UK Health Security Agency

Public health guidance for bloodborne virus testing in prisons and other places of detention

Contents

Summary

Who this guidance is for

This guidance is for:

- healthcare teams in secure settings
- NHS commissioners
- governors and directors (for information)
- health protection teams (HPTs) (for information)

The guidance outlines the recommended process for testing for bloodborne viruses (BBVs). In this guidance BBVs refer to hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

The prisons and other places of detention (PPDs) in England covered by this guidance are:

- prisons and young offender institutions (YOIs) with individuals aged 18 and above
- immigration removal centres (IRCs)

This guidance does not cover:

- probation settings including approved premises (APs)
- the children and young people secure estate (CYPSE)
- mass accommodation sites for people seeking asylum

What has changed since this guidance was last updated

This guidance replaces the 6 separate documents published in 2014 to coincide with the launch of the BBV opt-out testing programme.

There have not been any fundamental changes to the BBV testing process. However, the options for testing have increased. Information on the different testing methods can be found within this guidance.

There has been a significant targeted HCV elimination programme supported by operational delivery networks (ODNs).

Summary of recommendations

This guidance outlines the recommended approach to testing for BBVs among people in PPDs in England.

BBV testing should be routinely offered to all individuals entering a PPD and at least every 12 months thereafter, unless they meet one or more of the following criteria:

- have been tested at any point within the past 12 months and have not engaged in any behaviours, as detailed in section 4, that place them at risk of infection since that time
- have previously had a ribonucleic acid (RNA) positive test for a BBV within the past 3 months and are linked to further assessment or care – however, they should still be tested for the remaining BBVs
- are already known to have previously tested positive for a BBV and did not engage or are not currently engaged in treatment
- have documented evidence of a previous negative HBV test and a completed HBV vaccination course – however, they should be tested for HCV and HIV
- are known to be HIV positive, whether in treatment or not, but should still be tested for HBV and HCV

Laboratory arrangements

Services should have an agreement with a nominated laboratory that sets out arrangements for sample processing, turnaround times and prompt communication of test results. Where possible, PPDs should use laboratories that provide timely test results (this may be a local laboratory). Laboratories participating in the Sentinel Surveillance of Blood Borne Virus (SSBBV) testing scheme should be used where available to support national reporting of test results to UKHSA.

Care pathways

Clear and effective treatment pathways should be in place with local BBV services to facilitate rapid follow-up and treatment in the event of a positive, reactive or indeterminate result. If not in place, pathways should be strengthened and should also include primary care.

All test results, whether positive or negative, should be clearly recorded on SystmOne and shared with the appropriate services. All positive results should be reported to the UK Health Security Agency (UKHSA) as per the Health Protection (Notification) Regulations (HPNR) 2010.
Where possible, PPDs should use laboratories that have a quicker response time for test results (this may be a local laboratory).

Individuals who decline testing should be re-offered testing, ideally within 3 months of declining, or at a minimum either before release or transfer or after 12 months.

The NHS Making Every Contact Count (MECC) approach makes use of routine interactions between individuals and healthcare teams as opportunities to initiate supportive conversations about positive changes to health and wellbeing. This approach could also be applied to help reduce declined offers of screening, by encouraging brief, tailored discussions that raise awareness, address concerns and support informed decision-making.

Supporting evidence

These updates are informed by expert opinion and bring this guidance into alignment with current practices for managing BBV cases and incidents in other settings.

Background

BBVs, including HBV, HCV and HIV, remain a significant public health concern within prison settings. These infections are both preventable and treatable (HIV or HBV) or curable (HCV), yet undiagnosed and untreated cases continue to drive avoidable morbidity and mortality.

Because PPDs are closely connected to the wider community, effective BBV prevention, testing and treatment in custody is essential to protecting population health.

People in PPDs are disproportionately affected by BBVs. National and international evidence consistently shows elevated rates, particularly for HCV, reflecting the vulnerabilities of individuals entering custody and the higher likelihood of previous exposure to BBV risk factors.

Risk-enhancing behaviours, such as sharing injecting equipment, condomless sex, tattooing and sharing personal care items such as razors and toothbrushes continue to occur within prisons, reinforcing the need for comprehensive health education and targeted harm-reduction approaches.

Ensuring timely access to opt-out BBV testing and high-quality treatment equivalent to that available in the community is a core requirement of prison healthcare services. Early diagnosis and prompt, evidence-based care reduce transmission, improve health outcomes and strengthen health equity for a population that experiences significant barriers to healthcare both prior to and during custody.

Hepatitis B

Hepatitis B is a bloodborne viral infection that is preventable through vaccination. It is often asymptomatic until many years after infection when the liver has been significantly damaged. When symptoms do occur, they can often be non-specific, like tiredness, unexplained weight loss or an elevated temperature, and be dismissed or mistaken for other conditions. Infection with HBV causes hepatitis (inflammation of the liver) and may lead to long-term liver damage such as scarring of the liver (cirrhosis), damage to liver function and liver cancer. Appropriate treatment can help avoid longer-term damage and can reduce the virus to undetectable levels.

Comprehensive information on the diagnosis, clinical management, treatment options and strategies to support vaccine uptake is available through the UKHSA Hepatitis B guidance pages.

Hepatitis C

Hepatitis C is a bloodborne viral infection that predominantly affects the liver and, if left untreated, can lead to serious and progressive liver disease such as scarring of the liver (cirrhosis), damage to liver function and liver cancer. It is often asymptomatic until many years after infection when the liver has been significantly damaged. When symptoms do occur, they can often be non-specific, like tiredness, loss of appetite or an elevated temperature, and be dismissed or mistaken for other conditions. Hepatitis C can be prevented by reducing exposure to the virus and can be cured with effective antiviral treatment. Further information on the epidemiology, diagnosis, management and treatment of hepatitis C is available through the UKHSA Hepatitis C guidance pages.

HIV

HIV can be asymptomatic, particularly in the early stages of infection, so people may not know they are infected. Without effective treatment however, HIV leads to a progressive decline in immune function, resulting in severe illness and increased vulnerability to opportunistic infections. Appropriate treatment can help avoid longer-term damage and can reduce the virus to undetectable levels. Further information on HIV, including epidemiology, prevention, testing and treatment, is available through the UKHSA HIV guidance pages.

Roles and responsibilities

For additional information on the roles and responsibilities in the event of identified BBV cases, refer to the Management of incidents and outbreaks of communicable disease in secure settings.

UKHSA HPTs are responsible for providing specialist support to prevent and reduce the impact of infectious diseases and environmental hazards. They manage outbreaks, conduct surveillance and advise local partners on health protection.
Find your local HPT at Health Protection Team.

Recommendations and public health actions

Every individual entering PPDs should receive a comprehensive initial health screening. This screening should include a full risk assessment at the point of entry and the collection of a complete medical history, in line with the NHSE Primary Care Service Specification for healthcare in prisons. The process should ensure the prompt identification of anyone requiring urgent clinical review including immediate BBV assessment or treatment.

Testing for BBVs should be offered to all eligible individuals and should include HIV (HIV Ab/Ag p24), HBV (HBsAg), and HCV (HCV antibody) testing. Refer to the eligibility criteria below.

Eligibility criteria

BBV testing should be recommended to all individuals, including those already in prison unless they:

- have been tested at any point within the past 12 months and have not engaged in any behaviours, as detailed in section 4, that place them at risk of infection since that time
- have previously had a ribonucleic acid (RNA) positive test for a BBV within the past 3 months and are linked to further assessment or care; however, they should still be tested for the remaining BBVs
- are already known to have previously tested positive for a BBV, did not engage or are not currently engaged in treatment
- have documented evidence of a previous negative HBV test and a completed HBV vaccination course – however, they should be tested for HCV and HIV
- are known to be HIV positive, whether in treatment or not, but they should still be tested for HBV and HCV

BBV testing should be offered within 72 hours of arrival, typically during the first-night health screen or secondary health assessment. Establishments should deliver testing at the most appropriate opportunity to maximise uptake. Optimal timing may vary depending on the prison category, patterns of new receptions and an individual's wellbeing. A flexible, person-centred approach should be adopted to achieve the highest possible testing rates to maximise health outcomes.
An opt-out screening and testing approach should be used to normalise BBV testing and reduce associated stigma.

Continuation of existing BBV treatment should be ensured for individuals who were receiving treatment before arrival. All prescribed medications should be administered promptly to prevent treatment interruptions, maintain therapeutic stability and reduce the risk of clinical deterioration.

Individuals entering PPDs should be encouraged to share their community GP record with the healthcare team. Discussions around sharing information and documentation of consent should therefore occur at the time of health appointments.

During the initial reception period, individuals should be informed about the full range of healthcare services available, including sexual health services, harm reduction services and the pathways for accessing these interventions. Information should be clear, accessible and non-stigmatising. As part of the induction process, the healthcare team should provide accurate information on the risks and routes of BBV transmission, available prevention (for example, HIV pre-exposure prophylaxis (PrEP) and HIV post-exposure prophylaxis (PEP)), harm minimisation (for example, not sharing personal care items), treatment and care options, and the benefits of HBV vaccination. Individuals should also be informed about the establishment's policy for access to condoms, other barrier methods and disinfectant tablets.

Individuals who decline testing at reception should be offered further opportunities throughout their time in custody. Testing should remain a standing offer and be integrated into routine clinical contacts, including HBV vaccination appointments and clinical or psychosocial reviews linked to substance-use treatment. In addition to opportunistic testing, all eligible individuals should be offered BBV testing at least once every 12 months, in accordance with the clinical criteria.

Testing models and local considerations

The type of test used may vary across establishments depending on local operational factors, including type of establishment, number of new receptions and clinical context.

It is regarded as good practice for healthcare teams not to rely solely on a single testing approach. Offering a range of testing options is essential to accommodate the diverse needs

and circumstances of individuals in custody and to maximise opportunities for engagement and early diagnosis.

Common testing options

Venous blood sample

The traditional laboratory method where blood is drawn from a vein and sent to a laboratory. This allows for a comprehensive and confirmatory test for all BBVs.

Capillary or finger-prick

A finger-prick sample that is then sent to a laboratory for analysis.

Dry blood spot (DBS)

A few drops of blood from a finger prick are placed onto a testing card and sent to a laboratory. It is a vein needle-free alternative option.

Cepheid testing

A rapid PCR-based diagnostic method that analyses various sample types using a self-contained cartridge for each virus, delivering accurate results within 1 to 2 hours. This is usually carried out using the finger prick method. It tests for HCV RNA (evidence of current infection).

Point-of-care (PoC)

Point-of-care tests are rapid screening tools used to detect the presence of antibodies (for HCV or surface antigens (for HBV and HIV)). These tests use a lateral flow method and typically provide results within 1 to 20 minutes. A positive PoC result is preliminary and should be followed by confirmatory laboratory testing (non-PoC) to diagnose HIV or HBV, or to determine HCV RNA status. All test results, whether positive or negative, should be clearly recorded on SystmOne and shared with the appropriate services, including UKHSA.

Annexe 1 outlines the different testing options available and provides guidance on the key considerations for each model.

Recording of results on SystmOne

All reception screening information, including results relating to BBV testing, should be recorded accurately on SystmOne and in full compliance with the National Clinical Template (SEAT). This requirement applies to every stage of the BBV testing pathway, from initial offer through to results and follow up. Healthcare teams should refer to the NECS SystmOne Clinical Template User Guides for detailed instructions on the correct use of the national BBV templates and to ensure that all relevant clinical information is recorded consistently and to the required standard.

Confirmatory testing and support

Individuals who receive a positive HIV screening result should undergo a confirmatory test in accordance with established clinical protocols. All people tested should be provided with appropriate harm minimisation advice as well as ongoing support and access to relevant healthcare and psychosocial services. This ensures that all individuals, regardless of test outcome, are offered clear guidance and pathways to maintain or improve their health and wellbeing.

Laboratory pathways and partnership arrangements

Each healthcare team should have a clearly defined and effective pathway with the laboratory responsible for processing BBV tests. This partnership should include explicit agreement and shared understanding regarding the process for sending tests for analysis, the expected turnaround times for results, and the method by which results are communicated back to the service. These operational measures should be routinely monitored, documented and form part of the formal partnership arrangements with the laboratory to ensure consistent quality and reliability.

Where possible, PPDs should use laboratories that are part of the Sentinel Surveillance of Blood Borne Virus (SSBBV) testing scheme. This helps to ensure the accurate national reporting of test results to UKHSA.

Treatment pathways

Each prison healthcare team should maintain robust and clearly defined treatment pathways that are fully integrated with local community BBV services. Consultant-led multidisciplinary team (MDT) monitoring should be established, with prison healthcare forming an essential and active component of the wider clinical oversight process. Treatment should be delivered through either in-reach specialist services or GP-led in-house models, as these are the preferred approaches for custodial environments and support continuity, accessibility and clinical governance. The use of telemedicine using IT could also be an option in most settings, where available.

Treatment pathways should provide access not only to prison-based services but also to relevant external services, including mental health, dermatology, sexual health, drug and alcohol use and other specialist support services. These linkages ensure that individuals receive comprehensive, holistic care consistent with national standards and best practice.

Initiation and continuity of treatment

Treatment for BBVs should be initiated promptly following a positive diagnostic result, including for individuals serving short sentences. Sentence length should not act as a barrier to commencing treatment. Continuity of care should be maintained across the prison estate, and treatment plans should be preserved during all internal transfers and continued seamlessly into the community on release. Services such as the NHSE-commissioned Reconnect Service and the Hepatitis C Trust Follow Me programme can support with continuation of treatment after release.

All individuals should be offered the full range of recommended treatment options following a confirmed test result. They should be promptly referred to the appropriate specialist service for further specialised support and treatment. The information on the different treatment options is below.

British Association for the Study of the Liver
European Association for the Study of the Liver
British HIV Association

Additional information from the National Institute for Health and Care Excellence (NICE):

NICE recommended treatment options for HBV
NICE recommended treatment options for HCV
NICE recommended treatment options for HIV

Ongoing monitoring is required by the specialist service. Prison healthcare services need to work with the treatment services to support ongoing care including the supply of medication if prescribed.

Healthcare professionals should discuss available choices openly and transparently, ensuring that neither transfer between establishments nor release into the community prevents or delays treatment initiation.

Supportive care and harm reduction

Harm reduction advice should be routinely available to all individuals, supporting safer behaviours and reducing the risk of onward BBV transmission. Psychological support should be available if required, ensuring that emotional and behavioural needs associated with diagnosis, treatment or substance use are addressed.

A clear local policy should be in place regarding access to disinfectant tablets and barrier methods for safer sex, ensuring consistency and transparency for individuals in custody. Further information about the limited strength of evidence for disinfectant tablets can be found within the UKHSA rapid review paper.

Information on HIV preventative medicines PrEP and PEP and their pathways to access should also be available.

Opioid use is associated with hepatitis C and HIV transmission and overdose, among other harms. Opioid agonist therapy (OAT) is an effective treatment for opioid use disorder and helps to address drug-related harms including lowering the risk of hepatitis C and HIV.

Each establishment should also train and maintain a cohort of BBV Peer Support Champions, enabling peer-led engagement, education and support throughout the prison.

Transfers between establishments

Prior to any prison transfer, the sending healthcare team should communicate directly with the receiving establishment in cases where BBV-related test results remain outstanding, or when the individual is currently receiving or requires BBV treatment or HBV vaccination courses are incomplete.
SystmOne medical records should be fully updated before transfer to ensure the receiving team has immediate access to accurate and complete clinical information.

Release planning and continuity of care

The discharging healthcare team should work collaboratively with the prison to develop a comprehensive release plan for all individuals. The National Probation Service should be notified when any individual due for release under their supervision has a positive BBV result or is undergoing BBV treatment at the point of release. This is subject to informed consent being given to share treatment information with the Probation Service.

Healthcare teams should liaise with secondary care services and community drug services prior to release where this will support continuity of care. They should also notify the individual's community GP and facilitate access to SystmOne records. Where individuals are not registered with a GP, support should be provided to ensure registration before or shortly after release. This should form part of the individual's pre-release planning carried out jointly between the healthcare team and the establishment. Adequate medication supplies should be provided to cover the transition period, and individuals should receive clear signposting to local and national BBV support services to ensure ongoing engagement with treatment and care in the community.

The British Association for Sexual Health and HIV (BASHH) Prison Standards consider it best practice for sexual health services to maintain their own separate patient records, and not to share identifiable information relating to an individual's sexual healthcare without their consent. Sexual health information should not, routinely, be shared with non-sexual healthcare workers without the consent of the patient, and therefore physical and electronic

records should be stored securely and ideally separately from general health records, so that confidentiality can be maintained.

Treatment pathway algorithms for HBV, HCV and HIV are provided in the annexes.

Further information

Further information and resources can be found by following the links below.

The Hep C Trust
NHS Hepatitis C information page
Living well with HIV | Terrence Higgins Trust
NHS HIV and AIDS information page
National AIDS Trust – We're the UK's HIV rights charity
NHS Hepatitis B information page
Hep B Companion
NICE HBV clinical summary
NICE HCV clinical summary
NICE HIV clinical summary

Feedback

Feedback on this guidance will be coordinated through internal UKHSA BBV forums. Formal feedback forms will be developed and disseminated to all users to obtain their input to support the development of future iterations of this guidance.

About the UK Health Security Agency

UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe, save lives and protect livelihoods. We provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

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