging effects of second-hand smoke. PHE has developed guidance for the management of smoking and nicotine withdrawal, which has been published on the gov.uk website. We are also working with NHS England to explore how the availability of prisons services to support people in stopping smoking can be matched to those available in the wider community. In moving towards a smokefree estate we will support NOMS and NHS England to reduce the number of people who currently smoke whist detained, so that the transition to smokefree will affect as few people as possible.

3.8 Public Health Intelligence in Prisons and Secure Settings Service (PHIPS)

Originally established in 2002, the then Prison Infection Prevention Team was set up within the Health Protection Agency to monitor the coverage of hepatitis B vaccinations within the prison population. The team is now called PHIPS and is based within the national Health & Justice Team. It has recently been re-branded to reflect the increasing role that the team has in gathering evidence and intelligence to improve the health of people in prisons and other PPDs. This includes:

- data to support HNAs
- HJIPs
- MMR and seasonal flu vaccine coverage

PHIPS works closely with the national Health & Justice (Health Protection) Network to receive reports of communicable diseases and develop national guidance for stakeholders within the field. The Network has published a range of materials to support stakeholders in health protection and also collect reports of infectious diseases throughout the estate.

Communicable diseases often affect a larger proportion of those in the CJS than the general population. Appendix A provides details of all communicable diseases reported to the Public Health Intelligence in Prisons and other Secure Settings Service during 2014. It also references other PHE data sources and makes comparisons between the prevalence of diseases in prisons compared to the community. For example Table 2 shows a higher incidence of infection such as hepatitis C amongst the prison population (8%) than in general primary care (2%).

Table 2: Trends in individuals tested for HBsAg, anti-HCV and HIV by service, 2014

Service type	Number tested for hep B	Number/ percentage of positive Hep B results	Tested for Hep C	Number/ percentage of positive Hep C results	Number tested for HIV	Number/ percentage of positive HIV results
Drug services	1,103	12/1.1%	1,136	106/9.3%	524	2/0.4%
Prison services	3,301	49/1.5	4,089	327/8.0%	2,834	16/0.6%
All primary care	135,372	1,898/1.4	113,367	2,263/2.0%	226,264	1,860/0.8%

Source: PHE sentinel surveillance of blood-borne virus testing in England, all age groups

Prisons and other detention settings are at risk of outbreaks of infectious diseases due to the population being at higher risk of infections and also living at close quarters to each other creating an elevated opportunity for transmission of disease. It is important that clear arrangements are in place to address this which is why PHE, in partnership with NOMS and NHS England have published a suite of guidance. Appendix A usefully explores the outbreaks reported to the PHIPS service during 2014 and addresses the trend of outbreaks throughout the year.

In light of the Ebola outbreak in West Africa, PHE Health & Justice Team organised and led a table-top event, Exercise Cerberus, for IRCs on the effective management of an incident of suspected Ebola virus with the aim of improving resilience within the IRC estate. The event was co-sponsored by NHS England and the Home Office. In addition to this we have led on the development of bespoke guidance on Ebola in PPDs.

3.9 Opt-out blood-borne virus testing

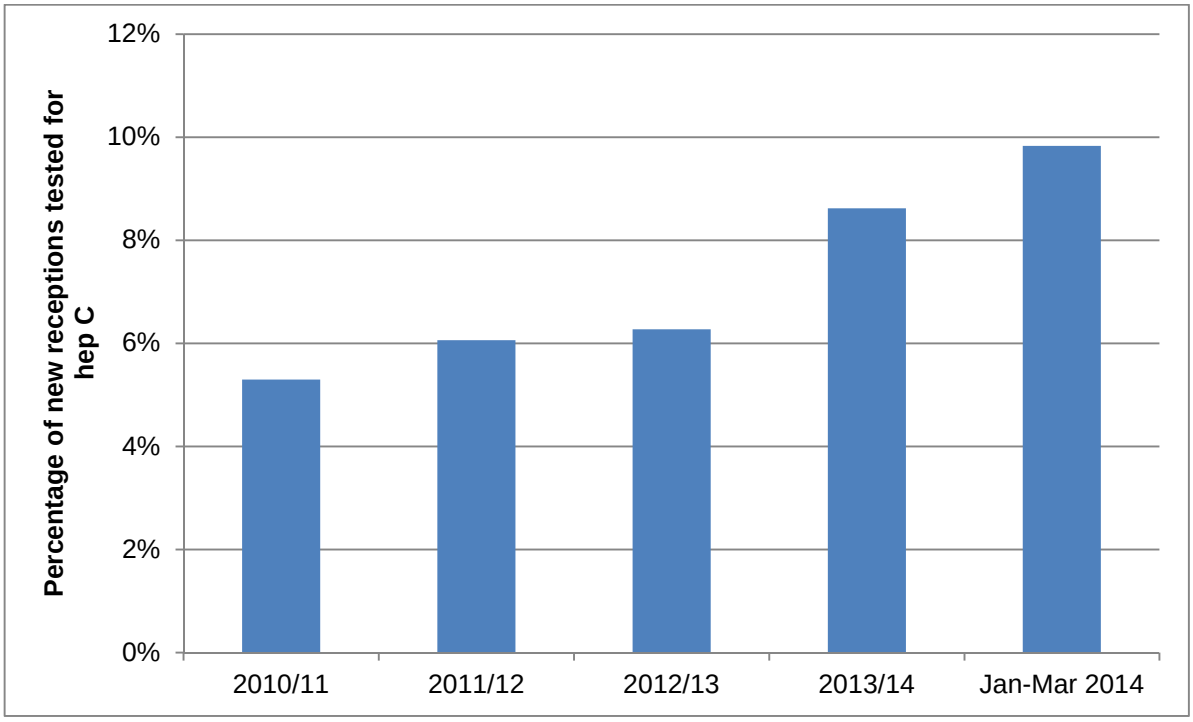
It has been evidenced that rates of illegal drug use amongst prisoners are higher than that of the general population[xxvii]. Injecting drug use is the main risk factor in the transmission of blood borne virus (BBV) for hepatitis C infection in the UK with over 90% of new infections acquired in this way[xxviii].

PHE has data from several different sources which measure and report the prevalence of infection among people in prison; however, all these data sources also show significant under-testing of prisoners. Influenced by the evidence of impact of switching to an opt-out policy in antenatal testing for HIV in the UK in the 1990s, and recognising that people in prison were missing an opportunity for testing and treatment, PHE in consultation with its partners including NHS England and the NOMS as well as patient advocates such as the Hepatitis C Trust and the National AIDS Trust, advocated for the introduction of an ‘opt-out’

testing policy for BBV for people in prisons. This was agreed and published as a joint developmental priority in the National Partnership Agreement between PHE, NHS England and NOMS in October 2013[xxix]. This commitment has continued through to the revised National Partnership Agreement 2015/16 identifying a commitment in priority 3 to 'Improve the proactive detection, surveillance and management of infectious diseases in prison and improve capability to detect and respond to outbreaks & incidents'' and will continue to implement an 'opt-out' policy and build on best practice for testing for BBVs and development of care pathways for those found to be infected.

The key aim of the policy is to increase the diagnosis and treatment of people in prison for infection with BBVs, namely hepatitis C, hepatitis B and HIV, through the introduction of an opt-out testing policy across all prisons in England. Already this is seen to have had results with an increase in hepatitis C tests performed since April 2010, rising steadily from just 4% of new receptions between April and June 2010 to 10% between January and March 2014[xxx].

Figure 10: % of hepatitis C tests performed by quarter on new prison receptions from Apr 2010 to Mar 2014



Source: PHPQI data, all age groups

Work during 2014 included a national event held which was held in Birmingham on 1 May 2014 to launch the work. A number of local events have also taken place for example in Yorkshire and the Humber and west Midlands and a range of supporting guidance has been developed to support the opt-out BBV testing programme.

Eleven initial 'pathfinder' prisons introduced the policy as part of the first phase of the programme and these have been evaluated by the national task and finish group to enable lessons to be learned from their experiences across the estate. The key findings from the report are as follows:

- preliminary data suggests a near doubling of BBV testing following the introduction of the opt-out testing policy

- the proportion of those testing positive for the three BBVs has remained stable from before the policy was implemented to after
- when asked, 8/11 respondents believe that they have identified people who would otherwise have remained undiagnosed
- numbers being referred for hepatitis C treatment have increased significantly since the introduction of the opt-out testing policy
- almost all pathfinders (10/11) provided hepatitis C treatment as an in-reach model except one which is done in-house as part of a wider multi-disciplinary team
- of those being referred for hepatitis C treatment, around 1 in 3 (69/226) commenced treatment in the 12 month period before the opt-out policy was introduced and around 1 in 4 (42/185) in the 6 month period after

There are now an additional eleven prisons implementing the policy as part of the second phase of the programme. All these prisons will also be evaluated after 6 months of implementation later in 2015. There are also an additional 32 prisons that are not part of the pathfinder programme but who report they are either implementing or well on their way to implementing the policy.

A second national event took place on 21 May 2015 in Birmingham to support stakeholders in implementing the work through learning lessons from the initial pathfinders. Also, working in partnership with the Hepatitis C Trust, a series of roadshows are being held during 2015 which will focus on hepatitis C generally but also serve to raise awareness about opt-out BBV testing in prisons. The first of these was held in Liverpool on 6 March and the second one is planned in London on 26 June 2015.

Promising practice:

East Midlands: Introduction of dried blood spot testing (DBST) in 12 prisons

As part of BBV opt-out programme, the east Midlands prisons have introduced DBST into its 12 prisons. DBST removes the need for venepuncture therefore is ideal for patients with damaged peripheral veins such as through drug use and it can be performed by any trained healthcare worker.

The programme was implemented in partnership with the NHS England area team, the 4 county hepatologists, providers and prison healthcare staff. An agreement with the local empath laboratory enables the tests to be conducted at a local NHS laboratory. Each sample is tested for hepatitis B surface antigen, hepatitis C antibody and PCR and HIV antibody and antigen. Any patient testing positive receives a venous blood test and is referred to secondary care as necessary.

The phased implementation of the programme has been successful enabling good practice to be replicated and any issues to be addressed. The method of testing is preferred by staff and prisoners and, as the method is quicker, clinics are able to offer testing to more prisoners. The programme has not required additional funding and more prisoners are accessing testing, the programme has not resulted in a large increase in testing requiring additional

clinics or resources. Some prisons receiving from local prisons have noticed an increased amount of prisoners at reception having already had BBV testing.

Promising practice:

Yorkshire and the Humber: Local planning for opt-out BBV testing

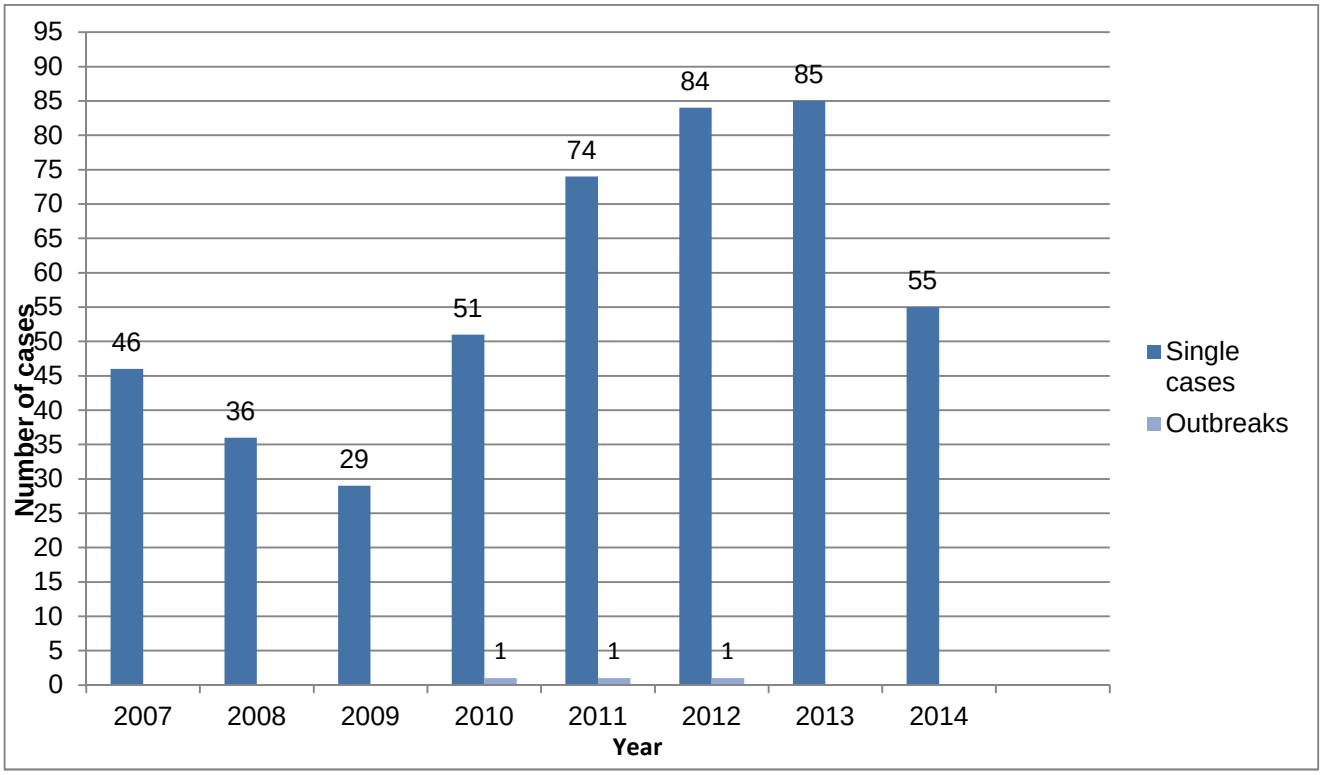
Local partnership planning to implement opt-out BBV testing in prisons was achieved in two ways. Firstly an event was held in May at HMP Askham Grange which involved key stakeholders from across the region to look at how BBV work can be implemented locally. The session consisted of presentations from NHS England, PHE national Health & Justice Team and clinicians providing treatment for hepatitis C in local prisons. In addition to this participants were asked to attend workshops to map out any local issues regarding implementing the pathway.

Secondly NHS England recruited a project manager to lead on the implementation of opt-out BBV testing in prisons. They are working in close partnership with the PHE health and justice public health specialist overseen by a multi-agency working group. Quarterly bulletins are also being circulated to stakeholders to inform them of progress.

3.10 Tuberculosis

TB infection is also higher amongst people in prison compared to the community. Prisoners, their social networks, and those who 'rotate' between prison and the community have long been recognised as being at risk of TB, due to the over-representation amongst them of risk factors including homelessness, drug use and alcohol misuse. Some forms of TB, particularly those affecting the lungs or larynx, can be transmitted to other prisoners and to staff. The most recent figures estimate that in the general population there were a total of 7,892 cases of TB notified in the UK in 2013, an incidence of 12.3/100,000 population[xxxi]. Places of detention report a higher incidence of TB, and using the standing prison population from the MoJ as a denominator and PHIPS reports there were 100.9 cases per 100,000 in 2013 and 64.3 in 2014. Figure 3 details reports of TB in prisons in England which showed an increase from 46 reported cases in 2007 to 85 cases in 2013. This may be partially attributable to a change in the reporting of TB cases which is further explored in Appendix A. During 2014 there were fewer cases reported (55) and during 2015 we will be monitoring this closely to see if there is a sustained reduction in comparison to previous years.

Figure 11: The number of TB cases in PPDs in England reported by year 2007 to 2014



Source: PHE, PHIPS data, all age groups

Prisons were identified as a key setting for TB control in the Chief Medical Officer's action plan for England, published in 2004. Also, PHE and NHS England have now published the Collaborative tuberculosis strategy for England: 2015 to 2020 in January 2015 which looks at building on the assets already in the NHS and the public health system, to support and strengthen local services in tackling TB. This includes tackling TB in under-served populations such as those in CJS.

PHE, NHS England and NOMS are committed to improving the detection and management of TB among prisoners at or near reception and will ensure that all fixed digital X-ray machines are fully operational and being used as part of an active care pathway in those prisons where they are currently installed. Work is ongoing in sites that have a digital X-ray machine installed in a local prison to improve the detection of TB on reception to prison. These prisons are HMP Holme House (north-east England), HMP Manchester (Greater Manchester), HMP Birmingham (west Midlands) and London prisons, HMP Wandsworth, HMP Belmarsh, HMP Wormwood Scrubs, HMP Pentonville, HMP Thameside and HMP Brixton. There has been delivery of a series of TB awareness and health promotion events in some prisons across London, Greater Manchester and west Yorkshire which has been led by PHE health protection staff with the support of other key local partners. Furthermore a London TB improvement strategy was agreed by NHS England London (health and justice) and PHE (London).

Whilst there has been progress across the estate to address TB we are still faced with challenges and there are currently only 2 out of the 8 digital X-ray machines in use. Work is ongoing to address this and addressing this is included in the National Partnership Agreement for 2015 to 2016.

Promising practice:

London: Development of a London TB service improvement plan for prisons and IRCs

Following a TB service audit across all prisons and IRCs in London by NHS England and PHE, a plan was developed to help improve local TB services. The plan was designed and agreed over a 2 month period and included specific recommendations for each of the prisons/IRCs. Key themes include:

- regular TB review at contract management meetings: NHS England will regularly review TB services at each establishment contract management meetings with providers
- enhanced support where necessary: Further advisory support will be available to prisons and IRCs where need is identified
- facilitating improvements by sharing good practice: PHE has started work on building good practice case studies around ways to improve TB identification and management in relevant detention settings

3.11 Oral health

The prison population generally has poor oral health, with reports of periodontal disease and/or decayed, missing or filled teeth scores around 4 times higher than the general population[xxxii]. Studies have shown that oral health is poorer in a population of criminally convicted individuals before entering prison[xxxiii]. Despite the increased need for treatment, evidence suggests that people in prison infrequently seek dental care[xxxiv]. Shortcomings in dental care have been attributed to both infrequent clinical sessions and poorly equipped clinical services. This problem is exacerbated by the rising numbers of people in prison, as well as an aging prison population, which has increased the strain on all healthcare provision in prisons.

In partnership with NHS England, NOMS, Public Health Wales and the National Association of Prison Dentistry UK, a national survey was published in 2014 which looked at the variations in dental health services located within prisons in England and Wales and provides recommendations for future planning. A national multi agency working group focusing on dental public health in PPDs has now been developed led by PHE's dental public health team and is tasked with responding to the introduction of the recommendations in the report.

Promising practice:

Yorkshire and Humber: Collaborative working between NHS England and PHE to improve the delivery of integrated dental services in PPDs

Previously dental contracts were not fully in place with inadequate service specifications in some prisons and concerns were raised around quality of services, waiting lists, 'did not attends'/cancelled sessions and lack of integration with healthcare.

The Yorkshire and Humber PHE centre health and justice public health specialist and dental public health lead worked closely with NHS England to support the procurement of healthcare provision, including dental services in the Humber cluster (3 prisons) between February and November 2014. This included a comprehensive review of dental services and support is currently extending into the contract mobilisation period. A similar approach is being adopted to support a larger procurement of healthcare services across west Yorkshire, planned for 2015.

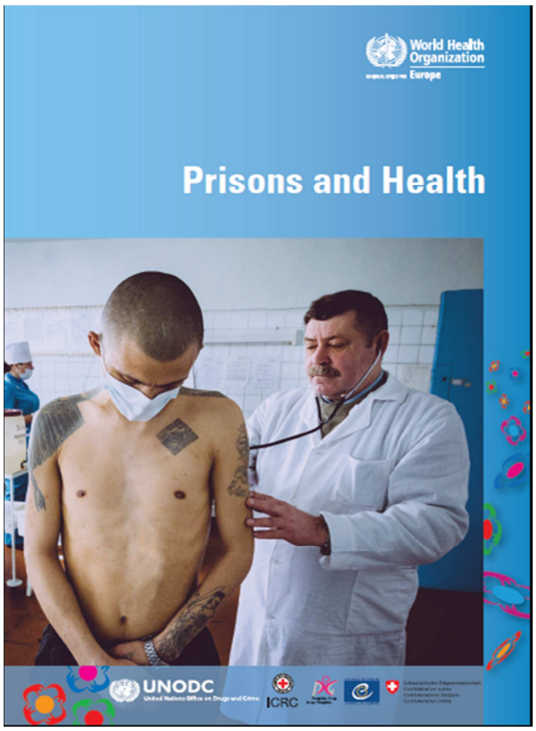
Through collaborative working with NHS England, dental public health expertise has contributed to the effective commissioning of prison dental services, to ensure that high quality and evidence based services meet the needs of the prisoners providing improved health including oral health outcomes.

4 International engagement in health and justice work

WHO Health in Prisons Programme Collaborating Centre (WHO HIPP CC)

In 1995, the World Health Organization (European Region) and the UK established a network for the exchange of experience in tackling health problems in prisons. From this network emerged the WHO Health in Prisons Programme (WHO HIPP), which includes member states in the European region. The purpose of the network is to exchange experience in tackling the health issues facing prisoners and prisons and to produce consensual statements of advice.

The aim of the programme is promoting health in prisons as part of the overall public health agenda. The European Network for Prisons and Health currently includes most of the 53 member states of the WHO European Region. The WHO pages contain further information.



On April 1 2014, PHE took over the function of the WHO HIPP Collaborating Centre from the University of Central Lancashire, who had previously been contracted by the Department of Health to deliver this function. This change heralded the integration of the function of the WHO HIPP CC into the wider work of PHE and aligned the structure of the WHO HIPP CC with other WHO Collaborating Centres hosted by PHE.

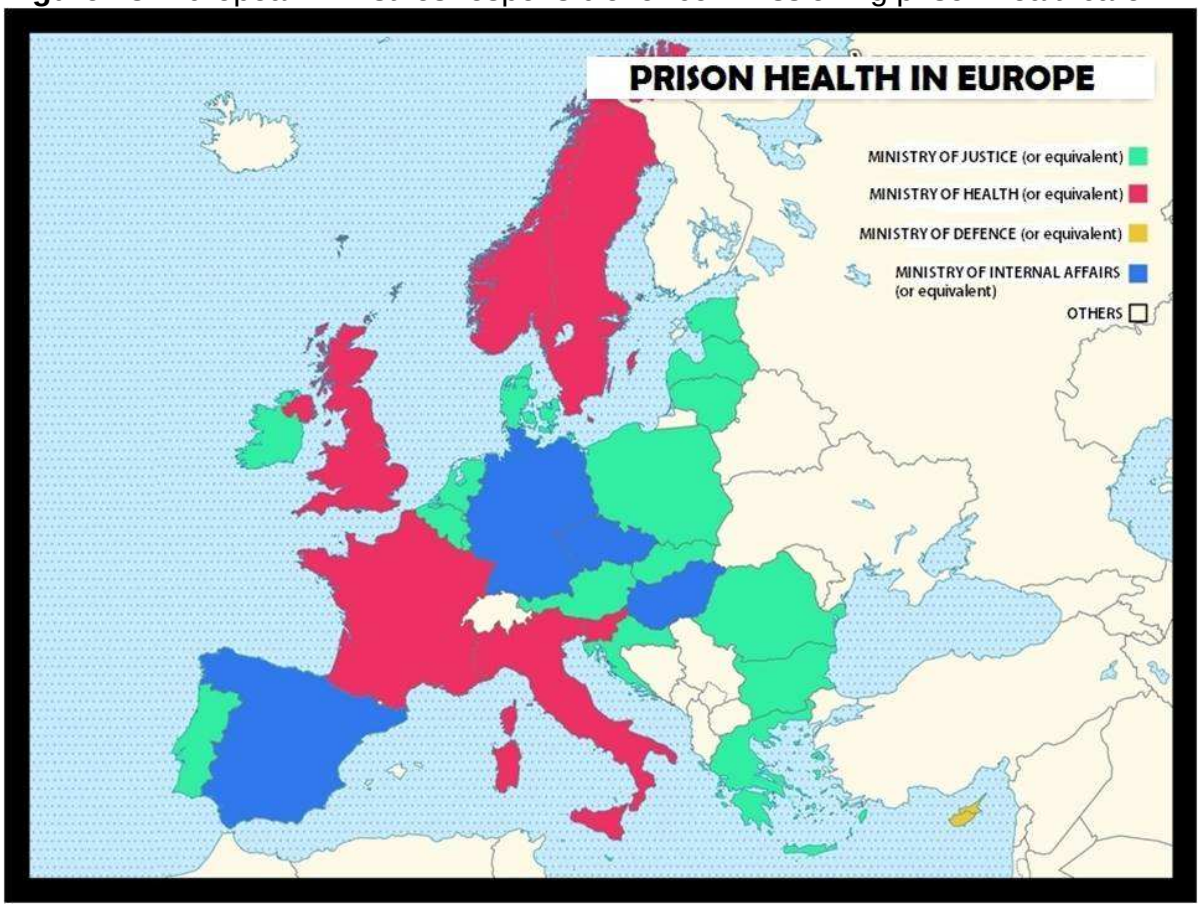
The UK Collaborating Centre

The work of the WHO HIPP CC is unique in that it is not mirrored in other WHO regions. Its focus on prison populations makes a significant contribution to taking forward work on the WHO European health policy framework, Health 2020, which aims to improve public health and reducing health inequalities. The framework views social values such as human rights and equity as key to good governance for health. As such, when a state detains people it must guarantee their right to health and provide them with the best possible care. While great strides are being made to improve the health of prisoners in the European Region, many member states in the European region still do not fully meet their responsibility to protect the health of their prisoners. An expert group advising the WHO Office (Europe) on the organisation of prison health concluded that:

- the management and co-ordination of all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility
- health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions[xxxv]

The focus of the collaborating centre is to support the development of a European network to exchange experience, expert advice and promote innovation in addressing health and healthcare challenges facing prisoners and prisons. This can be achieved by promoting health in prisons as part of the overall public health agenda and, crucially, advocating that Health Ministries should be responsible for commissioning prison healthcare as opposed to Justice Departments/Ministries – see figure 13 below. Outlined below are some of the key achievements of the WHO HIPP CC work in 2014 which have underpinned the approach.

Figure 13: European Ministries responsible for commissioning prison healthcare



Key achievements:

In February 2014, the WHO HIPP CC founded, with other member states, the Five Nations' Health & Justice Collaboration with England, Northern Ireland, the Republic of Ireland, Scotland and Wales and held the first meeting in London which agreed membership, terms of reference and to rotate the host and chair of the meeting across member states with three meetings planned for 2014.

At this same meeting, the WHO HIPP CC secured the support of both the Irish Prison Service and the WHO Regional Office to hold the next WHO HIPP European network meeting in the Republic of Ireland with an associated two day international conference on

prison health. PHE agreed to co-produce the conference with the Irish Prison Service (IPS).

In May 2014, the Director of the WHO HIPP CC attended an expert meeting on prison health in Strasbourg sponsored by the Council of Europe and presented PHE's vision for health and justice and some of the achievements to date of the WHO HIPP CC. The director of the WHO HIPP CC attended a meeting of the European Network the next day to review the organisation of the network and to seek assurance of WHO regional office in Europe and its director to the continuation of the work of the WHO HIPP CC. PHE also pledged to support the WHO HIPP CC function following the departure of staff sponsored by the Swiss government. PHE would deliver this by appointing an interim public health lead to work across England and Copenhagen.

In June 2014, PHE created the post of public health specialist to support the work of the WHO HIPP and the WHO HIPP CC.

In June 2014, the WHO HIPP CC supported the IPS in hosting the second meeting of the Five Nations' Health & Justice Collaboration in Dublin, which was also attended by Dr Lars Møller, programme manager alcohol and illicit drugs and prison health programmes in the Division of Non-communicable diseases and Promoting Health through the Life-course, WHO Regional Office for Europe. This meeting agreed an outlined work programme for the collaboration and discussed details about the next network meeting and international conference on prison health which was held in Portlaoise in October 2014.

During summer 2014, the WHO HIPP CC worked with the IPS to organise the second annual prison health conference in Portlaoise, the Republic of Ireland. The event was aimed at all 53 member states in the European region, particularly staff working in prisons, in partner organisations, including commissioners and providers of health and social care, and others that work to meet the health needs of people in prisons, as well as people in contact with CJS in the community. Over 2 days presentations addressed 2 themes: prisoner empowerment and improving lives in the community. The Prisoner empowerment theme detailed the highly successful and influential work from the Irish Prison Service, the Irish Red Cross and Education and Training Boards Ireland. In addition to highlighting the WHO document 'Prisons and Health', launched earlier in 2014, the conference received an update of 'Prevention of acute drug-related mortality in prison populations during the immediate post-release period.'

The WHO HIPP CC has also supported collaboration with international partners on research and development of prison health systems in both Europe and North America.

Future plans

The third annual Prison Health Conference will be held in October 2015 in Bishkek, Kyrgyzstan. The programme and theme will be developed by a steering group during the spring 2015.

The WHO HIPP CC will continue to support the development of Health without Barriers and its associated projects.

The European Federation for Prison Health has promoted the collection of information from member states on: the statutory responsibility for the health of prisoners in each country; estate and demographic profile and prevalence of major infections, such as BBVs, amongst the prison population in each of the 6 state members. The results of this survey will help inform the work priorities of the working groups in the short and medium term.

Leadership and resources to support the Five Nations' Health & Justice Collaboration across the countries and devolved administrations of the UK and the Republic of Ireland will also be part of the WHO HIPP CC work programme. There is also a plan and deliver an annual meeting of the WHO HIPP Network and a wider international conference on health and justice within the jurisdiction of the Five Nations.

Finally, the WHO HIPP CC will be working closely with colleagues in Copenhagen to take forward proposals to develop a minimum data set for health indicators in prisons that could be adopted by all member states. This will be supported by a web-based platform to assist ease of access. The WHO HIPP CC will be assisting in the development of the minimum data set variables.

5 Conclusions and looking forward

The legislative and structural changes to the health and justice landscape in the financial year 2014 to 2015 have created new opportunities to address the health inequalities faced by people in prescribed detention. However, the overwhelming majority of people in contact with the CJS will live most of their lives in the community which means that the needs of this population need to be addressed by a wide range of stakeholders. We know that addressing the health needs of people in contact with CJS plays a key role in cutting crime, reducing reoffending and tackling health inequalities and this delivers a community dividend in tackling wider health issues in under-served populations.

In order to really have an impact on the health needs of this population and the wider community we need to also improve prevention efforts to begin to address some of the determinants of health affecting this population.

The needs of people in detained settings vary widely depending on the type of setting and the demographics of the individuals within it. Our understanding of need is improving all the time with the introduction of the HJIPs, the development of a second generation IT system (Health & Justice Information Service) which will enable records to be shared across detained settings and with the community and the availability of guidance to assess the needs of people in the various settings through HNAs. We have started already to make progress on some of the key issues affecting this population by introducing preventative measures such as vaccination and screening programmes and the imminent introduction of health checks in prisons. Furthermore, Chapter 3 provides examples of ways we are addressing health needs such as the introduction of the opt-out BBV testing policy.

The WHO HIPP CC will continue to develop its work programme across the 53 member states promoting the benefits of healthcare being commissioned by health ministries.

The WHO HIPP annual conference for 2015 will take place in October in Bishkek, Kyrgyzstan and will continue to promote a range of good practice initiatives with a diverse international audience. This will build on the work that has been highlighted in our London and Portlaoise conferences rallying efforts to introduce and implement work designed to have a significant impact on the health and healthcare or prisoners across the European region.

In 2015 we also intend to embark on new initiatives with European partners to create a minimum dataset for comprehensive, consistent and reliable public health data on the prison populations across the WHO European region which would allow both in-country assessment of health needs as well as comparisons between countries and their respective prison populations.

The focus in 2015 will ensuring that the key public health issues affecting this population are being identified and sufficiently robust plans are being developed to meet them at various levels across those stakeholder organisations described in this report.

Some of the key areas we will be working on with partners as part of the National Partnership Agreements during 2015 include:

Adult Prisons

1. Review and align NHS England and NOMS' commissioning systems and strategies to ensure quality services which support health and justice outcomes.
2. Strengthen integration of services and continuity of care between custody and the community, including through development of liaison and diversion services.
3. Improve the proactive detection, surveillance and management of infectious diseases in prison and improve capability to detect and respond to outbreaks and incidents.
4. Reduce levels of smoking amongst prisoners.
5. Review the management of medicines and the impact of NPS in prisons to address risk of misuse and resultant harms.
6. Strengthen multi-agency approaches to managing prisoners and learning from services and pathways at serious risk of harm and further embed shared learning to continuously improve practice.
7. Undertake joint priority services reviews to ensure that best practice is being adopted and promoted.
8. Introduce integrated health and social care services for prisoners in line with the Care Act 2014.

Children and Young People

1. Improve the quality and delivery of health care services to children in the CYPSE appropriate to need and informed by rigorous formal assessment of health needs, including improving access to appropriate screening and immunisation programmes.
2. Work collaboratively to support the commissioning of clinical management for substance misuse.
3. Work collaboratively to support the commissioning of assessment and intervention services for children and young people who exhibit sexually harmful behaviour.
4. Develop liaison and diversion services at the point of arrest that are suitable to meet the needs of children and young people.

IRCs

1. Development and delivery of a consistent and recognised approach to mental health assessment and appropriate treatment for detainees.
2. Improve the pro-active detection, surveillance and management of infectious diseases in IRCs and improve capability to detect and respond to outbreaks and incidents.
3. Improve access to treatment for chronic infectious diseases.
4. Strengthen multi-agency approaches to managing detainees at serious risk of harm and further embed shared learning to continuously improve practice including lessons learned from serious untoward incidents and deaths in detention.
5. Align NHS England and Home Office Immigration Enforcement commissioning systems and strategies to ensure quality services which support health and Home Office outcomes.

Within PHE Health & Justice we will be taking the lead on the following priorities:

1. Improving the proactive detection, surveillance and management of infectious diseases in prison and improve capability to detect and respond to outbreaks and incidents.
2. Increasing the identification of people with HIV, hepatitis B and hepatitis C and increasing access to treatment.
3. Protecting the detention estate from flu outbreaks. The final flu vaccine coverage figures for April 2014 to March 2015 show only 48% of all those at risk in prisons have been vaccinated. This is insufficient to protect the detention estate from flu outbreaks and there is work to be undertaken during 2015 before next season's flu season to improve coverage.
4. Supporting local authorities to ensure that all JSNAs capture the needs of offenders in detention and in the community.

Data sources

Ministry of Justice	Safety in custody statistics Offender Management Statistics Quarterly Publications: January to March 2014 April to June 2014 July to September 2014 December 2014
Home Office	Immigration statistics quarterly release
Youth Justice Board	Youth custody data
PHE	PHIPS data GUMCAD Sentinel Surveillance of BBV Testing SOPHID
ImmForm	Flu vaccine coverage in prisons
NOMS	Flu vaccine coverage of staff working in prisons
NHS Trust Development Authority	PHPQI data

Glossary of abbreviations

BBV	Blood-borne virus
BI	Brief interventions
CYPSE	Children and young people's secure estate
CCGs	Clinical commissioning groups
CHIMAT	Child and Maternal Health Intelligence Network
CJS	Criminal justice system
CRCs	Community rehabilitation companies
DBST	Dry blood spot testing
DsPH	Directors of public health
GI	Gastrointestinal
GUM	Genitourinary medicine
GUMCAD	Genitourinary medicine clinic activity dataset v2
HJIPs	Health and justice indicators of performance
HNAs	Health needs assessments
IPS	Irish Prison Service
IRC	Immigration removal centre
JSNAs	Joint strategic needs assessments
MoJ	Ministry of Justice
NOMS	National Offender Management Service
NPS	Novel psychoactive substances
OMCCS	Offender management community cohort study
PCR	Polymerase chain reaction (shows active infection of hepatitis C)
PHIPS	Public Health Intelligence for Prisons and Secure Settings Service
PHPQIs	Prison health performance and quality Indicators
PPDs	Prescribed places of detention
PVL	Panton-valentine leukocidin
SOPHID	Survey of prevalent HIV infections diagnosed
SPCR	Surveying prisoner crime reduction
STI	Sexually transmitted infection
TB	Tuberculosis
WHO HIPP CC	Collaborating Centre for World Health Organization Health in Prison's Programme based in PHE
YJB	Youth Justice Board

Ages of detainees in PPDs

Secure children's home	Generally under 15
Secure training centre	Generally up to 18
Young offender institution	Generally 15 to 20
Adult prisons	Generally 21 and over
IRCs	All age groups

Some women's prisons have specific areas for young offenders, so generally only 17 year old women will be held in young offender institutions with other age groups being held in SCHs, STCs or women's prisons.

Appendix A: PHIPS data outputs[2]

As discussed above the PHIPS service within PHE's Health & Justice Team collects information on communicable disease in PPDs in England for all age groups although the data mainly represents adults. In addition to this there are also other useful data sources within PHE which capture information on diseases in this setting.

This appendix provides national and local data on the incidence of single incidents as well as outbreaks reported over 2014 and earlier.

A. PHIPS reports, 2014

A1. Single reports to PHIPS

The number of single reports made to PHIPS has doubled since the publication of our last report when there were 549 made to us during 2011 compared to 1,268 during 2014. This is due to the improvement made on the number of chronic hepatitis B and C cases now being reported, which account for the majority of cases (1,174/1,268). The other noticeable differences are the decrease in cases of PVL reducing from 6 in 2011 to less than 5 in 2014 and flu which had 6 cases reported in 2011 compared to just 1 in 2014.

Table 1a: Single reports made to PHIPS in 2014

Infection	2014	2011
Campylobacter	<5	9
E Coli 0157	<5	<5
Food poisoning	<5	0
Giardia	<5	<5
H1N1	<5	5
Hep B and C chronic	<5	0
Hep B acute	<5	<5
Hep B acute and hep C PCR+ve	<5	0
Hep B chronic	104	45
Hep B chronic and Hep C	<5	0
Hep C acute	<5	<5
Hep C antibody+ve	526	289[3]
Hep C antibody+ve / PCR-ve	63	0
Hep C PCR+ve	477	89
Herpes zoster (Shingles)	9	0
Invasive group A streptococcus (IGAS)	<5	<5

[2] Numbers under 5 have been suppressed to ensure that a breach of confidentiality does not occur.

[3] 2011 data did not specify if hep c was antibody +ve with PCR -ve

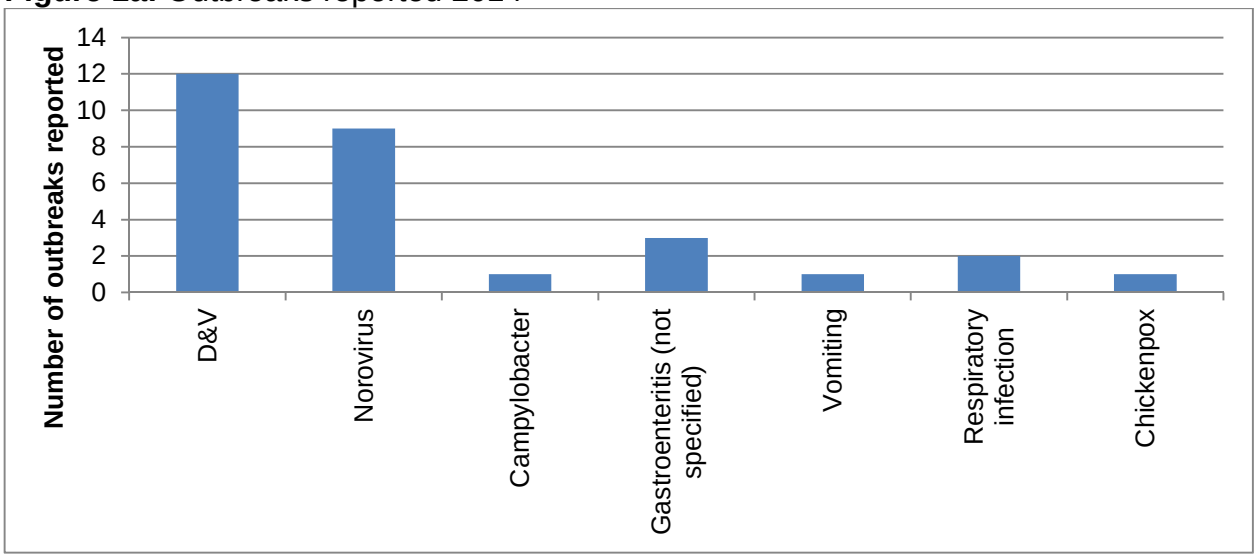
Infection	2014	2011
Meningitis	<5	0
Mumps	<5	<5
Methicillin-sensitive staphylococcus	<5	<5
Salmonellosis (Salmonella enterica)	<5	0
Scabies	5	6
Staphylococcus aureus / PVL	<5	0
TB (site not specified)	<5	9
TB incident (pulmonary)	43	39
TB single case (non-pulmonary)	10	15
Varicella (chickenpox)	<5	6
Other		25
Grand Total	**1,268**	**549**

Source: PHE, PHIPS

A2. Outbreaks

In total there were 29 outbreaks reported in 2014, 26 of which were due to gastrointestinal (GI) illness. This number is similar to the number reported in 2011 (28 outbreaks reported).

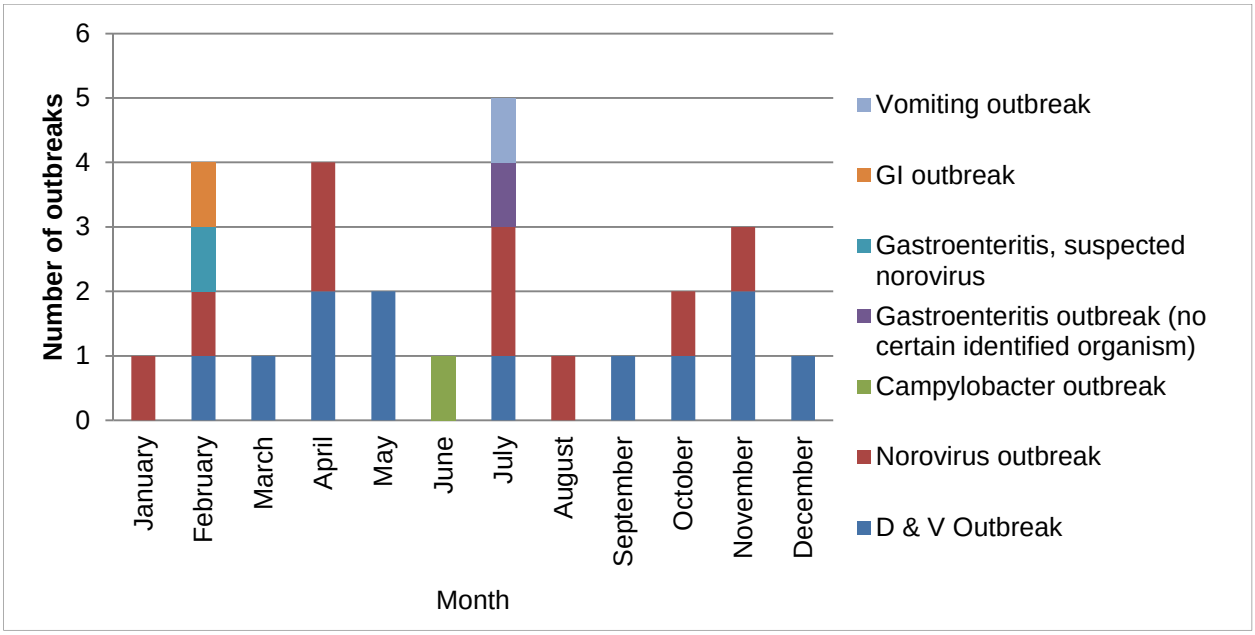
Figure 1a: Outbreaks reported 2014



Source: PHE, PHIPS

Each year the majority of GI outbreaks occur over the summer and autumn months. However this was not the case during 2014 where the reports were spread across each of the months (see figure 2a). PHIPS data on GI outbreaks in prisons and other secure settings has been analysed over the last 3 years (2011 to 2014) to identify any patterns and trends and compare these with data from the national PHE norovirus surveillance for the same period[xxxvi]. It was found that the number of outbreaks in PPDs shows less fluctuation than that in hospitals, indicating that although certainly not “immune” from GI outbreaks, prisons might be less subject to the marked epidemiological variation registered in hospitals and the community.

Figure 2a: Number of GI outbreaks reported by month, 2014



Source: PHE, PHIPS

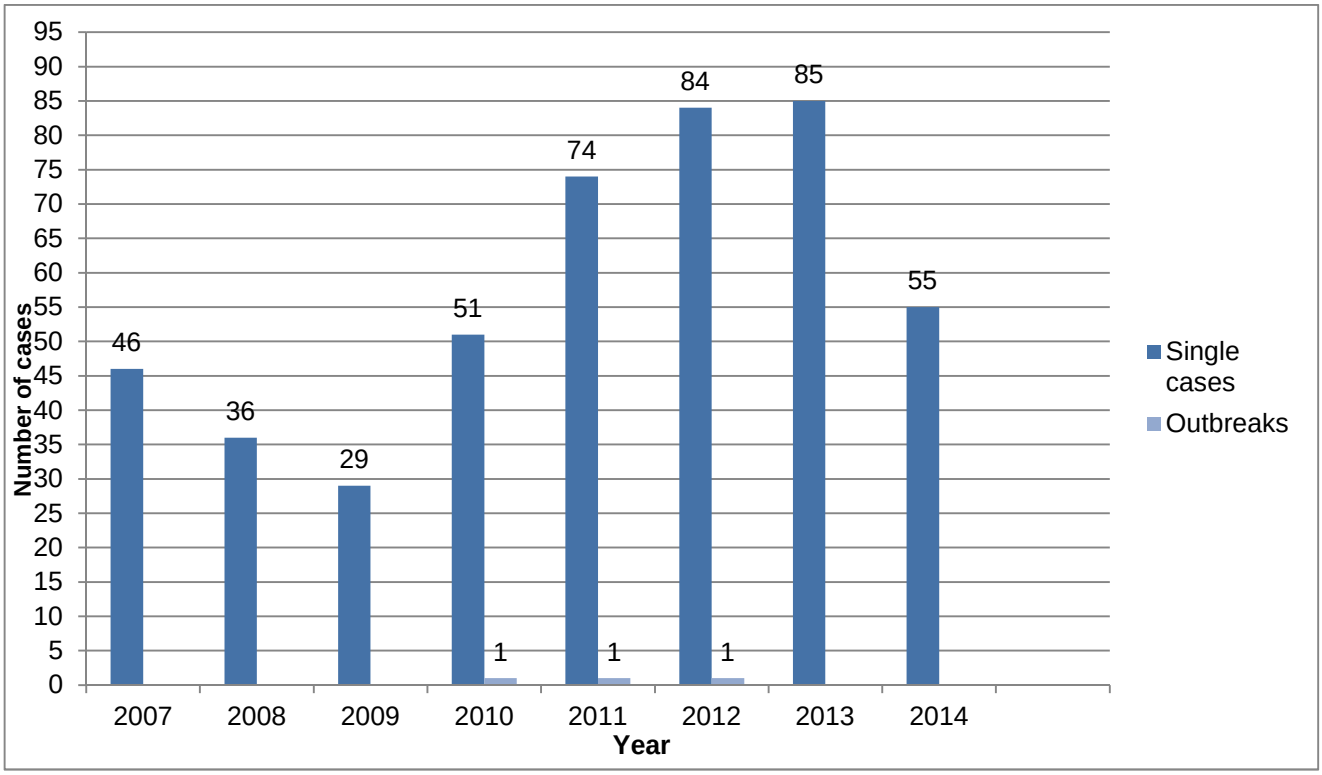
A3. TB reports

2014 saw a drop in the number of TB reports made to PHIPS in comparison to recent years. As shown in Figure 3a there has been a steady rise in the number of cases reported until 2013 with a large increase between 2010 (51 cases) and 2011 (74 cases). However, the data shows a decrease in 2014 where we have received 55 reports.

There has been 1 outbreak (ie evidence of transmission within the prison) each year between 2010 and 2012. In 2010 and 2012 these were in the south-east area (affecting different prisons) and in 2011 the east Midlands. There has been no TB outbreak reported during 2014.

The rise in single TB cases since 2011 may partly be due to the work that has taken place with both the PHE Enhanced TB Surveillance Team and the London TB Register Team to ensure that all cases are cross-referenced and that correct numbers can be accurately reflected. Furthermore, PHIPS has worked closely with the PHE Health and Justice Health Protection Network to improve the reporting of all infectious diseases locally and health protection teams throughout England have been very proactive in improving reporting of infectious diseases from their prisons, which may also account for some of the increase in numbers.

Figure 3a: The number of TB cases reported by year 2007 to 2014



Source: PHE, PHIPS

Table 2a and figure 4a below both show the number of TB reports made by site and PHE Centre. London has considerably more cases of TB (20/55) than anywhere else in the country accounting for 36% of all reports. Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire received 9/55 reports making up 16% of all cases.

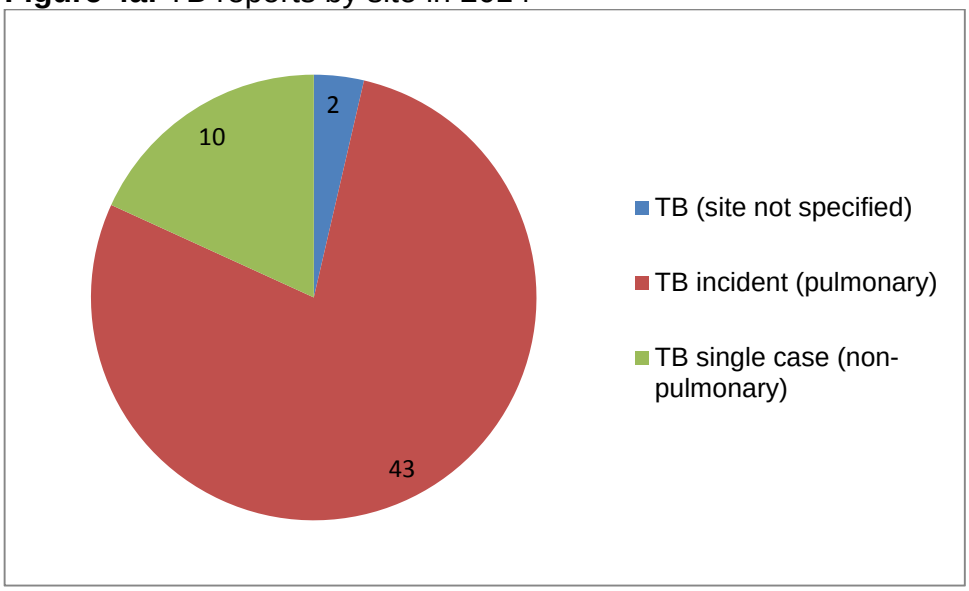
Table 2a: TB reports by PHE Centre, 2014

PHE Centre	Total single reports	TB (site not specified)	TB incident (pulmonary)	TB single case (non-pulmonary)
Anglia and Essex	<5	0	<5	<5
Avon, Gloucs and Wilts	0	0	0	0
Cheshire and Merseyside	<5	0	<5	0
Cumbria and Lancs	<5	0	<5	0
Devon, Cornwall and S'set	<5	0	<5	0
Greater Manchester	<5	0	<5	0
Lincs, Leics, Notts and D'shire	9	<5	7	0
London	20	0	15	5
North east	0	0	0	0
S Mids and Herts	<5	0	0	<5
Surrey, Sussex and Kent	<5	0	<5	0
Thames Valley	<5	0	<5	<5
Unknown	<5	0	<5	0
Wessex	<5	0	<5	<5
West Midlands	<5	0	<5	0
Yorkshire and Humber	<5	0	<5	<5
Grand Total	55	<5	43	10

Source: PHE, PHIPS

The vast majority of reports made to PHIPS are pulmonary making up 78% of the cases.

Figure 4a: TB reports by site in 2014



Source: PHE, PHIPS Service

B. Other surveillance systems

There are a number of other useful data sources available which provides us with additional information about infectious diseases in prisons. These are detailed below.

B1. Flu vaccine coverage in prisons

During the 'flu season', data is collected from ImmForm (a system used to record data in relation to uptake against immunisation programmes). This data is extracted from SystmOne and circulated to stakeholders nationally on a weekly basis.

Every year PHE publishes guidance for PPDs on responding to cases or outbreaks of seasonal flu and this year, in partnership with NHS England, the document set an ambition of 75% flu vaccine coverage in PPDs.

Table 3a below shows the vaccine coverage in prisons using the final flu vaccination data collected from week ending 30 November 2014 to week ending 25 January 2015. Some prisons have reached the ambition of 75% coverage; however the total England coverage is only 48% which is not sufficient coverage to protect the estate from outbreaks. PHIPS is liaising with prisons who have managed to achieve 75% plus coverage to share lessons across the estate and help other prisons achieve this during the next flu season.

Table 3a: Flu vaccine coverage in prisons, week 4, week ending 25 January 2015

Commissioning Region & Area Team	Total number of at risk patients registered on day of extraction	Total number of patients within A that have received the Flu vaccine since 1 September	Vaccine Uptake (%) calculated by the system	Number of patients refused/ declined vaccine	Number of patients already vaccinated at another site

		2014			
North					
Durham, Darlington and Tees	1,016	615	60.5	167	83
Lancashire	1,927	915	47.5	164	157
West Yorkshire	1,836	918	50	399	109
Midlands and east of England					
Derbyshire and Nottinghamshire	1,972	978	49.6	191	135
East Anglia	1,850	1,004	54.3	193	118
Shropshire and Staffordshire	1,790	792	44.2	105	89
London					
London	1,470	417	28.4	125	91
South					
Bristol, north Somerset, Somerset and south Gloucestershire	931	447	48	88	58
Kent and Medway	1,732	760	43.9	125	137
Thames Valley	1,076	643	59.8	185	77
England Total	15,600	7,489	48.0	1,742	1,054

Source: ImmForm

Data is also collected on the number of staff receiving a vaccination working in NOMS commissioned PPDs. Table 3b below shows that of the 105 establishments that provided data 21% of **all** staff in the prison were vaccinated[4].

Table 3b: Flu vaccine coverage in prisons amongst staff in England 2014/15

Number of establishments	Number of staff in post as at 30 September 2014	Number of flu clinics held	Number of employees vaccinated	Vaccine Uptake
105	32936	265	6866	21%

Source: NOMS

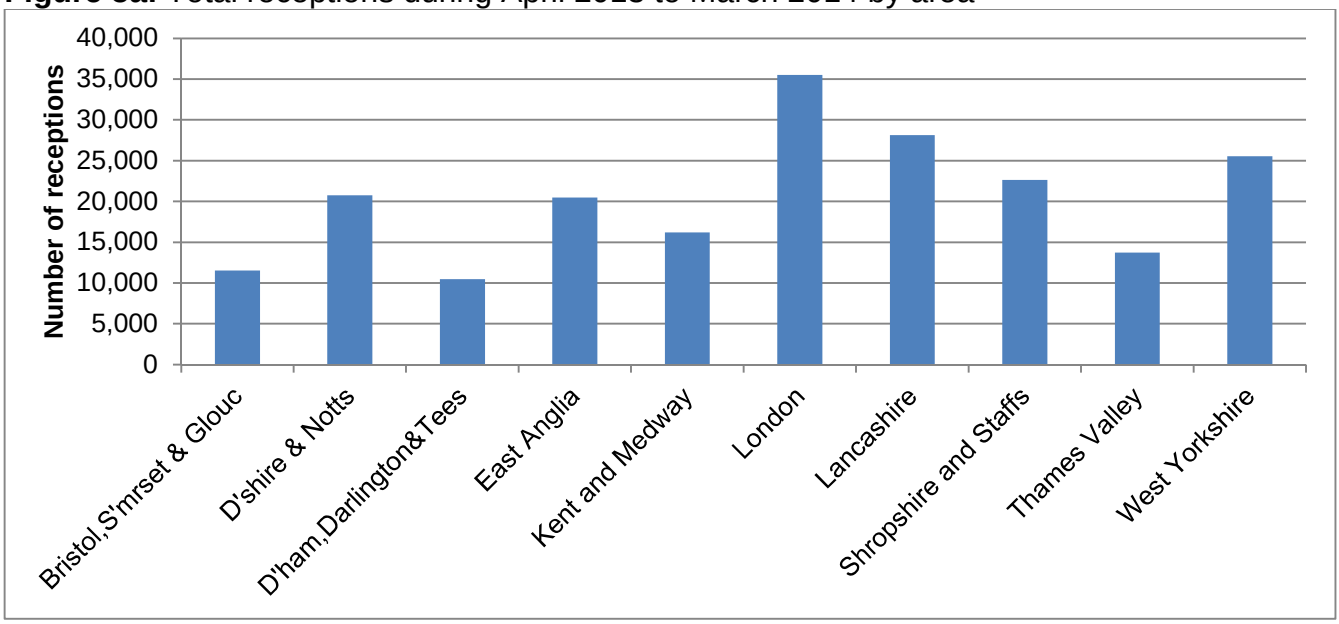
B2. Prison health performance quality indicators (PHPQIs)

As discussed above the PHPQIs were replaced with HJIPs in April 2014. For the reporting period April 2013 to March 2014 PHPQI data is used.

[4] Note this percentage calculates all staff in the prison and not the percentage of those eligible for it (ie those in frontline prisoner facing roles only). Those eligible would account for just over half the staff in each prison.

Figure 5a below shows the number of new receptions for the year amounting to a total of 204,941 for England[5]. This provides a useful picture of how many prisoners and detainees are moving through the system in each area.

Figure 5a: Total receptions during April 2013 to March 2014 by area

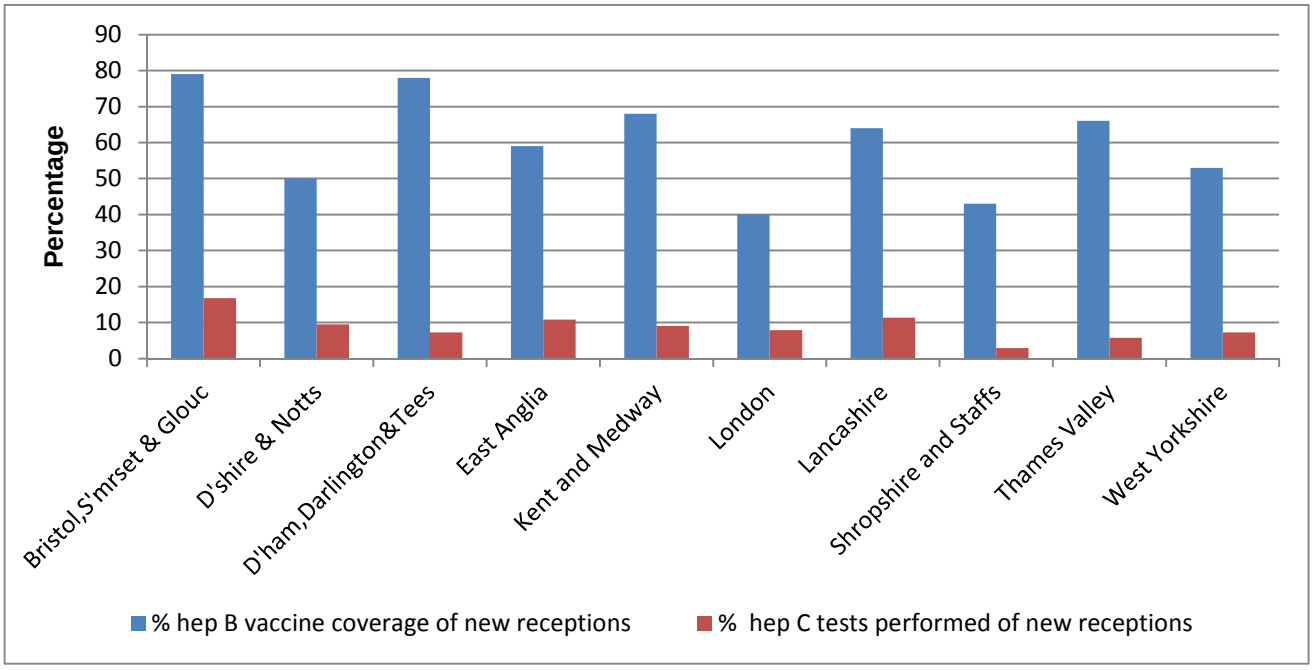


Source: NHS Trust Development Authority, ages 18+

Figure 6a shows the percentage of new receptions protected against hepatitis B and the percentage of new receptions being tested for hepatitis C during the reporting period April 2013 to 2014. In England, 56% of new receptions were protected against hepatitis B but only 8.6% of new receptions were tested for hepatitis C. However figure 7a below shows a national increase in hepatitis C tests being performed since April 2010 rising steadily from just 4% of new receptions between April and June 2010 to 10% in between January to March 2014. This is likely to be largely attributable for the introduction of opt-out BBV testing across the estate.

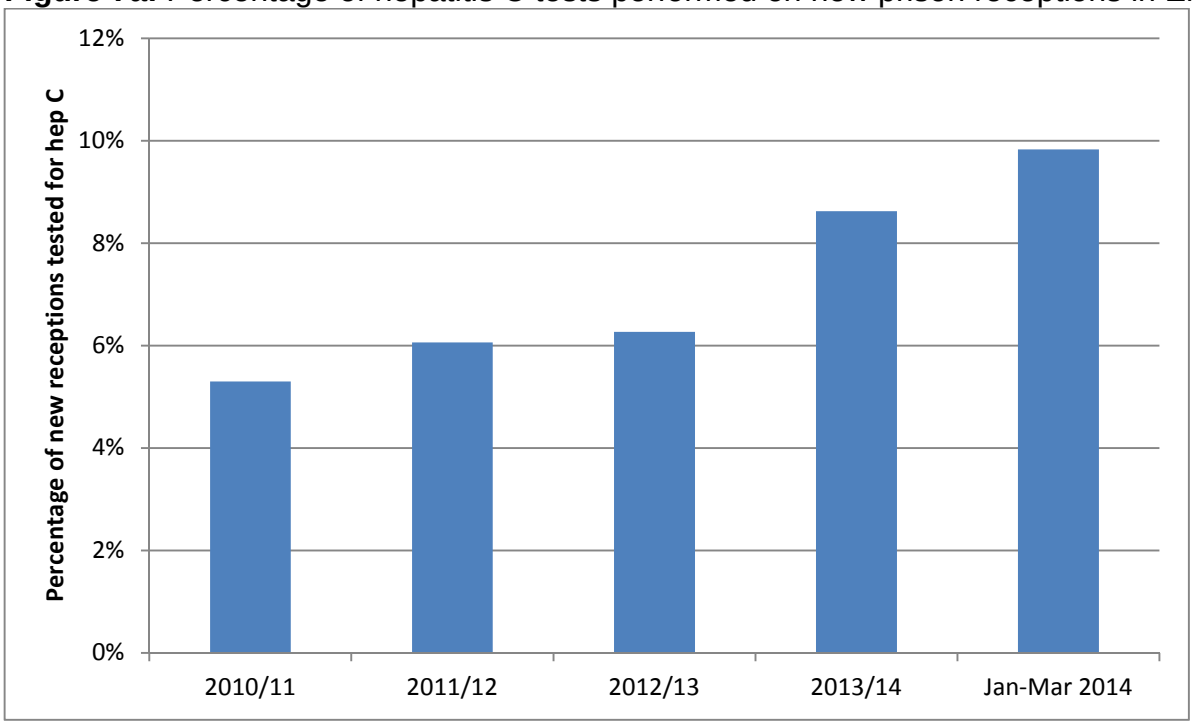
Figure 6a: Percentage coverage of hepatitis B vaccine and hepatitis C tests performed April 2013 to March 2014 by local area

[5] Note: The PHPQI data will under-represent the total receptions and those vaccinated against hepatitis B and tested for hepatitis C in the areas where not all PPDs submitted their activity.



Source: NHS Trust Development Authority, ages 18+

Figure 7a: Percentage of hepatitis C tests performed on new prison receptions in England



Source: NHS Trust Development Authority, PHPQI data, ages 18+

B3. Sentinel surveillance of blood-borne virus testing in England

This sentinel surveillance study began in 2002 with the aim of gathering information on testing for hepatitis C within sentinel laboratory services, to inform local and national healthcare planning and help reduce incidence and prevalence. It has since been expanded so as to cover all regions and to include hepatitis B and HIV. Approximately a third of the prison estate is covered by the scheme. The study collects information on testing carried out in participating sentinel centres regardless of test result and therefore can also be used to

estimate prevalence in those individuals tested. There are now 24 participating laboratories across England.

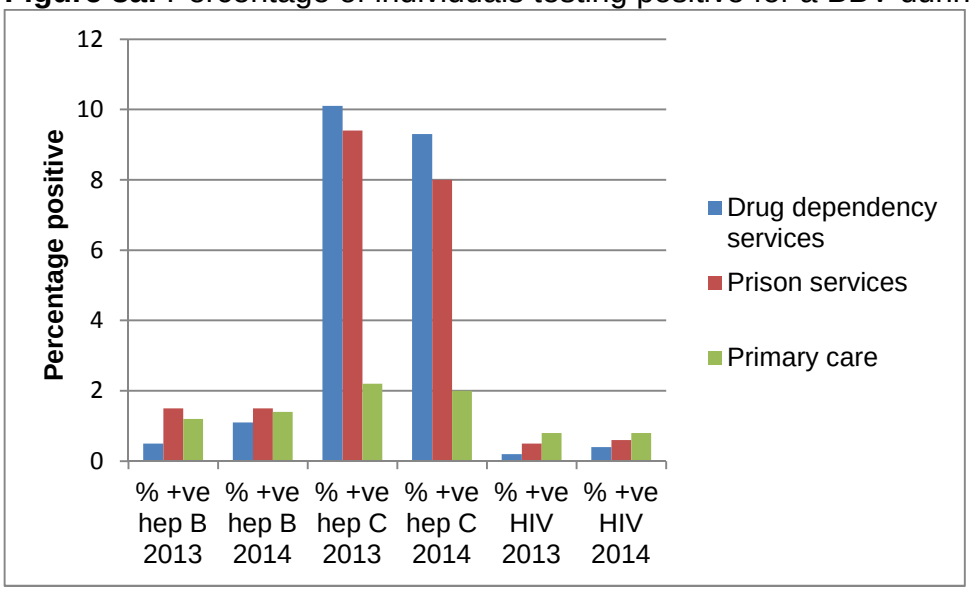
Table 4a shows the total number of individuals testing for hepatitis B, hepatitis C and HIV in different service types and figure 8a usefully shows the proportion of those tested who are positive for a BBV. Not surprisingly the proportion of those testing positive for hepatitis C are far greater in the prison services and drug services than in primary care generally. For HIV and hepatitis B however the percentage of those testing positive is more consistent with primary care generally.

Table 4a: Trends in individuals tested for HBsAg, anti-HCV and HIV by service type, 2013 and 2014

	Drug Services		Prison Services		All Primary Care	
	2013	2014	2013	2014	2013	2014
Tested for hep B	1,506	1,103	3,477	3,301	141,293	135,372
Positive for hep B	8 (0.5%)	12 (1.1%)	51 (1.5%)	49 (1.5%)	1,706 (1.2%)	1,898 (1.4%)
Tested for hep C	1,536	1,136	4,242	4,089	111,066	113,367
Positive for hep C	155 (10.1%)	106 (9.3%)	400 (9.4%)	327 (8%)	2,412 (2.2%)	2,263 (2%)
Tested for HIV	587	524	3,627	2,834	254,496	226,264
Positive for HIV	1 (0.2%)	2 (0.4%)	19 (0.5%)	16 (0.6%)	1,940 (0.8%)	1,860 (0.8%)

Source: PHE sentinel surveillance of BBV testing, all age groups

Figure 8a: Percentage of individuals testing positive for a BBV during 2013 and 2014



Source: PHE sentinel surveillance of BBV testing, all age groups

B4. Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD) v2

Research from the US has reported higher rates of STIs among prisoners compared to the general population.[xxxvii] However, until 2011 collection of routine data on the sexual health of prisoners was not in place. Since then, GUMCADv2 (a pseudo-anonymised patient-level electronic dataset collecting information on diagnoses made and services provided by GUM clinics) has been collecting routine data on prisoners. However, it was noted that not all testing, diagnoses and treatments for STIs take place in GUM clinics in prisons and therefore not all data for STIs in prisons is reported to GUMCAD. Nevertheless, the dataset does provide us with a useful picture of new STI diagnoses among prisoners in England.

Table 5a: Number of new STI diagnoses among prisoners in England, 2011 to 2013[6]

	2011	2012	2013
Chlamydia	114	183	163
Gonorrhoea	12	23	15
Herpes: anogenital herpes (1st episode)	11	10	14
Syphilis: primary, secondary and early latent	<5	6	<5
Warts: anogenital warts (1st episode)	249	424	341

Source: GUMCADv2

Total number of new STI diagnoses* among prisoners in England, 2011 to 2013

	2011	2012	2013
All new STIs*	545	864	710

*Includes chancroid / LGV / donovanosis, chlamydia, gonorrhoea, herpes: anogenital herpes (1st episode), HIV: new diagnosis, molluscum contagiosum, non-specific genital infection, pelvic inflammatory disease & epididymitis: non-specific, scabies / pediculosis pubis, syphilis: primary, secondary & early latent, trichomoniasis, warts: anogenital warts (1st episode)

Source: GUMCADv2

B5. Survey of Prevalent HIV Infections Diagnosed (SOPHID)

SOPHID began in 1995 is a cross-sectional survey of all persons with diagnosed HIV infection who attend for HIV care at an NHS site in England, Wales and Northern Ireland. This data set provides information of the numbers of individuals living with and diagnosed with HIV within PPDs.

In 2013, there were 9 adults (aged 15 or above) that were diagnosed with HIV at a prison service in the UK. Of the 74,159 adults living in England with a diagnosed HIV infection, 208 of them were likely to be prisoners. There were also likely to be 22 adults from immigration removal centres[7].

[6] 2011 data are underreported due to the phased introduction of prisoner coding during 2011

[7] The numbers are likely to be under-reported because the recording of prison status is not routine. Prisoners were identified if the residential postcode was a prison postcode. Therefore the completeness and accuracy of the numbers depends on the clinicians' reports. Data on patients seen for care at non-NHS funded services are not included and those with a short sentence be treated after release and therefore not captured.

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