



Public Health
England

Protecting and improving the nation's health

Blood-borne Virus Opt-Out Testing in Prisons: Preliminary Evaluation of Pathfinder Programme Phase 1, April to September 2014

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

Prepared by: BBV Opt-Out Task and Finish Group
For queries relating to this document, please contact: health&justice@phe.gov.uk

© Crown copyright 2015

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGL](http://www.ogil.io) or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published March 2015

PHE publications gateway number: 2014817



Contents

About Public Health England	2
1. Key messages	4
2. Introduction	6
BBV opt-out testing policy background information	6
Current policy and guidance	7
3. Pathfinders	9
4. Pathfinder evaluation results	9
Testing	10
Numbers tested and proportion positive	11
Treatment	144
Local implementation and concerns encountered	18
5. Conclusions and recommendations	200
Appendix 1: Evaluation questionnaire for pathfinder prisons: BBV opt-out testing	222
Appendix 2: BBV Opt-Out Task and Finish Group membership	29
Appendix 3: Timeline for introduction of BBV opt-out testing	300
Appendix 4: Key national policy and guidance documents	333
Appendix 5: Phase 2 pathfinder sites (commencing December 2013 to March 2015)	344
References	355

1. Key messages

1. Opt-out testing for blood-borne viruses (BBVs) was published as a joint developmental priority in the **National Partnership Agreement** between Public Health England (PHE), NHS England and National Offender Management Service (NOMS) in October 2013i. The lessons learned from the experience of 11 pathfinder prisons, reported here, will help to identify key factors for successful implementation of the programme across the adult prison estate by the end of 2016-17.
2. Preliminary data suggests a near doubling of BBV testing following the introduction of the opt-out testing policy.
3. Between April and September 2014, 21% of new receptions were tested for hepatitis C and HIV in nine out of the 11 pathfinder prisons that provided data. For hepatitis B, 8/11 prisons provided data showing 22% of new receptions being tested as part of the opt-out programme; these figures represent a significant improvement on levels of testing prior to the programme when 11% of new receptions were tested for hepatitis C and HIV (and 12% for hepatitis B). However, further work is required to explore why 79% of new receptions to these prisons were not tested.
4. Of the 11 participating prisons, 4/11 reported providing BBV testing during both the first and second reception screening, 4/11 provided it at the first reception screening only and 3/11 provided it at the second reception screening only.
5. All 11 pathfinder prisons use venous blood sampling as a method for testing while 7/11 also used dried blood spot testing (DBST).
6. Ninety percent of prisons (9/10 respondents) reported that healthcare teams undertook the testing.
7. Only 5/11 prisons reported BBV testing as per the **national guidance** for all BBVs with hepatitis C antibody (Ab) positive samples automatically being tested for hepatitis C virus (HCV) ribonucleic acid (RNA) by polymerase chain reaction (PCR), alongside a test for hepatitis B surface antigen (HBsAg) and HIV infection (HIV Ab and Antigen [Ag] P24 test).
8. Using the available data, the proportion of those testing positive for the three BBVs has remained stable, with 0.2% testing positive for HIV in the 12 month period from January to December 2013 and 0.3% in the 6 month period from

April to September 2014. The proportion testing positive for hepatitis B has remained consistent at 0.2% before and 0.2% after the introduction of the policy.

9. Collection and reporting of hepatitis C test results needs to be improved as it was not possible to ascertain the proportion who were chronically infected due to variable reporting of hepatitis C RNA status and hepatitis C Ab positivity. However, using results from the subset of prisons with data on hepatitis C Ab status before and after the introduction of the opt-out policy (4/11), the number testing positive for hepatitis C Abs has remained stable at 9% despite the change from targeted testing to opt-out testing.
10. When asked, 8/11 prisons believe that they have identified people who would otherwise have remained undiagnosed; in the two prisons that provided data on these, an additional 12 individuals were identified but the BBV they tested positive for was not specified.
11. Seven (7/11) prisons met the national waiting time criteria for referral to specialist services for HIV (2 weeks) and 10/11 prisons met the waiting time criteria for hepatitis B and C (18 weeks).
12. The numbers being referred for hepatitis C treatment have increased significantly since the introduction of the opt-out testing policy, with 226 being referred during the **12 month period** between January and December 2013 compared to 185 during the **6 month period** between April and September 2014.
13. 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.

2. Introduction

BBV opt-out testing policy background information

It has been evidenced that rates of injecting drug use among prisoners are higher than that of the general population (Surveying Prisoner Crime Reduction longitudinal cohort study of prisoners, Ministry of Justice, 2013ii). Injecting drug use is the main risk factor for the transmission of hepatitis C infection in England (over 90% of new hepatitis C infections are thought to be acquired via this route [PHE, 2013iii]).

PHE has data from several different sources which measure and report on BBVs among people in prison (Prison Health Performance Quality Indicators [PHPQIs], PHE Sentinel Surveillance of BBV testing, Genitourinary Medicine Clinic Activity Dataset [GUMCAD], Survey of Prevalent HIV Infections Diagnosed [SOPHID], and Public Health Intelligence for Prisons and Secure Settings Service [PHIPS] reports). People in prison are at a higher risk of BBVs than the general population yet the annual PHPQI data for 2013/14 shows that less than 9% of new receptions have been tested for hepatitis C in prison. This can be explained by several factors, including biases in the way that testing is offered and in risk perception by both patients and staff. Antenatal testing for HIV infection was found to be highly influenced by the perception of risk of infection in pregnant women made by midwives offering the test, and this contributed to under-testing in this population. Switching to an opt-out policy in 1999 led to a significant increase in the level of testing and diagnosis of HIV infection in pregnancy. This model has also worked in genito-urinary medicine (GUM) services in the community where there has been a significant rise in both the offer and uptake of testing for HIV following the introduction of an opt-out testing model.

Influenced by the impact of switching to an opt-out antenatal testing policy 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 NOMS, as well as patient advocates such as The Hepatitis C Trust, the British Liver Trust and the National AIDS Trust (NAT), advocated for the introduction of an opt-out testing policy for BBVs for people in prisons. This was subsequently agreed and published as a joint developmental priority in the National Partnership Agreement between PHE, NHS England and NOMS in October 2013. The second partnership agreement which is due for publication also prioritises implementation of the policy. The work leading up to the new model is detailed in **Appendix 3**.

The opt-out policy advocates that people in prison should be offered the chance to test for BBV infection at or near reception, and at several time points thereafter, by appropriately trained staff in a range of different healthcare services within the prison. Those patients testing positive for either hepatitis C, hepatitis B, or HIV, should then be

able to access care and treatment pathways, both in prison and following release into the community. However, it has to be recognised that commissioning of treatment for hepatitis C and other BBVs is complex and dependent on the setting in which care is delivered as well as the specific treatment programme and this affects the ability of patients in prison to access care and treatment pathways.

Current policy and guidance

Guidance specifically developed to support the opt-out testing policy in prisons

Key issues covered in our national **guidance** that are important when implementing BBV opt-out testing in prisons are as follows:

Testing

- BBV testing should be recommended to all prisoners, including those already in prison **unless**:
 - they have been tested in the last 12 months and have NOT subsequently put themselves at risk of infection
 - they have been tested and are positive
 - they are known to be positive for a BBV. For hepatitis B, if a patient has documented evidence of a negative result and has been vaccinated against hepatitis B they do not require further testing for this BBV infection
- new receptions should be recommended to have a test within 72 hours of detention
- the following tests should be performed for eligible patients within four weeks of reception using DBST or venous sampling:
 - HBsAg
 - Hepatitis C Ab (with PCR testing for all hepatitis C Ab positive cases)
 - HIV Ab and Ag P24 test
- where a prisoner tests positive for antibodies to hepatitis C, it is essential that a PCR test is undertaken to establish whether the individual is chronically infected (or acute). It is important that the PCR test is carried out on the same sample. Samples should therefore be of sufficient quantity that they can be PCR tested following a positive antibody test. No prisoner should receive a positive hepatitis C Ab result without a PCR result
- healthcare staff should also recommend testing to **EXISTING** prisoners, not just new receptions
- suitably qualified healthcare workers should provide a pre-test discussion according to national guidance; ideally the same person should deliver the result
- prison healthcare should start the super-accelerated hepatitis B vaccination programme (days 0, 7 and 21) preferably when bloods are taken for BBV testing (ideally a fourth dose should be given at one year and a booster at five years)

Patients testing positive should be referred to secondary care treatment pathways (for hepatitis B positive, suspend vaccination and refer for further testing to specialist service) and should be assessed by a specialist (for HIV this must be within two weeks of referral and for hepatitis B and C within 18 weeks).

Treatment

- short sentences should **not** be an obstacle to starting treatment in prison
- prisoners with hepatitis B and C should be treated in the prison ideally via in-reach services involving local specialist secondary care providers or via prison healthcare (NICE Public Health Guidance 43) as part of a multidisciplinary approach
- treatment options should be considered and discussed with patients and all patients should be given the option of treatments commissioned by NHS England and recommended by NICE. The release or transfer of a prisoner should not prevent them from starting and continuing treatment
- the care pathway should include access to mental health services, drug and alcohol treatment services and other relevant support services where necessary, as recommended in non-prison-based services

Continuity of care

Transfer

- the healthcare team should contact the receiving prison healthcare team and secondary care provider(s) if:
 - hepatitis B vaccinations are incomplete
 - the patient has any outstanding test results
 - the patient is receiving or requiring treatment for BBVs
- healthcare should ensure that SystmOne medical records are up to date

Resettlement/release

- patients who have been tested for BBVs should receive their results when they are available, regardless of whether they have been released
- healthcare should make community rehabilitation companies (CRCs)/National Probation Service aware of continuity of healthcare plans for BBVs and of needs arising from BBV status where they may affect accommodation, employment support, training/education and family/social support. CRCs will be creating resettlement plans for all prisoners and the opportunity should be taken to ensure that resettlement plans support access to BBV treatment and support. Healthcare should ensure that:
 - liaison with secondary care providers takes place before release, including liaison with community drug services where relevant

- links are made with the patient's GP in the community
- where patients do not have a GP, they should be informed about identifying and registering with one in the community
- when unplanned releases take place, healthcare should make sure communications take place as above

Other key national policy and guidance documents are included in **Appendix 4**.

3. Pathfinders

'Pathfinder' sites were identified because they were already at, or near, implementing the recommended opt-out policy so their key challenges and successes could be used to help implement the policy in other prisons. Pathfinders are defined as those prisons who are recommending BBV testing to people in prison and have a well-defined care pathway for individuals testing positive as per national guidance.

Table 1: Phase 1 pathfinders

Area team	Prison
Derbyshire & Nottinghamshire	HMP Nottingham
	HMP Stocken
Lancashire	HMP Kirkham
	HMP Manchester
	HMP Buckley Hall
	HMP and YOI Forest Bank
West Yorkshire	HMP Hull
	HMP Leeds
Bristol, North Somerset, Somerset and South Gloucestershire	HMP Dartmoor
	HMP Channings Wood
	HMP Exeter

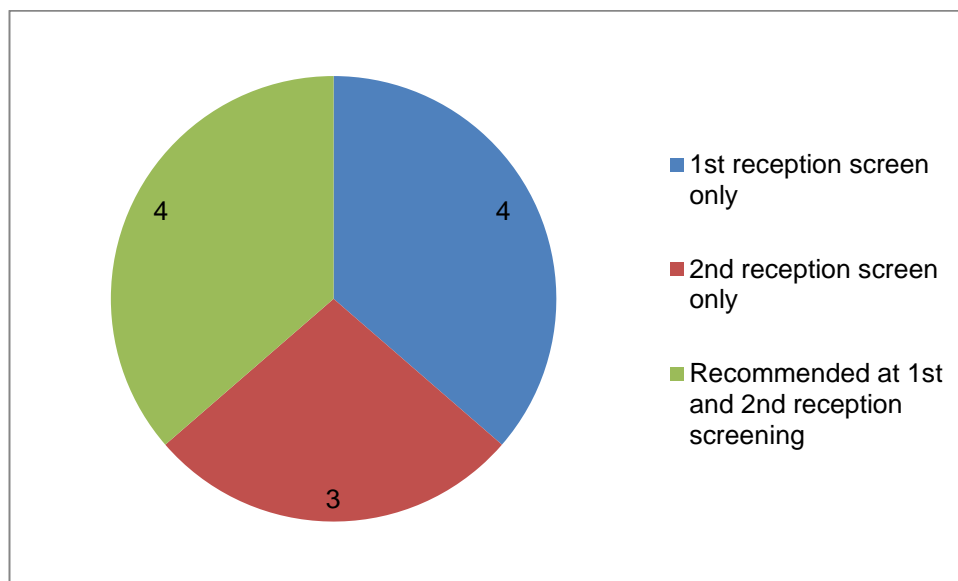
4. Pathfinder evaluation results

The phase 1 pathfinders were asked to complete the questionnaire included as **Appendix 1**. The questionnaire was piloted at HMP Leeds before it was circulated to the other 10 pathfinders.

Testing

Figure 1 below shows that 4/11 prisons reported carrying out BBV testing at the first reception screening, 4/11 reported carrying it out at the second reception screening and the remaining 3/11 prisons carry out testing at both reception screenings. Since October 2014 however, HMP Hull have started to provide testing at the second screening instead of the first screening as they have found that uptake is better.

Figure 1: When BBV testing is carried out within the prison



In terms of the teams recommending the testing, of the 10/11 prisons that responded to this question 9/10 reported that healthcare do this with 1/10 reporting that the drugs team, GUM services and the prison GP recommend testing. 9/10 prisons report that more than one team actually carrying out the testing (for example healthcare, drugs team and GUM services).

What testing is undertaken and the method used

Only 5/11 prisons reported testing as per the national guidance for hepatitis C Ab and reflective PCR, alongside HBsAg and HIV infection (HIV Ab and Ag P24 test); 3/11 prisons reported that they do not use all these specific tests when testing for BBVs (for example one prison reported not currently routinely testing for HBsAg) and 3/11 prisons did not respond to the question.

All (11/11) pathfinder prisons use venous blood sampling as a method for testing with 7/11 also using DBST. The reasons why DBST was also being used was not stated but this is a useful method for those with difficult venous access and can also be undertaken by suitably trained non-clinical staff. 3/11 prisons also use oral swabs (2/3 in

addition to venous and DBST and 1/3 in addition to venous). However oral swabbing is not recommended as a modality of testing in prisons by PHE.

Information provided to prisoners when they receive their test results

Only 5/11 prisons explicitly reported providing harm reduction advice and information to prisoners who receive a negative result. 4/11 prisons simply send a standard letter informing the person of the result and one prison does not routinely inform prisoners of negative results. The remaining prison stated that 'nursing staff provide the results.'

For those prisoners receiving a positive result, in addition to harm reduction advice and information being given, 10/11 prisons report referring the patient on to specialist services and the remaining prison stated that prisoners are simply seen and informed by the GP. Prisons did not provide specific details of which leaflets/materials they use.

Testing for existing prisoners

The majority of prisons (8/11) reported that testing is recommended to existing prisoners on an on-going basis through various means; 6/8 prisons do this through the use of health promotion displays and 1/8 reported the use of peer educators who promote testing on the wings. The remaining 3/11 prisons did not provide details on testing for existing prisoners.

Numbers tested and proportion positive¹

Pathfinders were asked to report on the number of new receptions to prisons who had been tested between January and December 2013 (the **12 month period** prior to the introduction of the opt-out testing policy) as well as between April and September 2014 (the **6 month period** after introduction of the policy). **Table 2** shows the breakdown of new receptions tested by BBV during both time periods evidencing a near doubling of the proportion of individuals tested.

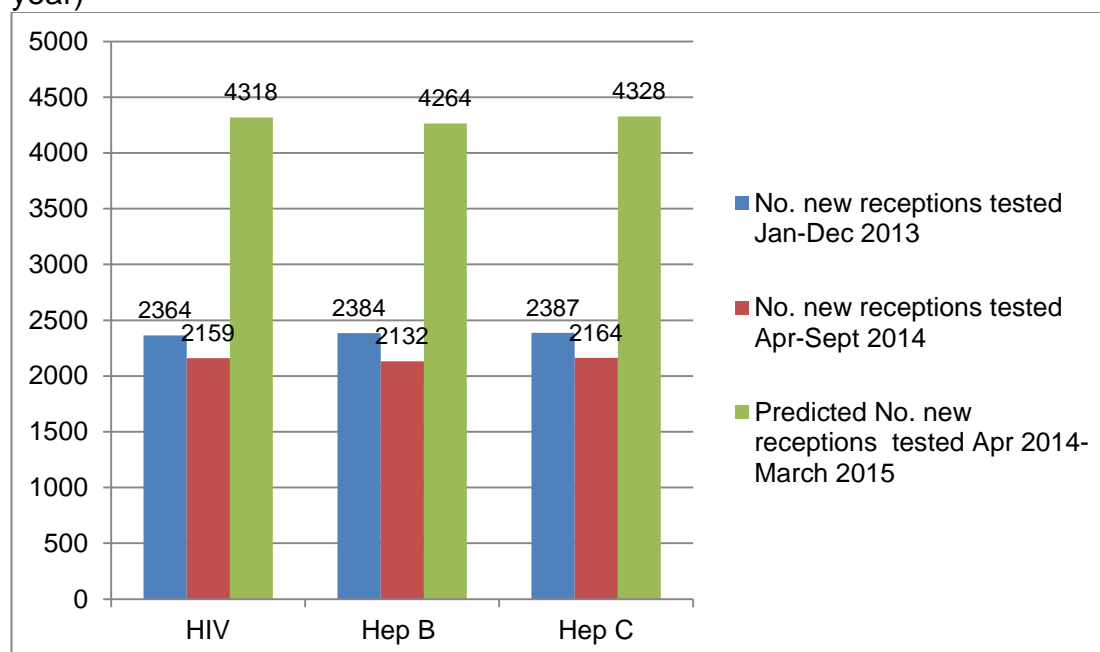
Table 2: Numbers and proportions of new receptions tested before the introduction of the opt-out policy (**12 month period** between January and December 2013), after the introduction of the policy (**6 month period** between April and September 2014)

¹ 9/11 prisons submitted testing data (HMP Nottingham and HMP Manchester did not submit testing data) except for hepatitis B where 8/11 submitted data as HMP Kirkham do not routinely test for this virus.

	Numbers and proportions tested out of new receptions ² Jan-Dec 2013	Numbers and proportions tested out of new receptions Apr-Sept 2014
HIV	2364/20,605 (11%)	2159/10,302 (21%)
Hepatitis B	2,384/19,528 (12%)	2,132/9,764 (22%)
Hepatitis C	2,387/20,605 (11%)	2,164/10,302 (21%)

Between April and September 2014, 21% of new receptions were tested for hepatitis C and HIV in 9 of the 11 pathfinder prisons as part of the opt-out programme and 22% for hepatitis B; this represents a significant improvement on previous levels of testing when 11% of new receptions were tested for hepatitis C and HIV during the 12 month period between January and December 2013 (and 12% for hepatitis B) (see **Table 2**). Whilst this represents good progress, it will be important to learn more about why the remaining 79% of new receptions were not tested and this should be addressed in future evaluations.

Figure 2: Numbers tested in prisons before the introduction of the opt-out policy (**12 month period** between January and December 2013), after the introduction of the policy (**6 month period** between April and September 2014) and the predicted numbers tested between April 2014 and March 2015 (**12 month period**) (assuming testing levels between April and September 2014 are maintained in the second half of the financial year)



² This figure is taken from National Drug Treatment Monitoring System and is based on the annual healthcare screens during 2013/14

Figure 2 shows the numbers tested for these same time periods and also shows the predicted numbers tested for a comparative period if opt-out testing levels are maintained in the second half of the financial year.

For hepatitis C, only one of the nine prisons reporting results reported hepatitis C results by Ab and RNA for both time periods, 3/9 provided Ab results only for both periods, 1/9 provided PCR results only for both periods and the remaining 4/9 provided a mix of Ab and PCR results which meant comparisons could not be accurately made between the time periods. However, using data from the subset of prisons that provided Ab data for both time periods (4/11), it is possible to see that the proportion testing positive for hepatitis C Abs remained stable at 9% (**Table 3**). Using the available data, the proportion found to be positive for hepatitis B and HIV have also remained stable before and after the introduction of the policy

Table 3: Numbers testing positive for BBVs between January and December 2013 (the **12 month period** before the introduction of the opt-out testing policy) and between April and September 2014 (the **6 month period** after the policy had been introduced)

	Number of new receptions testing positive for a BBV during between January and December 2013 (12 month period)			Number of new receptions testing positive for a BBV between April and September 2014 (6 month period)		
	HIV	Hepatitis B	Hepatitis C Ab +ve (using subset of 4/11 prisons where Ab result given)	HIV	Hepatitis B	Hepatitis C Ab +ve (using subset of 4/11 prisons where Ab result given)
Nos. tested	2364	2384	1,096	2159	2132	966
Nos. positive (n)	6	6	100	7	5	91
Proportion positive of those tested ³ (%)	0.2	0.2	9	0.3	0.2	9
No. submitting data for No.s positive	7/11	8/11	4/11	7/11	8/11	4/11

³ Calculated using numbers tested and positive for that time period.

When asked whether the policy had resulted in cases being diagnosed that would otherwise have remained undetected, 8/11 prisons believed that they had; 1/11 prison said it was too early to say and another did not believe that the new policy had identified any additional cases. The other prison reported that the policy had possibly resulted in additional cases being found. Only 2/11 prisons could supply data on the number identified that would otherwise have remained undiagnosed (n=12 individuals), with one reporting that these were patients who have previously used drugs such as cocaine. The BBV these cases tested positive for was not specified.

Treatment

Model of treatment provision

Most treatment provided for hepatitis C was delivered via an in-reach model from local NHS Acute Trust specialist providers (**Table 4**). HMP Leeds has a slightly different model of working with the local NHS Acute Trust specialist provider under a multi-disciplinary team (MDT). In this case, the secondary care provider does not provide sessions in the prison, with this being done by the prison GP. Treatment for HIV and hepatitis B is delivered via a combination of in-reach and outpatient appointments. All prisons report close working between healthcare and specialist services which is seen as essential in offering holistic BBV support.

Table 4: Model of treatment provision

Prison	Service that provides treatment			What is the model of provision		
	HIV	Hepatitis B	Hepatitis C	HIV	Hepatitis B	Hepatitis C
HMP Leeds	Sexual health service with shared care involving viral hepatitis nurse specialist and GP	Shared care: Secondary care, viral hepatitis nurse specialist and GP with specialist interest in hepatitis C	MDT under the leadership of hepatologists with viral hepatitis nurse specialist and GPSI in hepatitis C	Shared care: Some outpatient appts	Shared care: Some outpatient appts. with monitoring by prison GP	Led by prison GP under hepatology MDT

Blood-borne Virus Opt-Out Testing in Prisons: Preliminary evaluation of pathfinder programme.

Phase 1, April to September 2014

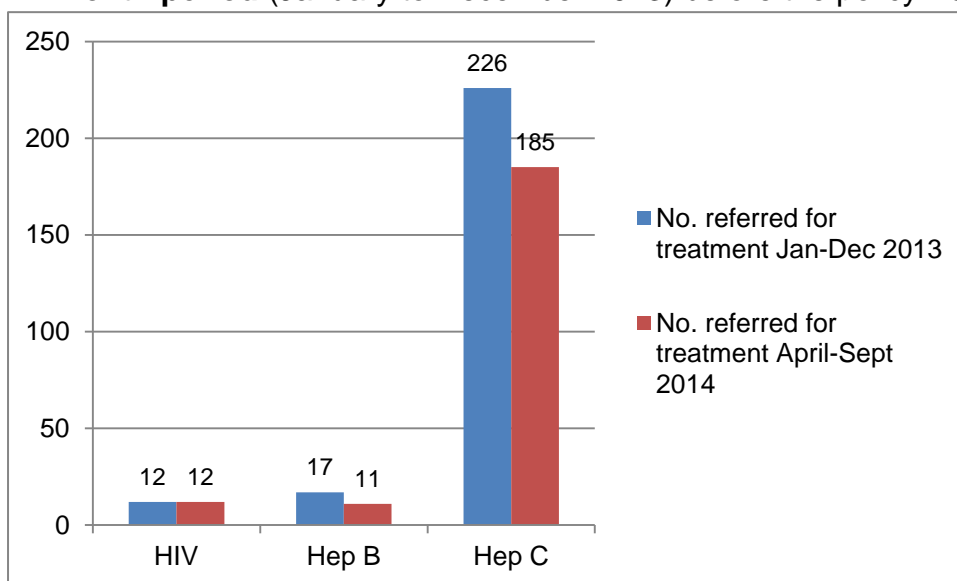
HMP Stocken	Secondary care		Referral to secondary care	In-reach nurse led clinic with support once a month from a liver nurse specialist secondary care	
HMP Nottingham	Secondary care		In-reach by specialist doctor and lead nurse	In-reach from specialist nurse from hospital and lead nurse	In-reach from specialist nurse from hospital and lead nurse
HMP Hull	GUM consultant In reach service clinic (once a week)	Infectious disease secondary service (in reach) approx. monthly	In-reach by secondary care		
HMP Exeter	Terrence Higgins Trust (THT)	Secondary care	THT/In-reach and healthcare team	In-reach BBV nurse specialist and healthcare team	In-reach local BBV nurse specialist and healthcare team. (Fibroscan carried out in local outpatient dept.)
HMP Dartmoor	THT	Secondary care	THT	In-reach local BBV nurse and healthcare team. (Fibroscan carried out in local outpatient dept.)	
HMP Channing's Wood	THT	Secondary care	THT	In-reach local BBV nurse specialist and healthcare team. (Fibroscan carried out in local o/p dept.)	

HMP Kirkham	Community services	Secondary care	Outpatient	Outpatient and in-reach	In-reach specialist
HMP Manchester	Secondary care		In-reach by secondary care		
HMP Buckley	Secondary care		In-reach by secondary care (if fibroscan required, an outpatient appointment is needed)		
HMP Forest Bank	Secondary care		In-reach by secondary care		

Numbers referred for treatment⁴

Numbers being referred for treatment have increased as shown in **Figure 3**, with almost the same number being referred in the six month period between April and September 2014 as were referred throughout the whole of 2013.

Figure 3: Numbers referred for treatment in the **6 month period** after the introduction of the opt out testing policy (April to September 2014) compared to the number referred during the **12 month period** (January to December 2013) before the policy was introduced

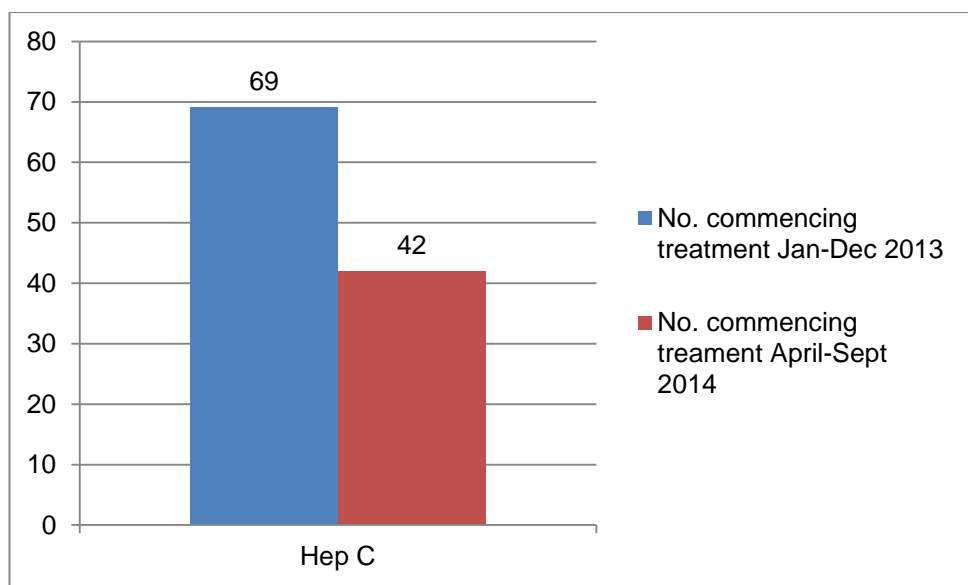


⁴ 8/11 prisons provided hepatitis C data for both time periods; HIV and hepatitis B data was provided by 7/11 prisons.

Numbers starting treatment⁵

For hepatitis C, of those being referred around 1 in 3 (69/226) commenced treatment before the opt-out policy was introduced and around 1 in 4 (42/185) after the opt-out policy. For HIV and hepatitis B during both time periods, less than five people commenced treatment before opt-out and after.

Figure 4: Numbers starting treatment for hepatitis C in the **6 month period** after the introduction of the opt out testing policy (April to September 2014) compared to the numbers starting treatment during the **12 month period** (January to December 2013) before the policy was introduced



Waiting times

The recommended maximum time from referral to review by specialist services for HIV infection is two weeks. In our evaluation survey, 7/11 prisons met this criterion: 3/11 prisons report the waiting times taking up to four weeks, and 1/11 prison did not have any newly diagnosed HIV patients.

The recommended maximum time from referral to review by specialist services for hepatitis B and hepatitis C infection is 18 weeks. Our evaluation shows the waiting times for hepatitis B and C are within this period for 10/11 prisons.

⁵ 8/11 prisons provided hepatitis C data for both time periods; HIV and hepatitis B data was provided by 7/11 prisons.

Table 5: Waiting times reported by prison from referral to assessment

Prison	Waiting time from referral to assessment by specialist provider (weeks)		
	HIV	Hep B	Hep C
HMP Leeds	2	6	4
HMP Stocken	No new diagnoses	No new diagnoses	has been up to 6 months
HMP Nottingham	1	1	1
HMP Hull	1	5-6	5-6
HMP Exeter	2	2	2
HMP Dartmoor	2	2	2
HMP Channing's Wood	2	4	4
HMP Kirkham	Referrals made immediately	2	3
HMP Manchester	approx. 4 weeks	approx. 4 weeks	approx. 4 weeks
HMP Buckley	approx. 4 weeks	approx. 4 weeks	approx. 4 weeks
HMP Forest Bank	4	4	4

Local implementation and concerns encountered

All the prisons except one (HMP Hull) have a local group overseeing the implementation of the work, with 9/10 of them involving partners outside the prison such as PHE and NHS England. However, HMP Hull is part of the regional Yorkshire and Humber BBV Group which is leading on the implementation of the policy across the area; this is led jointly by NHS England and PHE.

The main concerns raised in relation to implementation of the policy included the following:

- healthcare management concerns relating to funding of additional tests
- time constraints during second reception screening and challenges with DBST, eg having somewhere appropriate to dry cards and having to repeatedly prick patient's fingers to obtain sufficient blood
- lack of staffing resource due to staff vacancies
- additional training required and improvement in communication between teams to ensure testing not repeated
- changing how staff approach interview questioning in reception and ensuring staff have sufficient knowledge to answer questions relating to BBV testing at reception

Of the 8/11 prisons who responded to the question about whether the policy raised awareness and reduced stigma attached to being tested, 7/8 believed that it did with the other saying that no stigma existed beforehand.

Suggestions to other prisons implementing the opt-out policy

Pathfinders were asked to provide useful suggestions to assist other prisons implementing the opt-out BBV testing policy:

- ensure accurate and consistent READ coding in SystemOne for offers, tests, results and referrals to help with the preparation of Health and Justice Indicators of Performance (HJIP) reports and audits of BBV screening
- make the offer of BBV screening a mandatory field in reception screening on SystemOne
- educate reception nurses and GPs about the importance of BBV testing
- ensure a robust referral pathway is in place
- must have liaison with prison staff, full support of management team, training for healthcare staff and identify clinical time that can be sustained
- introduction of DBST which also allows non-clinical staff to provide the testing
- introducing a dedicated BBV lead to run one-to-one clinics with all new receptions
- ensure all members of healthcare staff have the knowledge and skills to support opt-out testing
- ensure all members of the team understand the importance of their role in this process and how important this is
- provide training for the team to understand the implications of not receiving the testing
- ensure that the numbers tested are visible to the team, eg on a noticeboard so they can see the activity
- include the work as part of clinical and service meetings
- give presentations to healthcare staff and also prison staff to raise awareness;
- continual education and updates for all staff working with the wider teams eg mental health and GUM health promotion

5. Conclusions and recommendations

This is a preliminary evaluation of the first six months of the BBV opt-out testing policy in prisons in England. Eleven prisons, ie 9% of the total estate in England, were identified as pathfinders for the introduction of the new opt out policy from 1 April 2014. These prisons already had pre-existing robust arrangements for BBV testing at reception and well established care pathways for the referral of individuals testing positive.

The opt-out BBV testing programme is an ambitious programme, which requires a shift in culture, so that the universal offer of BBV testing on an opt-out basis becomes the norm in prisons. Despite the short evaluation period of 6 months and the limitations of the information available, there are already some key findings which, if actioned, will help the future implementation of this programme nationally.

Local leadership and partnership amongst key players is essential to the successful introduction of the programme. The complexity of the challenges and practical barriers that need to be overcome to enable the offer and uptake of BBV testing of all new receptions, and to ensure the accurate and comprehensive reporting of results, are illustrated by the different arrangements that pathfinders have adopted in their prisons and the variable quality of data recorded. It is vital that prisons use appropriate READ codes on SystemOne to record the specific activities undertaken with regard to offer and uptake of testing, recording of results, provision of results to patients and onward referral and management of infected patients by specialist healthcare teams. This data will also be required by the HJIPs dataset which were rolled out in July 2014, retroactive to April 2014 and which capture information not only regarding BBV testing and treatment but also a broad range of other health needs and health services provided.

Despite the short time frame, there are initial indications of the benefits of the BBV opt-out testing programme. The number of individuals testing positive for hepatitis B is reassuringly low, testifying to the robustness of hepatitis B prevention in prison (eg hepatitis B vaccination programme and other harm reduction activities). This is also true for HIV where we have seen a consistently low proportion of people in prison testing positive. As expected we are seeing considerably more individuals testing positive for hepatitis C Ab than HIV and hepatitis B. Some of these people may not have been identified as early or at all without the switch from risk based testing to a universal BBV opt-out testing policy, although the precise number remains unclear due to data collection and reporting problems.

The persistently low number of people accessing treatment for hepatitis C following diagnosis through the programme remains a concern, and is a result of multiple, complex factors. These include the present standards for referral time, which are up to

18 weeks for hepatitis C; the type of service arrangements, ie in-reach, out-reach or residential GP services; and the current work around clarifying commissioning arrangements for access to current and newer treatments both in prisons and in the community. Patient choice may also be a factor with some prisoners choosing to defer treatment until they return to their home communities although this information was not collected in this evaluation.

On the basis of the above conclusions the following recommendations are made:

1. Local commissioning specifications for prison healthcare providers should aim to include BBV opt-out testing and associated referral and care pathways for patients testing positive for infection in prisons by 2016/17.
2. Local service specifications should be consistent with NICE guidelines and any national guidance provided by NHS England and/or PHE.
3. Laboratory services should be commissioned so that appropriate testing is conducted for BBVs including PCR testing on all samples testing positive for hepatitis C Ab as per national guidance.
4. Healthcare providers in prisons need to improve their data collection so we have better information on testing and treatment. This should include appropriate training in correct use of health informatics system (SystemOne & HJIPs) and coding using READ codes to allow data to be consistently, accurately and reliably entered, collected and collated. Prisons must separate out hepatitis C PCR and Ab results. Commissioners and healthcare providers should together explore the reasons why some people in prison are not been tested for BBVs.
5. NHS England, PHE and NOMS should ensure that findings for this evaluation are fed back to commissioners and providers not only in the pathfinder programme but right across the estate so that lessons learnt can be applied to those entering the programme as well as those preparing to do so at a future date.
6. A second evaluation covering Phase 2 of the implementation of the opt-out programme will be conducted during Q1-Q3 2015-16 and a report published in Q4 of that financial year. The next evaluation should include information collected directly from prisoners about their choice to start treatment while in prisons and any levers or barriers affecting that decision.

Appendix 1: Evaluation questionnaire for pathfinder prisons: BBV opt-out testing

Note: This questionnaire has been designed by the national BBV Opt-out Testing Task and Finish Group for pathfinder prisons to complete to enable us to learn lessons from these sites and share experiences in an objective and consistent way.

The questionnaire should be completed and overseen by the PHE Health and Justice lead in consultation with the health protection lead, AT commissioner, prison healthcare providers and others as relevant.

There are 5 sections to complete (A, B, C, D and E).

Please complete one questionnaire per prison.

Please return the completed questionnaire by Friday 7 November to

health&justice@phe.gov.uk

Name of person completing questionnaire	
Who else has been involved in completing this questionnaire?	
Name of prison	
Category of prison	
Capacity of prison	
Date	

Section A: Testing

A1. When did you introduce the BBV opt-out testing? (mm/yy)

--

A2. When do you recommend testing for BBVs to new receptions?

First reception screen (provide brief details)

Second reception screen (provide brief details)

Other (please state)

A3. Which team(s) recommend the testing (delete ones not relevant)?

Healthcare

Drugs team

GU services

Other (please state)

A4. When do you actually test for BBVs?

A5. Which team(s) actually provides the testing and pre and post-test discussion (delete ones not relevant)?

Healthcare

Drugs team

GU services

Other (please state)

A6. Do you test for HCV antibody and automatic PCR, HBsAg and HIV Ab and Ag P24 test?

Yes or no (Please state what you do test for if not ones above)

A7. What method of testing do you use (delete ones not relevant)?

Venous

DBST

Oral

A8. What information is given to prisoners when they are given their results (please state educational materials provided)?

When negative

When positive (also refer to any wider support services patients are referred to)

A9. How is the prison addressing testing for EXISTING prisoners?

Section B: Specialist services – referrals and treatment

B1. Which service provides treatment for positive diagnosis (please specify for hepatitis B, hepatitis C and HIV)?

HIV:

Hepatitis B:

Hepatitis C:

B2. What is the model of provision, ie in-house led by the prison doctor as part of an MDT, in-reach by secondary care or outpatient (please specify for hepatitis B, hepatitis C and HIV):

HIV:

Hepatitis B:

Hepatitis C:

B3. What is the waiting time from referral to assessment by a specialist provider for:

HIV:

Hepatitis B:

Hepatitis C:

Section C: Planning and review of the BBV opt-out

C1. Do you have a local group overseeing the implementation of the BBV opt-out testing policy? If so please describe this below.

C2. Who are the key stakeholders you engage with when introducing the BBV opt-out work?

C3. What are the issues (eg commissioning, prison regime, staff time etc) have you had to address to effectively introduce the work and how have you done this?

C4. Has the introduction of the BBV opt-out work resulted in patients been diagnosed that maybe wouldn't have been prior to the policy and if so how many?

C5. Has the introduction of the policy helped to raise awareness among staff and people in prison and reduce the stigma attached to being tested for BBVs? If so please give examples

C6. What were the main obstacles to policy implementation?

C7. What are the current issues affecting policy implementation, if any?

Section D: Activity

D1. How many new receptions were tested during 2013 (January-December) for:

HIV:

Hepatitis B:

Hepatitis C:

D2. How many new receptions were tested during April - September 2014 for:

HIV:

Hepatitis B:

Hepatitis C:

D3. Of those tested, how many new receptions were positive for a BBV during 2013 (January-December) for:

HIV:

Hepatitis B (chronic):

Hepatitis C (state antibody +ve only and also PCR+ve):

D4. Of those tested, how many new receptions were positive for a BBV during April - September 2014 for:

HIV:

Hepatitis B (chronic):

Hepatitis C (state antibody +ve only and also PCR+ve):

D5. How many prisoners were referred for treatment during 2013 (January-December) for:

HIV:

Hepatitis B:

Hepatitis C:

D6. How many prisoners were referred for treatment during April - September 2014 for:

HIV:

Hepatitis B:

Hepatitis C:

D7. How many prisoners commenced treatment during 2013 (January-December) for:

HIV:

Hepatitis B:

Hepatitis C:

D8. How many prisoners commenced treatment during April - September 2014 for:

HIV:

Hepatitis B:

Hepatitis C (also state numbers commencing treatment April-June 2014):

Section E: Other comments

E1. Please provide details about what the impact has been in relation to the BBV opt-out testing policy, ie how many additional cases do you think you have identified as a result of the work

Blood-borne Virus Opt-Out Testing in Prisons: Preliminary evaluation of pathfinder programme.
Phase 1, April to September 2014

E2. Can you provide any further details about how you have managed to implement the BBV opt-out testing policy which may help other prisons?

Thank you for your time. Please return the questionnaire to:

health&justice@phe.gov.uk

Appendix 2: BBV Opt-Out Task and Finish Group membership

Andrew Langford, British Liver Trust
Becky Hug, The Hepatitis C Trust
Cathie Railton, Health & Justice, PHE
Charles Gore, The Hepatitis C Trust
Chris Kelly, Health & Justice, NHSE
Claire Foreman, Specialist Commissioning, NHSE CRG
Denise Farmer, Health & Justice Pharmaceutical Advisor, NHSE
Dr Alan Tang, Sexual Health & HIV Consultant & BHIVA representative
Dr Autilia Newton, Health & Justice, PHE
Dr Éamonn O'Moore, Health & Justice, PHE
Dr. Iain Brew, MO, HMP Leeds and member of CRG Health & Justice
Dr. Peter Moss, CRG Chair (infectious diseases) and Consultant, Hull and East Riding
Eleanor Briggs, National AIDS Trust
George Leahy, Public Health Consultant, NHS England
Grace Everest, The Hepatitis C Trust
Dr Helen Harris, Colindale, PHE
Joe Sparks, Communications, PHE
John Ratchford, Communications, PHE
Kate Davies, Health & Justice, NHS England
Kieran Lynch, PHE Drugs & Alcohol
Lynn Emslie, Health & Justice, NHSE
Prof. Jane Anderson, Consultant, PHE
Rupert Bailie, Health & Wellbeing, NOMS
Dr Sema Mandel, Colindale, PHE
Steph Perrett, Public Health Wales
Susanne Howes, Health & Justice PHE
Ursula Peuple, Specialist Commissioning, NHSE CRG

Also receiving papers from Department of Health:

Anne McDonald
Mark Noterman
Rowena J ECock
Ben Cole

Appendix 3: Timeline for introduction of BBV opt-out testing

- July 2012: Department of Health (DH) and Health Protection Agency (HPA) publish 'National survey of hepatitis C services in prisons in England'

The report details good practice guidance around the provision of testing and access to treatment for people in prisons.

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/PrisonInfectionPreventionTeam/Guidelines/>

- July 2012: HPA publish the 'Annual Hepatitis C in the UK report, 2012'

The report makes a public health recommendation around the need to strengthen hepatitis C awareness, testing and access to treatment for those in the prison setting.

<http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListNameDesc/Page/1317132329712>

- December 2012: NICE publish 'Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection'

The document makes recommendations in relation to hepatitis C and prisons and detention centres including the need to ensure that '*all prisoners and immigration detainees are offered access to confidential testing for hepatitis B and C when entering prison or an immigration removal centre and during their detention*'.

<http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43/recommendations#recommendation-5-testing-for-hepatitis-b-and-c-in-prisons-and-immigration-removal-centres>

- February 2013: Prison health expert group convened by The Hepatitis C Trust
Following this meeting, The Hepatitis C Trust published recommendations in May 2013 to NHSE to introduce opt-out hepatitis C testing to all prisoners. The group also recommended in-reach or GP-led treatment should be the model of prison treatment delivered in prison, in accordance with NICE guidance.

<http://www.hepctrust.org.uk/Resources/HepC%20New/Hep%20C%20Resources/Reports/Addressing%20hep%20C%20in%20prisons%205%2030%2005%2013%20FINAL%20COPY.pdf>

- May 2013: PHE and DH publish 'An audit of hepatitis C services in a representative sample of English prisons, 2013'

The report makes recommendations which include the need to increase hepatitis C testing and treatment in prisons and places of detention.

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/PrisonInfectionPreventionTeam/Guidelines/>

- May 2013: Joint NHSE and PHE Health and Justice Board make commitment to audit recommendations

Dr. Éamonn O'Moore presented the findings from the audit of hepatitis C services document above to the Board who committed to supporting the implementation of the report's recommendations.

- 9 July 2013: PHE Health and Justice Team host a multi-agency meeting and agree to implement a BBV 'opt-out' testing policy across all prisons.

The meeting included representation from NOMS and NHSE as well as third sector organisations.

- July 2013: PHE publish the 'Annual Hepatitis C in the UK report, 2013'

The report makes explicit public health recommendations on the need to improve testing, diagnostic and treatment provision around hepatitis C for people in prisons.

<http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListNameDesc/Page/1317132329712>

- August 2013: Tri-partite agreement

The national partnership agreement is developed between NHSE, NOMS and PHE which includes the commitment to introduce an opt-out policy for BBV testing in prisons and places of detention.

<https://www.justice.gov.uk/about/noms/working-with-partners/health-and-justice/partnership-agreement>

Following the publication of the tri-partite agreement there were further key developments:

- Prison Health and Performance Quality Indicators (PHPQIs) review

In response to the new opt-out policy for BBV testing work has been carried out at national level to review the PHPQIs and include more indicators around BBV testing, results, specialist assessment and treatment. The new indicators, now called Health and Justice Indicators of Performance (HJIPs) were published in July 2014.

- National BBV Opt-Out Task & Finish Group

A national multi-agency group was established in January 2014 following a meeting held on behalf of Ministers. The Group is chaired by PHE and has representation from NHS England Health and Justice and Specialised commissioning, NOMS, Public Health Wales, secondary care, prison GP, The Hepatitis C Trust, National AIDS Trust, BHIVA and the British Liver Trust. The membership is included in **Appendix 2**.

Blood-borne Virus Opt-Out Testing in Prisons: Preliminary evaluation of pathfinder programme.
Phase 1, April to September 2014

- National event in Birmingham, May 2014

A national event took place in May 2014 to launch the new policy and provide stakeholders with information and guidance to assist with implementing the work.

The various work leading up to the new model:

Appendix 4: Key national policy and guidance documents

The following policy and guidance documents are the key ones to consider when implementing the BBV opt-out testing pathway in prisons:

- NICE Public Health Guidance 43, Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection. December 2012, Last modified March 2013

<http://guidance.nice.org.uk/PH43/Guidance/pdf/English>

- PHE, Opt-out blood-borne virus opt-out supporting documents, May 2014

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/PublicHealthInPrisonsTeam/Guidelines/>

- British Viral Hepatitis Group, Provision of antiviral services for patients with chronic viral hepatitis: BVHG Recommendations, 2010

(<http://www.basl.org.uk/microsites/bvhg/resources.cfm>)

- Department of Health and National AIDS Trust, Tackling Blood Borne Viruses in Prisons. A framework for best practice in the UK. Updated May 2011

<http://www.nat.org.uk/media/Files/Publications/May-2011-Tackling-Blood-Borne-Viruses-in-Prisons.pdf>

- WHO, Guidelines for the screening, care and treatment of persons with hepatitis C infection, April 2014

<http://www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en/>

- NHS England specialised commissioning documents

<https://www.england.nhs.uk/ourwork/commissioning/spec-services/key-docs/>

<http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/>

Appendix 5: Phase 2 pathfinder sites (commencing December 2013 to March 2015)

In addition to the 11 pathfinders discussed in this report, there are now an additional 15 prisons that are aiming to implement this work during the second stage. While not all prisons have agreed dates for implementation, the provisional next stage pathfinders are detailed below.

Phase 2 pathfinder sites

Area team	Prison
East Anglia	HMP Bedford
	HMP Hollesley Bay
North East	Durham
	Northumberland
Derbyshire & Nottinghamshire	HMP Glen Parva
	HMP Foston Hall
	HMP Sudbury
	HMP Whatton
	HMP Gartree
	HMP Lowdham Grange
	HMP Lincoln
	HMP North Sea Camp
	HMP Leicester
West Yorkshire	Doncaster
	New Hall

References

- ⁱ **National Partnership Agreement** between the National Offender Management Service, NHS England and Public Health England for the co-commissioning and delivery of healthcare services in prisons in England, 2013
<https://www.justice.gov.uk/about/noms/working-with-partners/health-and-justice/partnership-agreement>
- ⁱⁱ **Ministry of Justice**, Gender differences in substance misuse and mental health issues among prisoners, 2013 <https://www.gov.uk/government/publications/gender-differences-in-substance-misuse-and-mental-health-among-prisoners--2>
- ⁱⁱⁱ **Public Health England**, Hepatitis C in the UK, 2013 Report, 2014
<https://www.gov.uk/government/publications/hepatitis-c-in-the-uk>
- ^{iv} **British Journal of Obstetrics and Gynaecology** November 1996, Vol. 103, pp. 1129-1133, Voluntary universal antenatal HIV testing
<http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.1996.tb09596.x/abstract>
- ^v **Select Committee on HIV and AIDs in the United Kingdom**, First Report No vaccine, no cure: HIV and AIDS in the United Kingdom, 2011 Parliament, No vaccine, no cure: HIV and AIDS in the United Kingdom - Select Committee on HIV and AIDs in the United Kingdom
<http://www.publications.parliament.uk/pa/ld201012/ldselect/ldaids/188/18802.htm>
- ^{vi} MedFASH Progress and priorities – working together for high quality sexual health, Review of the National Strategy for Sexual Health and HIV, 2008
http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCEQFjAA&url=http%3A%2F%2Fwebarchive.nationalarchives.gov.uk%2F%2B%2Fdh.gov.uk%2Fen%2FPublichealth%2FHealthimprovement%2FSexualhealth%2Findex.htm%3FIdcService%3DGET_FILE%26dID%3D169705%26Rendition%3DWeb&ei=sNQGvae9OdlaiFgvAL&usg=AFQjCNGf1kMoYeIwV6NAWHivPiv_CeEU_Q