



Public Health
England

Protecting and improving the nation's health

Public Health England

Health and Justice Annual Review 2018 to 2019



“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. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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The now decommissioned HMP Reading, 2016. Photo by Maciej Czachorowski.

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This phrase, attributed to Dr. Éamonn O'Moore, National Lead for Health & Justice, PHE, was adopted by the World Health Organization's Health in Prisons Programme and the Council of Europe at a meeting of prison health experts held in Strasbourg in 2014 which endorsed the position that health and justice organisations cannot achieve their respective aims in isolation.

Contents

About Public Health England	2
Acknowledgements	3
Glossary	5
Introduction	6
Working in partnership	8
Partnership work with Police	9
Improving outcomes for victims/survivors of sexual assault and abuse in England	10
Tackling increasing crack/cocaine prevalence in England	11
Public health approaches to reducing violence and re-/offending	14
Developing a whole system approach to support collaborative work to improve outcomes for vulnerable children and young people – Project CAPRICORN	16
Data and intelligence	20
The ‘Reading Model’:	22
Protecting health in custodial settings	24
Summary of health protection incidents/outbreaks reported 2018/19	24
Key health protection incidents 2018/19	24
Major health protection programmes 2018/19	25
Managing the risk of blood-borne virus infection in emergency workers	27
Regional engagement	29
North East: Syphilis testing in prisons	29
Yorkshire and the Humber: Improving continuity of drug treatment on release from prison	30
East of England and North West: Bowel cancer screening in prisons	31
East Midlands: Continuity of care in oral health for people leaving secure settings – a model oral health pathway	32
West Midlands: Improved data for improved outcomes for young offenders	33
London: Protecting health through best practice and training	33
South East: Reducing TB in prisons	34
South West: Collaborative approach to tackling flu in secure settings	35
International engagement	37
International prison health: UK Collaborating Centre for the WHO Health in Prisons Programme	37
Strengthening co-ordination of global prison health: 6th Prison Health Conference, Helsinki – March 2019	38
Health in Prisons European Database: a minimum public health dataset for prisons	39
WEPHREN: building international research and professional development capacity	40
References	42

Glossary

ADTJ	Alcohol, Drugs, Tobacco and Justice
BBV	Blood-borne virus
CJS	Criminal justice system
CRC	Community rehabilitation company
CYPSE	Children & Young People's Secure Estate
DAA	Directly acting antiviral
DBST	Dried blood spot testing
DEI	Data, Evidence and Intelligence Group
DHSC	Department of Health and Social Care
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FNP	Foreign national prison
HIPED	Health in Prisons European Database
HIPP	Health in prisons programme (WHO)
HIV	Human immunodeficiency virus
HJIP	Health and Justice Indicators of Performance
HJIS	Health and Justice Information Service
HMPPS	Her Majesty's Prison and Probation Service
HO	Home Office
HPT	Health protection team
ICRC	International Committee of the Red Cross
ICT	Incident control team
IRC	Immigration removal centre
MOQ	Maximum Ordering Quantity
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPA	National Partnership Agreement
OCT	Outbreak control team
PCC	Police and Crime Commissioner
POCT	Point of care testing
PPDs	Prescribed places of detention
TB	Tuberculosis
T&F	Task and Finish
UKCC	United Kingdom Collaborating Centre
UNODC	United Nations Office on Drugs and Crime
WEPHREN	Worldwide Prison Health Research and Engagement Network
WHO	World Health Organization
YJB	Youth Justice Board
YOI	Young Offender Institute

Introduction

Public Health England (PHE) works to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-class science, advocacy, partnerships, knowledge and intelligence, and the delivery of specialist public health services. PHE provides expert advice to Government and policy makers.

PHE's National Health and Justice Team sits within the Health Improvement Directorate. Our mission is to improve health, reduce health inequalities and drive down offending and reoffending behaviour by understanding and meeting the health and social care needs of people in contact with the criminal justice system (in custody and in the community) through collaborative work with statutory and voluntary sector partners and with service users.

The Health and Justice team works in partnership with health and social care commissioners, service providers, academic and third sector organisations 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.

The scope of our work includes settings like prisons, Young Offender Institutes (YOIs) and Immigration Removal Centres (IRCs) but we also work across the entire health and criminal justice pathway, working on health needs of justice-involved people, victims of crime as well as perpetrators. We work with Police and Crime Commissioners, police and probation services, and statutory and voluntary sector partners. Our role covers all aspects of public health practice, including health protection, health improvement and healthcare public health.

This report focuses on some aspects of our work during the 2018/19 financial year, specifically with regards to:

- public health approaches to reducing violence and reoffending and improving health outcomes for people in contact with the CJS
- protecting health – including responding to challenges seen in response to bacterial wound infections and the implementation of communicable disease screening programmes in prisons
- regional engagement – a look at some of the work being undertaken by PHE Centre and Regional Health and Justice teams to improve the health of justice-involved people across England
- international engagement – reporting on work undertaken with international partners through our role as a UK Collaborating Centre for the World Health Organization's (WHO) Health in Prison Programme (HIPP)

While this report highlights some of the key developments and projects undertaken by the team over the course of the last financial year, it is not intended to describe every aspect of the national Health and Justice work programme. Interested readers are encouraged to visit the Health and Justice website where much of our work from preceding years can be found (including previous issues of this report):

<https://www.gov.uk/government/collections/public-health-in-prisons>

Working in partnership

To address the complex health and social care needs of people resident in custodial settings, effective partnership work is required, not only between health partners and the prison service but also with health and justice policy makers. Three new national partnership agreements have been drafted and signed off in 2018 that inform work related to the adult prison, children and young people's secure estate (CYPSE) and immigration detention estates:



Agreement: National Partnership Agreement for Prison Healthcare in England (2018-2021)

Partners: Ministry of Justice / Department of Health & Social Care / Public Health England / Her Majesty's Prison and Probation Service / NHS England

Governance: Prison Healthcare Board for England



Agreement: The Children and Young Peoples' Secure Estate National Partnership Agreement (2018-2021)

Partners: Department for Education / Department for Health & Social Care / Ministry of Justice / Her Majesty's Prison and Probation Service / NHS England / Public Health England / Youth Custody Service

Governance: Children and Young Peoples' Secure Estate Assurance Group



Agreement: Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England (2018-21)

Partners: NHS England / Home Office Immigration Enforcement / Public Health England

Governance: National IRC Assurance Group

These partnership agreements describe the commitment of all partners to working together to achieve shared priorities as well as relevant governance structures. Some of the work enabled through such partnerships is highlighted in this report.

Partnership work with police

Less than 20% of calls to the police are about crime ^[2]. Many of the remainder (as well as some of the crime-related calls) are about complex social need or 'vulnerability'. An upstream and collaborative approach to preventing harm arising is therefore required. PHE colleagues worked with the National Police Chief's Council and other partners including NHS England, the College of Policing and the Faculty of Public Health to develop a **national consensus** agreement that sets out a commitment to working better together around prevention and early intervention. The document was published in February 2018 ^[3]. Since then, a multi-agency working group has led work to implement this consensus.

There were 4 themes to the workplan in 2018/19, and a summary of achievements is set out below.

Communications

Aims have been to raise awareness of the consensus messages, and to make links between different groups and workstreams operating in the public health and policing arena. Links to a blog series and other material can be found on the Royal Society of Public Health's **Emergency Services Hub**, which provides a resource bank for emergency services and health collaborations.

A Twitter account, **@police_health**, was also curated to reach a different and broader audience.

Presentations at several conferences and events, including the International Law Enforcement and Public Health Conference and the national Police Problem Solving Conference. Learning has also been shared with colleagues in Scotland as they develop their own Health and Justice collaborative statement.

Data

Data and information sharing between police and health at both population and individual level remains a key aspect of collaborative working where partners are seeking to overcome barriers. We hosted a round table event in June 2018 to enable stakeholders to discuss their priorities for national action. Colleagues in Thames Valley are leading the way with their Reading Model (see Data and intelligence section below')

Workforce

A focus of this work stream has been the development of the National Police Wellbeing Service and its web resource, [Oscar Kilo](#) [4].

Public Health approaches in Policing

A [discussion paper](#) was developed in response to the challenge: what exactly is a public health approach to policing? The paper was published in May by the College of Policing and co-badged by PHE [5].

Plans for the next year include:

- developing a practical public health approaches implementation resource
- further developing links with colleagues working in related areas
- continuing to champion upstream preventative approaches

Improving outcomes for victims/survivors of sexual assault and abuse in England

WHO describes sexual violence as “a serious public health and human rights problem with both short- and long-term consequences on [victims’] physical, mental, and sexual and reproductive health” [6]. Sexual violence is also a health inequalities issue disproportionately affecting young women and often compounding other social, economic or cultural problems. Sexual violence causes significant harm, impacting in various ways on the dignity, sexual and bodily autonomy of those it is directed against.

PHE have worked in partnership with NHS England, the Department of Health and Social Care (DHSC), Home Office (HO), and the Ministry of Justice (MoJ) to implement the vision described in the [Strategic Direction for Sexual Assault and Abuse Services \(SAAS\)](#) [7], published by NHS England in April 2018, which outlines how services for victims and survivors of sexual assault and abuse, in all settings of the health and care system, need to evolve between now and 2023. The Strategic Direction is underpinned by the

6 core priorities:

1. Strengthening the approach to prevention.
2. Promoting safeguarding and the safety, protection and welfare of victims and survivors.
3. Involving victims and survivors in the development and improvement of services.
4. Introducing consistent quality standards.
5. Driving collaboration and reducing fragmentation.
6. Ensuring an appropriately trained workforce.

PHE also co-chairs a National Partnership Board on SAAS, which is the cross-sectoral governance structure overseeing implementation of the SAAS strategy and associated work streams. To support this work, in November 2018 PHE co-convened a meeting of senior system leaders, alongside HO, MoJ, NHS England and DHSC. The aims of the meeting were to:

- discuss and explore what the SAAS means for the individuals and organisations represented
- provide an update and share best practice on the work already underway to support delivery of the 6 core priorities
- discuss and explore collaborative ways of working, as well as opportunities and challenges in progress shared priorities over the next 5 years

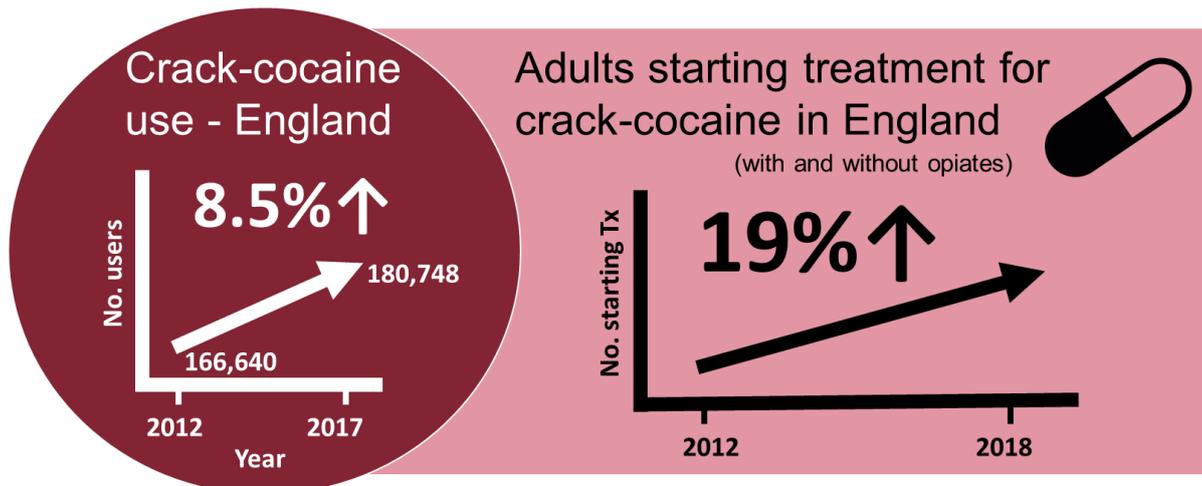
The event was informed by the experiences of victims/survivors of both recent and non-recent sexual assault and abuse. Two government ministers, Jackie Doyle-Price MP, Parliamentary Under Secretary of State for Mental Health, Inequalities, and Suicide Prevention, DHSC and Edward Argar, Parliamentary Under Secretary of State and Minister for Victims, Ministry of Justice, described government support for the work and their commitment to supporting it going forward.

The outcomes of the event have informed the work programme for the SAAS Board for financial year 2019 to 2020 (FY19-20). A second event will be held during the FY19-20 to reflect on progress made and identify areas for further action at both national and local level.

PHE have also worked with NHS England to develop and improve indicators of performance for sexual assault referral centres (SARCIPs) as part of a quality improvement programme to ensure the needs of victims/survivors are met when they present to these services.

Tackling increasing crack/cocaine prevalence in England

The **Serious Violence Strategy** ^[8] identified drugs as an important reason for the increase in serious violence and committed government to understanding more about this rise in crack use. Recent evidence from PHE also suggests that there has been a rise in crack-cocaine use in England ^[9,10].



In response, PHE and the HO established a joint project to investigate the underlying reasons for the increase in crack use by undertaking fieldwork in 6 Local Authority areas across England where treatment data indicated a pronounced increase in individuals entering treatment with crack problems. Working with colleagues in the relevant PHE centres and commissioners and providers of drug treatment services in those areas, PHE and HO staff undertook a series of focus groups and interviewed 3 participant groups: drug treatment workers, service users and police officers. Semi-structured questionnaires were used to guide the discussions, which were tailored to each participant group. Notes were taken or the interviews were recorded and transcribed. The project was approved by the PHE Research Ethics Committee and data collection took place based on the informed consent of research participants.

Some of the key findings of the research indicate:

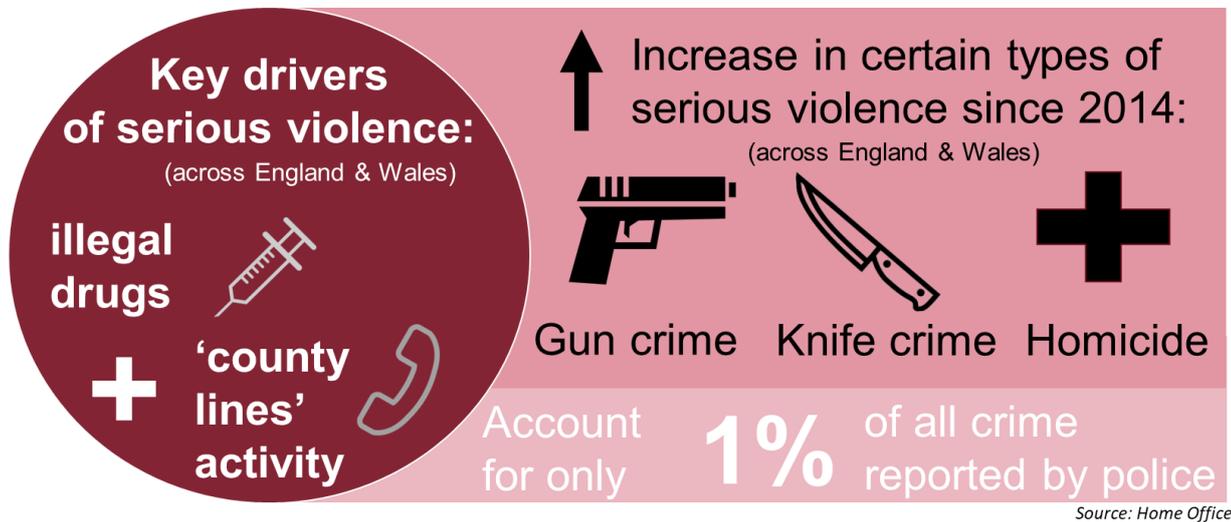
- that the increase in crack use was observed to have mainly taken place among existing heroin users, who have now also started to use crack on a daily basis.
- there were also suggestions of a ‘hidden’ cohort of crack users who had not presented to treatment, such as women and younger people

Main drivers reported for increase in crack use in England	
 <p>Aggressive marketing tactics</p>	<p>'3-for-2' e.g. dealers giving heroin free to users or as part of '3-for-2 deals'</p>
 <p>Wide availability...</p>	<p>...and delivery e.g. delivery described as 'quicker than a pizza'</p>
 <p>Improved affordability</p>	<p>size : price e.g. reported that crack was being sold in smaller quantities to make it more affordable</p>
 <p>Changes in purity</p>	<p>crack v. heroin the purity of crack had increased while heroin purity had fallen, making crack more appealing</p>
 <p>Reduced stigma</p>	<p>'No worries!' suggestions that this may be due to the way crack is marketed by dealers</p>
 <p>Lack of police resources</p>	<p>generally observed that fewer police on the streets, and lack of resources make it difficult to prioritise drug-dealing</p>

Source: Public Health England and Home Office

The full findings of the inquiry were published by PHE in March 2019 in a report entitled [Increase in crack cocaine use inquiry: summary of findings](#) ^[11], and were widely picked up by the media. This helped to raise awareness of this issue and the challenges presented to criminal justice agencies, commissioners and providers of drug treatment services and is feeding into the [independent review of drugs led by Dame Carol Black](#) ^[12]. The impact is reflected by the requests to present the findings of the report at national and regional conferences and events run by the police, PHE and Local Authorities.

Public health approaches to reducing violence and re/offending



In response to the increase in knife crime, gun crime and homicide across virtually all police force areas in England and Wales (see infographic above), the government published its **Serious Violence Strategy** in April 2018 [8]. The strategy represents a step change in the way we think and respond to serious violence, establishing a new balance between prevention and law enforcement. It declares a call to action to partners from across different sectors to come together to understand the issues they are experiencing locally and encourages a locally driven response supported by national initiatives and funding [8]. This approach has been termed a public health approach to preventing and tackling serious violence.

Taking a public health approach to violence is not new. In 1996 the World Health Assembly declared violence a leading worldwide public health problem [13]. The World Health Assembly called upon member states to give urgent consideration to the problem of violence and requested the Director-General of WHO to develop a science-based approach to understanding and preventing violence [13,14]. This led to the development of the WHO 4-step process for implementing a public health approach to violence [15]:

1. To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence and the factors that could be modified through interventions.

3. To find out what works to prevent violence by designing, implementing and evaluating interventions.
4. To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

Since then, public health approaches to violence have been implemented throughout the world, each with consideration of the WHO 4-step process but with variation, taking into account local systems, the type of violence and factors driving increases in violence [16,17,18,19].

Due to the unique drivers of serious violence that England is experiencing and the complexity of partners, the need to be involved in preventing and tackling serious violence, and the systems that they work in, it is critical that England establishes its own public health approach based on the WHO 4-step approach and underlying public health principles (Box 1).

Box 1: The underlying principles of a public health approach:

- focused on a defined population, often with a health risk in common
- with and for communities
- not constrained by organisational or professional boundaries
- focused on generating long-term as well as short-term solutions
- based on data and intelligence to identify the burden on the population, including any inequalities
- rooted in evidence of effectiveness to tackle the problem

Approach

In response to the need for an England-specific public health approach to preventing and tackling serious violence, the Health and Justice team has commenced a programme of work encompassing a range of activities, which include:

- working directly with the Home Office to implement the Serious Violence Strategy and provide Public Health expertise into the development of **Violence Reduction Units**
- engagement with key internal and external stakeholders across England, Scotland and Wales currently working in the serious violence space
- establishment of a PHE Serious Violence Prevention Working Group and Network to provide strategic oversight and alignment of PHE work undertaken on serious violence
- evidence review and critique of existing international public health approaches to serious violence
- development of a public health place-based approach to serious violence for England

Looking ahead

The Health and Justice Team will be publishing a resource in the Summer of 2019 outlining the public health place-based approach for England. The resource will be aimed at system leaders from across health and social care, local government and police. It will provide practical information about how 'places' (which we consider to be a meaningful description of a locality as defined by the local area) can implement the approach. The resource will include examples from places already implementing elements of the approach and will incorporate the facilitators and barriers they have experienced in adopting collaborative ways of working.

Following the publication of the public health place-based approach for England, the Health and Justice Team will host a system leadership event towards the end of 2019. System leaders from across health and social care, local government and police will be invited to attend the event which will facilitate and encourage place-based conversations about the implementation of a public health approach to preventing and tackling serious violence.

Developing a whole system approach to support collaborative work to improve outcomes for vulnerable children and young people – Project CAPRICORN

The number of children and young people in contact with the CJS in England has been decreasing, but the reoffending rate remains high at 40.9% [20]. There has been a recent sharp increase in youth violence and knife crime and a growing number of vulnerable children involved in gangs and county lines [21,22]. The reasons for this increase and the risk factors for offending are often multi-factorial.

Children who experience adversity in childhood are more likely to become victims or perpetrators of criminal offences than people without these vulnerabilities. The **Lammy review** highlighted the disproportionality of Black, Asian and Minority Ethnic (BAME) young people within the youth justice system, indicating a 16% increase in the proportion of BAME young people in the last 10 years, as well as an increase in first time entrants and levels of reoffending [23]. The **Timpson review** on school exclusion has also highlighted that there are groups of children who are more likely to be excluded compared to others, including children with some types of Special Educational Needs, those who have been supported by social care or are disadvantaged, black minority ethnic groups, gypsy or Roma and Travellers of Irish heritage [24]. The review also highlighted that fixed period and permanent exclusion can, rather than providing an intervention point to get the right support in place, entrench poor outcomes for vulnerable children. The HM Chief Inspector of Prisons, wrote in 2015: "We cannot ignore the link between mental health and school exclusion. We cannot ignore the link between school exclusion and entrance into the CJS. When children are excluded from school it should trigger an alarm that this child needs extra support and help" [25].

One of the solutions lies in taking a long-term, multi-sectoral public health approach and investing in prevention, ensuring vulnerable children and young people get the support they need and are provided with opportunities to flourish. A whole system approach at a local level helps to bring organisations together to work towards providing these children with:

- ‘an alternative narrative’
- to build and enhance ‘protective factors’
- to increase their resilience and above all to give them an alternative path in life with positive outcomes

As the **Timpson review** highlights, “effectively ensuring children, particularly vulnerable children, are properly engaged in education will help to ensure children avoid becoming at risk in the first place, tackling the root cause and not just the symptoms of disengagement as they arise” [24].

Approach

To tackle these issues, a range of stakeholders from across academia, national and local government and the third sector combined efforts to develop a resource outlining a public health approach to preventing children offending and reoffending. A Steering Group Committee and focus groups were set up with representation from policy, commissioning and provider organisations, including:

- Public Health England
- Ministry of Justice
- Home Office
- Youth Justice Board
- Department of Health & Social Care
- Department for Communities
- National Health Service England
- The Office of the Children’s Commissioner
- Thames Valley Police
- Revolving Doors
- Exeter University
- Gloucestershire County Council

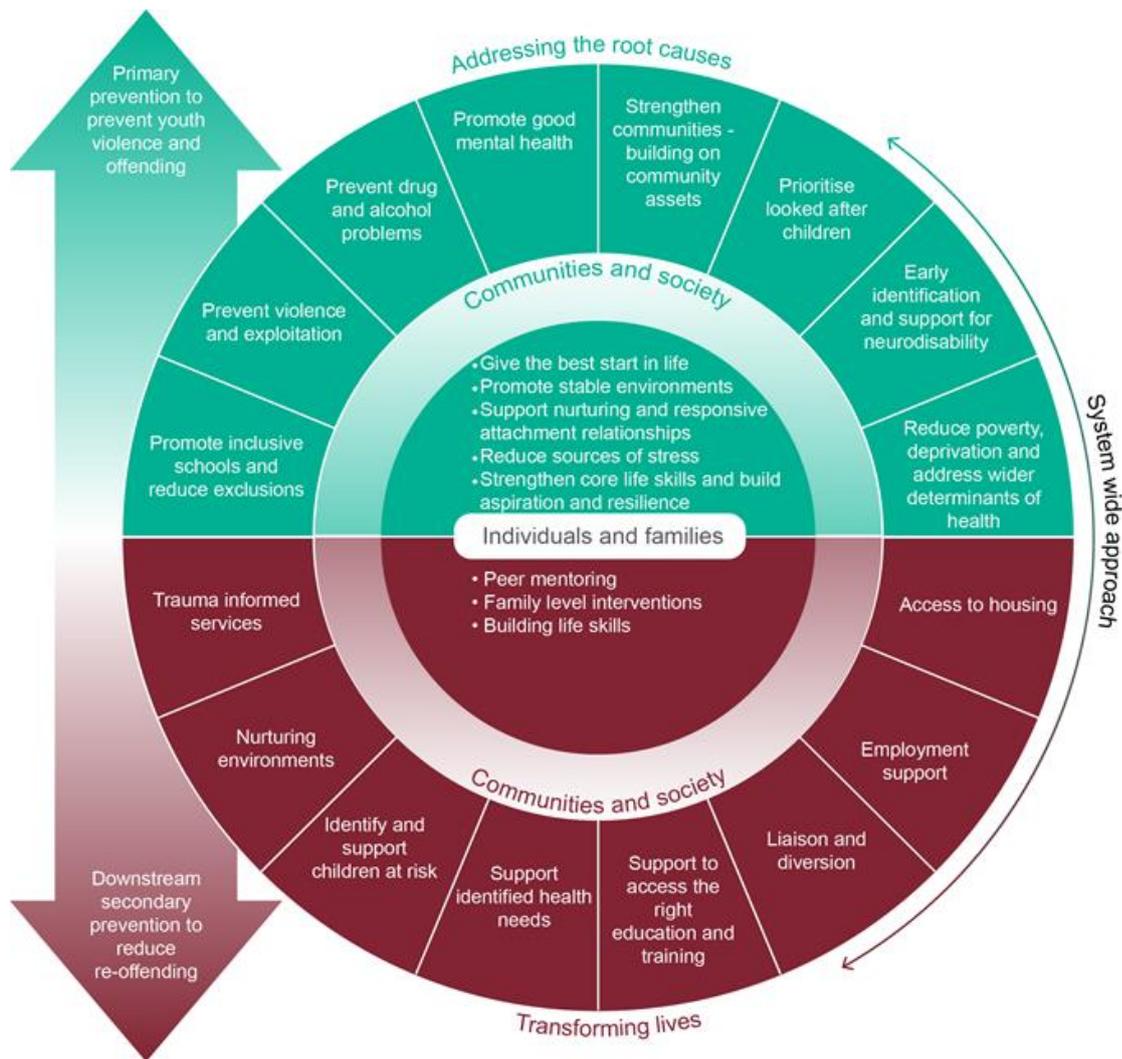
A rapid review of evidence relating to preventing offending and reoffending, and youth violence was carried out. A rapid review is a form of knowledge synthesis in which components of the systematic review process are simplified or omitted to produce information in a timely matter.

This has been complemented by a ‘deep dive’ approach informed by qualitative interviews with key stakeholders, a series of workshops at a national and local level to gain insight from main stakeholders who work in the system as well as qualitative interviews with children in contact with the CJS and. A small editorial committee reviewed the development of the framework.

Impact

The Collaborative Approaches to Preventing Offending and Reoffending in Children (CAPRICORN) (to be published in Summer 2019) resource outlines a public health approach to preventing children offending and reoffending, which starts with the local data and identifying risk and protective factors and introduces a framework to guide action in a collaborative and whole system approach. The framework illustrates areas to focus upstream and downstream prevention that can be undertaken at individual, family and community levels. It outlines the key aspects of a place-based, whole system approach, which can be adapted to suit the local area (Figure 1). The resource also highlights relevant literature and guidance which is applicable to taking a public health approach to preventing youth offending and reoffending and violence. It provides an overview and helps to point readers who wish to have a more comprehensive understanding into different action areas to the relevant more detailed guidance.

Figure 1. The CAPRICORN framework (source: PHE)



PHE promotes a life course approach to improving health and well-being, and CAPRICORN illustrates how important it is to start with upstream prevention and early intervention, giving children the best start in life and supporting especially the most vulnerable of children. There are many points along the pathway where children become vulnerable and it is the role of local authorities, Police and Crime Commissioners (PCCs), Directors of Children's Services, Directors of Public Health and voluntary groups to ensure that agencies are working in a collaborative way, sharing information and giving all-round support to vulnerable children. Strong, cohesive communities are part of the solution. This resource encourages local areas to use the skills and assets available in the local area to develop innovative approaches to work together to improve the life chances of vulnerable children and to build community resilience.

Data and intelligence

Our work is facilitated by the availability of robust data and evidence on the health of people in contact with the criminal justice system.

Prison healthcare services are commissioned by NHS England against national service specifications which are evidence-based and informed by an understanding of the health needs of prisoner populations through a rigorous process of health needs assessment using a **toolkit** designed by PHE.

The **SystemOne Offender Health module** is a healthcare informatics system that supports healthcare provision in custodial settings. Currently, the Offender Health Module can only share patient data/records between prisons.

Informing public health action

During the global hepatitis B vaccine shortage that lasted from 2017 into 2018, there was a need to access actual data on the number of people in prison who had received the vaccine to inform maximum monthly ordering quantities (MOQ) and preserve stock for allocation to priority groups. It was essential that the quota for people in secure environments was based on accurate need and data extracts on vaccine use for a 3-month period before the shortage were obtained from SystemOne to derive the MOQ. A final MOQ of 20 doses per month was assigned to each prison with protocols in place to override this restriction in the event that demand exceeded supply.

Performance against service delivery requirements in custodial settings is monitored through collection of data via the **Health & Justice Indicators of Performance (HJIPs)**, a set of performance metrics co-designed by PHE, NHS England and HMPPS informed by SystemOne

Informing public health action

Following implementation of blood-borne virus 'opt-out' testing across the prison estate in early 2018, HJIPs data has been used to identify attrition points along the care pathways for hepatitis B/C and HIV thereby informing testing/treatment optimisation. Information collected from the HJIPs regarding flu vaccine uptake has also proven useful during influenza outbreaks by providing an accurate picture of what proportion of the population of an effected prison is likely to have been vaccinated and thereby helping to inform the type of infection prevention and control measures to implement.

Information on drug and alcohol services is gathered via PHE's **National Drug Treatment Monitoring Service (NDTMS)** which is used by commissioners and service providers to understand health needs of drug and alcohol treatment services as well as how well health services provided meet those needs.

Surveillance information on notifiable/reportable communicable disease incidents and outbreaks in PPDs across England and Wales is collected in near to real time by the National Health and Justice team through reports received from Centre HPTs and PHE Enhanced TB Surveillance system.

Informing public health action

Surveillance data on the number of outbreaks and their impact is collected centrally by the National Health and Justice Team and this helps to inform real-time operational response as well as support planning and preparation. This intelligence has helped colleagues at HMPPS during the last flu season to coordinate population movements throughout the prison estate and has informed which establishments could reasonably be temporarily closed in light of ongoing infection.

These sources of data are complemented by comprehensive **sociodemographic and offending statistics** routinely collected by the MoJ and covering the entire English and Welsh prison estate.

The Health and Justice team also provide strategic leadership and oversight on cross-organisational work streams relating to information, intelligence and evidence by chairing the cross-organisational Data, Evidence and Intelligence (DEI) Group. This work helps to support improvements in understanding the health needs and quality of health services delivered to people in PPDs.

Upcoming developments to the custodial health informatics system

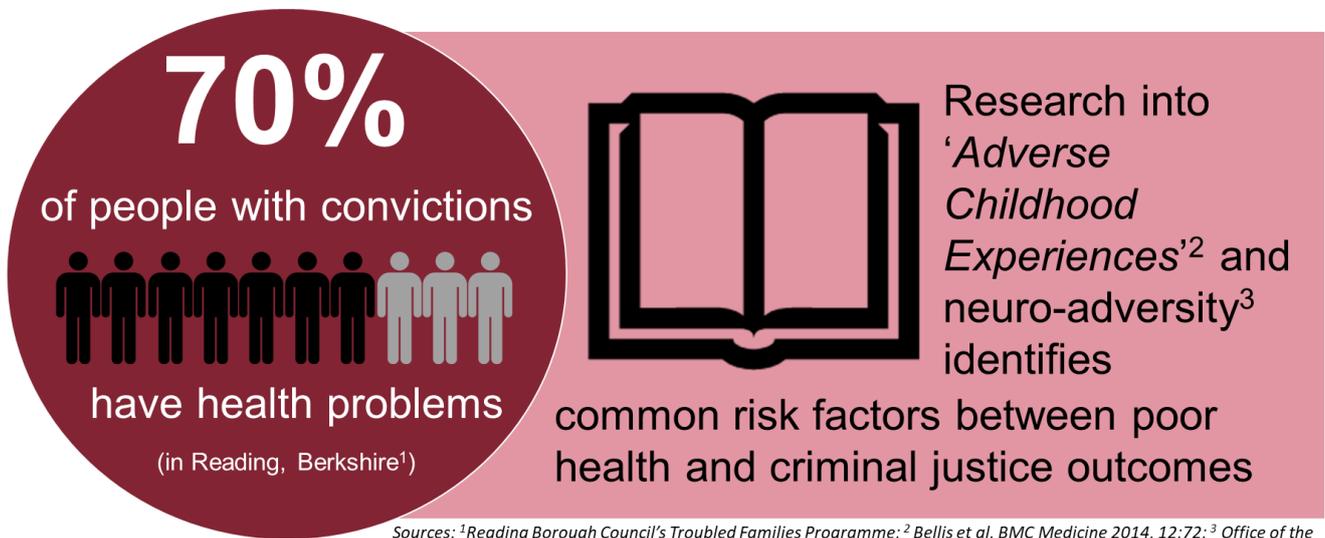
NHS England is improving the existing custodial health informatics system in England, known as SystemOne, to deliver a continuous healthcare record for those who go into residential criminal justice settings including prisons. This will be a major step forward in patient safety and will facilitate continuity of care. The system will enable automated global extraction of patient level data and introduce a number of other new functionalities.

1. Connection to the NHS Spine (the central NHS IT system in the community) as a prerequisite for GP registration by mid-2019 (see Box 2 below).
2. The full electronic transfer of patient medical records between the secure estate and the community by early 2020.
3. Electronic Referrals Service, Electronic Prescribing Service, GP Extraction Service, and Summary Care Record (eRS, ePS, GPES & SCR) by end of 2020.

Box 2: Using information technology to improve patient continuity of care beyond the custodial estate

Spine enablement, especially GMS registration and GP2GP functionality, will make a big difference to continuity of care. When patients GMS register on arrival in the residential estate, the GP2GP functionality will automatically transfer-in their clinical records from their last GP in the community, just as if the patient were moving from one surgery to another. On release from the residential estate, the full clinical record will transfer to the patient’s GP when they register back in the community.

The ‘Reading Model’



Given the strong associations between health and criminogenic behaviour, a project took shape to share information and identify risk factors across Reading’s ‘harmscape’. The outcome of which is to use the Public Health Approach (see reference [5]) ‘to problem solving and get support in place from a range of cross-sector partners in order to prevent harms from taking a grip.

A local governance arrangement was put in place whereby the ‘Troubled Families Management Board’ would take the lead for information sharing, including establishing protocols and conducting analysis to:

1. Describe what is happening in our communities, here and now, in order to respond more quickly and effectively to need.
2. Share appropriate information as soon as possible rather than waiting for referrals to be made.
3. Test, learn, and adapt to ‘what works’ by ‘working together, together’ and driving efficiencies and improving services by understanding risk and preventive factors and preventing unintended negative consequences of ‘working together, apart’,

4. Develop forecasting so people and places of highest risk of harm attract urgent support.
5. Enable a 'whole place' approach to issues of concern.

Key initial partners were:

- Thames Valley Police (its Reading Local Police Commander chaired the Management Board)
- Reading Borough Council (now Brighter Futures for Children)
- Department for Work and Pensions
- Royal Berkshire NHS Foundation Trust
- Reading Voluntary Association
- Reading Clinical Commissioning Group

A joint Information Sharing Agreement was developed and PHE joined as a Strategic Partner in 2018.

This work has been supported by a series of national workshops that have grown and are joint-chaired by Thames Valley Police and PHE, linked to the Policing, Health, and Social Care Consensus ^[3] outcomes and attended by a wide group of practitioners, academics, and policy makers from all sectors.

New multi-agency governance and delivery models have been created in Reading as a result of all of this work and the 'One Reading' Prevention and Early Intervention Partnership is now leading service transformation and the delivery of the 'Local Consensus'. Work is now underway to imagine ways of taking the Reading Model to scale across the country.

Protecting health in custodial settings

Summary of health protection incidents/outbreaks reported 2018/19

PHE’s Health and Justice team collects and collates data reported by health protection teams (HPTs) in PHE Centres across England and uses this intelligence to inform key stakeholders of new incidents and outbreaks in the secure and detained estate. A summary of reports received over the course of the last financial year is provided below.

Notifiable/reportable infectious disease incidents in prescribed places of detention reported to PHE Health & Justice surveillance by Centre health protection teams from April 2018 to March 2019, inclusive

Incident	HMP	IRC	Other
Hepatitis A (acute)	1		1
Herpes zoster (shingles)	5	6	
Invasive group A streptococcus (iGAS)	8		
Meningitis	1		
Mumps	2		1
Other	1		
Salmonellosis (Salmonella enterica)	2		
Staphylococcus aureus / PVL	1		
Tuberculosis (pulmonary / extrapulmonary)	35	3	1
Varicella (chickenpox)	4	2	
Total	60	11	2

Infectious disease outbreaks in prescribed places of detention reported to PHE Health & Justice surveillance by Centre health protection teams from April 2018 to March 2019, inclusive

Outbreak	HMP	IRC	Other
Diarrhoea / vomiting	19	1	1
Influenza	14	2	
Mumps	2		
Scabies	1		
Skin/soft tissue infection	5		
Tuberculosis (pulmonary)	1		
Varicella (chickenpox)	1		
Total	43	3	1

HMP: Her Majesty's Prison; IRC: Immigration detention centre; Other: bail hostel or secure children's home

Key health protection incidents 2018/19

Bacterial wound infections

An increase in cases of bacterial infections caused by Group A Streptococcus (GAS) among people in prison was reported across England in early 2019. Six clusters of infection, primarily wound infections, were initially reported to the Health and Justice team in prisons across Yorkshire and Humber, the North West, the East and West Midlands and the South West. Typing of samples collected from patients in affected

prisons has indicated shared strain types (predominantly emm 108.1 and 66.0). emm 108.1 has been associated with infections in people who inject drugs (PWID) and homeless people in recent community clusters and there are links between prison cases and these risk groups. In some of these GAS clusters there have also been coinfections with *Staphylococcus aureus* (MRSA and MSSA).

An initial national IMT was convened on 5 April 2019. The Health and Justice team has regularly participated in the respective regional outbreak control team meetings convened to manage clusters of infection in prisons as well as the national IMT. Further, Health and Justice have produced **guidance** aimed at Healthcare, custodial staff and responding HP services on managing clusters of skin and soft tissue infections in prescribed places of infection ^[26]. Centre HPT teams are also working closely with prison healthcare teams to identify any specific risk behaviours, transmission routes or common exposures by interviewing prisoner cases using a specially developed 'trawling' questionnaire.

Major health protection programmes 2018/19

Elimination of hepatitis C in the prison population in England

Following successful implementation of BBV opt-out testing in all adult prisons in England in March 2018, PHE Health and Justice have been working closely with national partners to improve treatment outcomes for prisoners. NHS England aims to eliminate hepatitis C in England by 2025 or sooner and, to this end, finalised a **medicines procurement deal** with the pharma industry in January 2019 worth nearly £1 billion for the supply of directly acting antivirals (DAAs) over a potential period of 5 years ^[27].

Eradicating hepatitis C in the prison population will be crucial to meeting national elimination targets, and PHE Health and Justice, together with national partners that include NHS England, HMPPS, the pharma industry and third sector agencies, have been involved in the planning of a strategic delivery plan for the testing and elimination of hepatitis C in prisons in England. The programme aims to cover 30% of prisons per year starting with select establishments where at least 80% of all prisoners will be tested over a 2-week period. Operational Delivery Networks (ODNs) will also be part of delivery so patients will have instant access to treatment.

To maximise engagement with all stakeholders involved in the initiative and improve patient outcomes, a series of multi-stakeholder workshops have considered the utility of point of care testing (POCT), process mapping DAA provision and dispensing in prisons and data capture/reporting. These workshops will also inform the 'go-live' date for the elimination initiative in 2019.

HPV vaccination of MSM in prison

Human papilloma virus (HPV) is spread through sexual intercourse and skin-to-skin contact of the genital areas and associated with a range of cancers including anal, oropharyngeal and penile cancers. Men who have sex with men (MSM) are thought to be at particular risk of developing these types of cancers.

HPV vaccination is available for MSM in the community but dependent on people self-identifying as MSM and then seeking vaccination through designated sexual health services. Identifying people as MSM in prisons, an environment where such behaviour is both stigmatised and not permitted, is likely to negatively impact on vaccine uptake rates. To overcome this challenge, the Prison Health Care Board for England has approved testing the offer of HPV vaccine in prison on an 'opt-out' basis following success with this approach for blood-borne virus testing in the prison estate.

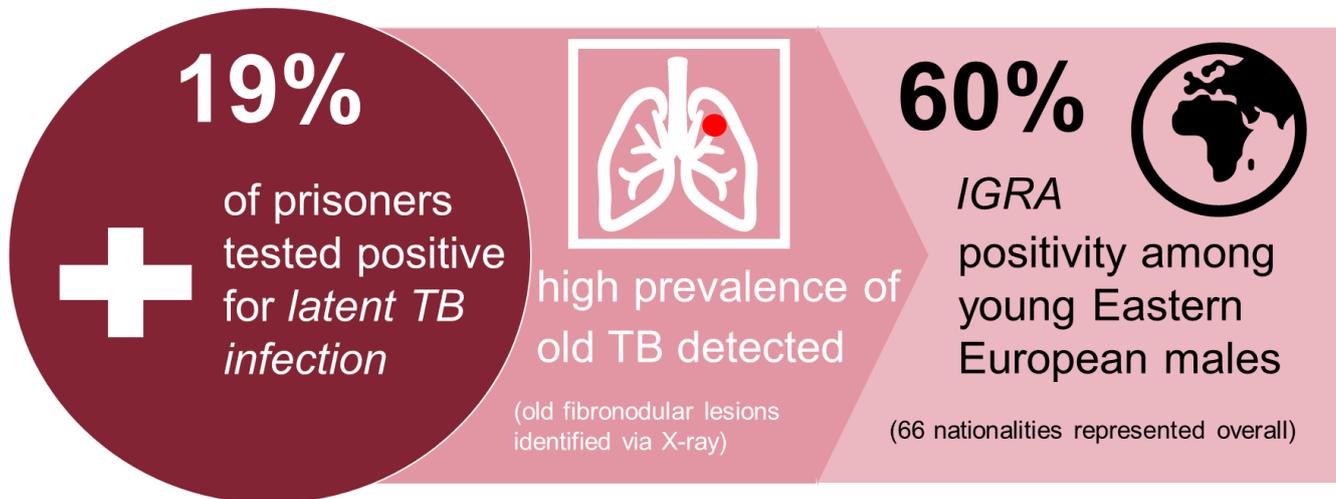
To this end, PHE together with NHS England and HMPPS have been working to implement a feasibility study that will be undertaken in 6 pathfinder prisons (3 in London and 3 in the South of England) in financial year 2019/20 to test the model of delivery and gather data on coverage in prisoner populations. First doses are expected to be offered in Q2. A further 3 pathfinder sites will be identified and tested in another region following the initial testing phase. The programme will be considered for national rollout based on results from pathfinder sites.

Testing for LTBI in the prison population

Foreign national prisoners in England are particularly at risk of TB infection and most active TB cases in England are thought to result from the reactivation of disease in persons with latent TB infection (LTBI). The National Institute for Health and Care Excellence (NICE) has recommended LTBI testing and treatment for people in prisons to be undertaken in 'high-risk' individuals, such as prisoners and foreigners from high TB incidence countries. The National Prison Health Care Board accepted LTBI testing in prisons in January 2017 as a means of preventing cross-transmission of disease and protecting the health of both prisoners and staff working with high-risk populations.

A 'pathfinder' programme for LTBI testing and treatment has been developed by PHE Health and Justice in collaboration with regional HPTs, NHS England and UCL's Find & Treat programme. The pathfinder will be implemented in 2 phases that will test the feasibility of a LTBI testing and treatment programme in prisons and inform future rollout of the programme across the wider English prison estate. Phase One (February and June 2019) took a census approach where all consenting eligible prisoners in the 2 FNPs were tested during a specific time period by UCL's Find and Treat Programme (see important findings below). Phase Two will examine the 'care pathway' approach where all new receptions will be offered testing for LTBI as per NICE guidance and will be implemented during financial year 2019/20 informed by findings of the first phase.

Important findings from Phase One of LTBI screening programme in a foreign national prison:



Managing the risk of blood-borne virus infection in emergency workers

The [Assaults on Emergency Workers \(Offences\) Act 2018](#) ^[28], prompted PHE and its partners to review current guidance and advice on emergency workers potentially exposed to risk of infection with blood-borne viruses (BBVs) following assault. There appeared to be more concern about the risk of transmission of BBVs than evidence suggested there need be, leading at times to stressful situations for the emergency workers, due to lack of understanding of infections and perpetuations of stigma and myths around them. While prevention of these incidents is paramount, there is a need for coherent guidance on what constitutes an exposure event, instances where there is no risk of transmission and how potential exposures should be managed.

PHE led by the National Health and Justice team, and its partners, including representatives from all emergency worker services have set up a Task and Finish (T&F) group to develop evidence-based guidance for emergency workers following potential occupational exposure to BBVs. The T&F group is currently working on the production of a new evidence-based guidance document summarising current understanding of risk of transmission of BBVs following biting, spitting and sharps injuries.

The BBVs specifically being considered in this document are Hepatitis B, Hepatitis C and HIV. This document sets out to give clarity on the scientific evidence around risk of potential BBV exposure and outline the highest standard of care to be provided if exposure has occurred, while detailing pathways specific to each frontline service.

This T&F group supports the development and implementation of evidence-based guidance on management by healthcare providers, occupational health services and employers of potential exposures to BBVs among emergency workers. The scope of this work targets a range of emergency workers, such as:

- police officers and service staff, including private sector employees providing services on behalf of the Chief Constable
- prison and probation service personnel (including private sector employees), including health care practitioners in custody suites
- ambulance workers, including paramedics and search and rescue services
- fire service personnel
- immigration staff, including border security and immigration detention staff

Among the most important considerations of the guidance are to:

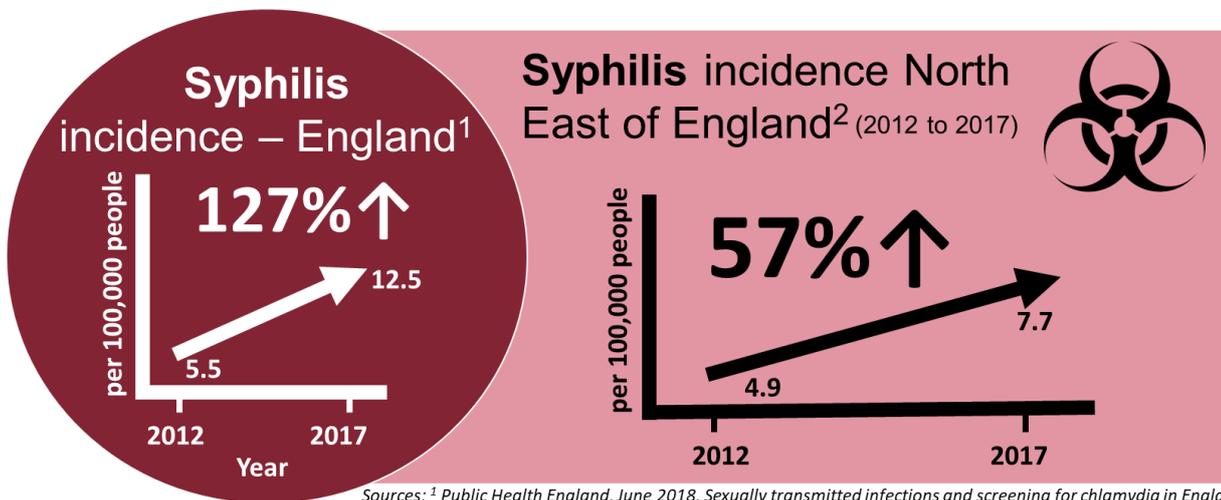
- carry out a health assessment to identify transmission of infection, including psychological support, and specific challenges the emergency workers may have acquired
- provide pathways which may impact on whether the emergency workers have been supported appropriately and understand the risk and risk perception (myth busting)
- standardise and personalise the guidance, with lived experience where possible
- include exemplars of good practice

This T&F group is simultaneously working on a communication plan to ensure that the resource is implemented regionally and locally. The stakeholders in the group will ensure that the completed document will be integrated into the work plan of the emergency worker services, and subsequently evaluated. This guidance document is scheduled to be launched in September 2019.

Regional engagement

The national Health and Justice Network is composed of representatives from the devolved administrations, the national team and public health specialists in the PHE centres who work to gather intelligence, share good practice and provide opportunities for collaboration across England and with Scotland and Wales. This section of the report provides a summary of just some of the work undertaken by Health and Justice leads in the 9 PHE Centres across England during the financial year to improve and protect health and reduce inequalities amongst people in contact with the CJS.

North East: Syphilis testing in prisons



In 2017, it was agreed by the BBV steering group (now sexual health strategic group) that given an increase in rates of syphilis in the community, further work relating to syphilis testing should be developed within the North East, based on the learning from the ‘opt-out’ BBV work done in prisons. NHS England agreed to fund a 6-month pilot and 2 potential pilot sites were identified in Durham – a busy male remand prison and a female prison.

A steering group was established to oversee the development of a universal offer of syphilis testing. A whole pathway approach was taken in planning for the pilot that would utilise dried blood spot testing (DBST) methodology to collect blood samples and would allow for incorporation of standard BBV tests as well (e.g. hepatitis B/C and HIV). Work was carried out by prison-based services to revise consent forms and develop prisoner information leaflets in preparation for implementation of the pilot. In addition, training sessions were put in place to ensure all relevant staff had a basic level of awareness of syphilis and DBST.

In the 6-month period from April to September 2018 there were a total of 1,461 syphilis tests performed within the 2 pilot sites, with 1 prisoner identified as positive for syphilis.

The pilot was extended to March 2019 and approximately 33% of new receptions took up the offer of a test during the reception process. This figure increases to 44% when engagement outside of the reception process is taken into account (based on the number of new receptions). No significant difference was seen in the rates of uptake between male and female establishments and 2 confirmed cases of syphilis have been identified to date as a result of the pilot.

Having a robust pathway between the prison and specialised sexual health services has been critical to the success of the pilot. All prisoners were seen swiftly by the community genitourinary medicine (GUM) consultant and contact tracing took place with minimum delay. Having a screening process that is focused on, but not exclusive to reception, has resulted in a more efficient use of time for the specialist prison GUM service as well as a reduction in waiting times for the service.

Further work is needed to address the relatively low uptake rate, and at present a T&F group is reviewing the current testing pathway including how the offer is framed. It is hoped that because of this work, there will be an increase in the uptake of syphilis testing going forward.

Yorkshire and the Humber: Improving continuity of drug treatment on release from prison

Only one-third of people leaving prison who have a need for ongoing structured drug treatment engage with community drug treatment services within a month of release ^[29]. PHE in Yorkshire and the Humber worked with local partners to organise workshops and take a public health approach to understanding and tackling continuity of structured drug treatment beyond the prison gates.

Three workshops were organised in partnership with NHS England and Police and Crime Commissioners (PCC) drawing in stakeholders from prisons and the community. The workshops adopted a public health approach with the following key elements.

1. System leadership: bringing stakeholders together and facilitating discussion.
2. Data: presentation and analysis of NDTMS to understand the scale of the problem, dispel myths and highlight areas to focus on.
3. Evidence: linking to the PHE Toolkit for Continuity of Care.
4. Knowledge: sharing innovative approaches, good practice, and tried and tested solutions.

Initial discussions with community commissioners suggested a disconnect. Prison providers indicated that they could not organise timely appointments for people on release while drug treatment service commissioners were not aware of any problems except for when releases were unplanned and little time was available for prison and community services to liaise. PHE brokered a meeting where NHS England commissioners, a prison governor and the lead PCC could review data on scheduled

treatment appointments that had been collected from a busy local prison. Of the 66 people released from prison that required an appointment for opiate substitution therapy, only 8 were unplanned. Nonetheless, 53 (80%) patients had to be given prescriptions by the prison to ensure that opiate substitution therapy could continue until a community appointment was provided. Discussions are ongoing to identify possible gaps in communication between prison and community treatment services so as to improve engagement with treatment uptake in the first month following release from prison.

East of England and North West: Bowel cancer screening in prisons

Older people (50 years+) are the fastest growing age demographic in prisons and comprise more than a sixth of the prison population. More than half of all prison deaths (mostly from natural causes) reported in England and Wales also occur in this demographic (see [PHE Health and Justice annual review 2017/18](#) ^[30]). To successfully promote health and wellbeing among older people in prison, various prison screening services are available. This includes bowel cancer screening (BCS) every 2 years for those aged 60 to 74 (with an opt-in programme from age 75+). In England, bowel cancer is the second most common cause of cancer death accounting for 10% of all cancer deaths in the general population, and limited evidence suggests that the incidence of bowel cancer in prisons is higher than in the community ^[31].

Prior to 2015, very few prisons in the English/Welsh prison estate were offering routine BCS to prisoners. Recognition that uptake was low and inconsistent across the 15 prisons in the North West and 14 prisons in the East of England triggered the respective Centre Health and Justice teams in partnership with various stakeholders including NHS England commissioners, HMPPS prison staff to develop and implement BCS pathways across all prisons and provide access to bowel screening kits.

In the East of England 3 prisons were initially selected to pilot the new pathway in 2016 and a multi-disciplinary implementation group evaluated the pilot sites being mindful of the prison operational environment and the needs and confidentiality requirements of the patients. Experiences from the 3 pilot sites were used to inform the national roll-out of BCS in prisons across England and Wales during 2017/18, and by May 2018 full roll-out was achieved in the East of England and North West prison estates.

BCS programmes saw further optimisation over the course of financial year 2018/19. Changes in data requirements and proposed new screening kits and methods of notification were implemented and activity reports for individual prisons as well as the East of England prison estate were developed.

To support improved programme uptake, the North West Centre undertook a qualitative evaluation of BCS across the North West prison estate to identify examples of good practice as well as barriers to screening and gaps with the aim of optimising services. A mixed method survey was used including an electronic questionnaire and interviews with healthcare staff, prisoners and the head of implementation for the national PHE Cancer Screening Programme. A report (not published ^[31]) of the key findings was

produced by the North West HPT identifying a high willingness on the part of prisoners to undertake screening and the essential role of healthcare and prison staff in working with prisoners to improve their overall health. Further recommendations from the findings will be considered by the North West Prison Partnership Board as part of its continued planning to improve the uptake of BCS.

East Midlands: Continuity of care in oral health for people leaving secure settings – a model oral health pathway

People residing in PPDs have significantly poorer oral health compared to the general population made worse by lifestyle factors such as alcohol, tobacco and substance misuse as well as a high consumption of sugary food and drinks. Untreated dental decay is 4-times higher in the custodial population than in people in the community due to a lower propensity to seek adequate treatment in the former ^[32]. Longer incarceration periods and a higher frequency of remand are also associated with poorer oral health. Some individuals are seen for dental treatment whilst in custody/detention but this can depend on various factors including the urgency of their problem, type of treatment required, waiting times, type of establishment, incarceration/detention period as well as their personal preference in seeking dental care.

Within the East Midlands, PHE, NHS England health and justice commissioners as well as commissioners and providers of healthcare and oral health, probation services, Community Rehabilitation Companies (CRC) and third sector organisations formed a working group to develop and consult on the development of a continuity of care oral health pathway for persons leaving prison/PPD.

Barriers to continuity of oral healthcare were identified through survey responses and extended discussions with stakeholders via telephone and face-to-face meetings. Several of these such as lack of oral health referral pathways, limited oral health promotion, poor integration between dental and other healthcare staff, limitations in sharing dental records on release and challenges in accessing dental care in the community, have been identified in similar work undertaken nationally across the UK ^[33]. Further, the work has brought to light a few specific issues for example: an oral health assessment is not always conducted at reception which may result in delays in receiving dental treatment. Pre-release planning doesn't always happen due to reasons such as insufficient notice of release date – patients being released directly from courts and remand centres and links between prison/PPD oral health providers and community oral health providers are not well established.

The model provides PPDs in the East Midlands with a framework around which to develop their own pathways to be integrated within existing health and social care pathways to provide a holistic care approach. The document that has been produced and distributed amongst PPDs in the region (unpublished), aims to close the gap in the continuity of oral healthcare for adults through an integrated oral health pathway from

the PPD into the community and highlights the challenges faced by individuals leaving PPDs by facilitating oral health continuity of care upon release.

A number of gaps were identified by the working group and recommendations were made on how they can be addressed prior to sentence commencement, while in custody/detention and after release. Improved training opportunities, raised awareness of challenges and barriers as well as sustainable partnership working between and across all staff in custodial/detention settings, community services and third sector organisations is key to achieving success and reducing health inequalities in this vulnerable group.

West Midlands: Improved data for improved outcomes for young offenders

Children and young people who offend are a marginalised group who often experience adverse health, educational, environmental and socioeconomic factors that increase the risk of offending and reoffending behaviour. Their health needs are often complex and are greater than those of the non-offending population. However, it is unclear what work had already been done in collating existing evidence on the health profile of young offenders both within and outside of custody. In May 2018, The West Midlands Local Knowledge and Information Service undertook a work programme to piece together publicly available information that exists around the health profiles of young offenders nationally and in the West Midlands to produce a Health and Justice, children and young people's data compendium that could be used to inform local planning for remodelling of the care pathways for youth justice and welfare.

Key evidence showed the number of children from looked after care that come into the justice system and is being used to argue for a local facility rather than sending children in secure care out of area. The report (unpublished) also highlighted the increasing level of violence within prison establishments in the West Midlands.

London: Protecting health through best practice and training

To ensure an efficient response to communicable disease outbreaks in PPDs and test the resilience of the wider secure estate when an outbreak is declared, PHE Centre HPTs are encouraged to regularly organise multi-stakeholder 'tabletop' exercises in which 'real-world' outbreak scenarios can be considered through face-to-face interaction. Such exercises provide an opportunity to:

- outline the associated roles and responsibilities of stakeholders in managing outbreaks
- highlight any threats and the consequences of communicable disease outbreaks in PPDs and their knock-on effects on the secure and detained estate and community (such as in the event of a prison closure or need for decanting)
- assist in the development of effective multi-agency communications through the inclusion of a wide variety of partners/stakeholders

- promote intelligence sharing and strengthen support networks
- help all partners understand each other's roles and responsibilities and test current tools (for example, guidance) are fit for purpose

Over the course of the last 2 financial years (2017/19), the PHE London Centre health protection and health and justice teams have organised tabletop outbreak exercises at 6 different adult prisons and an IRC in the region. The exercises considered the impact of seasonal influenza and gastrointestinal outbreaks on each establishment and included representation from a wide array of partners and stakeholders.

Common themes identified included:

- the importance of robust intelligence gathering at outbreak onset
- division of, or alternating, OCT chairing responsibilities between HP and secure estate colleagues to enable more targeted discussion given limited capacity of staff
- available contingency arrangements in case of kitchen closure may include a complete pop-up kitchen available at short notice – but costs could be prohibitive
- how isolation of cases can impact on their wellbeing/morale, and how clear communication with prisoners/detainees around the risks of not reporting sign/symptoms of illness can mitigate any underlying fears

Recommended guidance

Multi-agency contingency plan for disease outbreaks in prisons:

<https://www.gov.uk/government/publications/multi-agency-contingency-plan-for-disease-outbreaks-in-prisons>

South East: Reducing TB in prisons

The majority of active TB cases in England likely result from the reactivation of disease in persons with latent TB infection (LTBI), an asymptomatic and often prolonged phase of infection. LTBI can be diagnosed by a single, validated blood test, and is usually treated with antibiotics, thereby preventing active TB disease in the future. A history of incarceration is considered a social risk factor for TB infection and the prevalence of disease in prison populations is several times higher than that found in the community. It is estimated that the burden of disease is likely to be even higher in the foreign national prison (FNP) population, who without intervention will contribute towards the continued spread of TB within prisons and the wider community, posing a serious public health risk.

To reduce such risk, the National Institute for Health and Care Excellence (NICE) has recommended LTBI testing and treatment for people in prisons to be undertaken in 'high risk' individuals and a 'pathfinder' programme for LTBI testing and treatment has been developed by the Health & Justice teams at PHE and NHS England working with

HMPPS for implementation across 2 FNPs in the last quarter of 2018/19. The pathfinder was meant to collect information on current disease prevalence in prisons while testing the feasibility of LTBI testing and treatment in prisons with lessons learnt informing future development of the programme across the wider English prison estate.



Staff from Care UK, Find and Treat, Oxford Immunotec, HMP Huntercombe, PHE South East and NHS England

On 25 February 25, the first pathfinder testing week was undertaken in 1 FNP, which included utilisation of the mobile X-ray unit provided by the 'Find and Treat' service from University College London Hospital. In total, screening and Interferon Gamma Release Assay (IGRA) testing, undertaken by Oxford Immunotec, of 258 prisoners was undertaken. Alongside the pilot, the healthcare

team at HMP Huntercombe, provided by Care UK, carried out a 'Well Man Week', providing health and wellbeing support to the prison population, sexual health clinics and screening for chlamydia, gonorrhoea and syphilis. The team also provided an opportunity for eligible prisoners to receive MMR and MenACWY vaccinations.

Final results from the week showed a 19% positivity rate for LTBI (see Chapter 4 for full results). Alongside LTBI testing, BBV testing for HIV and Hep C, identified previously undiagnosed disease in 1 case of HIV as well as 1 case with HCV infection – both were engaged in appropriate treatment programmes.

This approach was repeated in a second FNP in the South East in June/July 2019. The second phase of the pathfinder programme will be implemented during financial year 2019 to 2020 and will test the 'care pathway' by offering LTBI testing to all new prison receptions, as per NICE guidance.

South West: Collaborative approach to tackling flu in secure settings

Flu in prisons poses the risk of significant and potentially more serious outbreaks than in the community. Prisons have a large population of people living in close proximity who transfer into and out of the community or to other prisons frequently.

The flu season 2017/18 saw a large number of confirmed outbreaks of influenza in secure settings, although there were confirmed outbreaks across the estate the concentration was in establishments in the North West and the South East. In the South

West, there was constant monitoring of flu activity across the wider communities and there were a small number of confirmed flu outbreaks very late in the season. Despite staff were prepared and active throughout flu season, the outbreaks were somewhat unexpected and presented challenges around access to Tamiflu and additional vaccines.

As part of evaluation and lessons learned, the strategic flu lead runs a workshop event which draws together all professionals across the South west and prison staff and health staff are encouraged to attend along with HMPPS leads. Discussion was around the merits of drawing together a representative group from health and prison chaired by Centre screening and immunisation leads for the 2018/19 flu season.

The approach for the flu season 2018/19 was to pull together a network to support implementation and monitor uptake of flu vaccines. This involved sharing this message and validating the importance at the partnership boards through the prison and health governors and Managers. As a NHSE H&J model, the Commissioners had established a group linked across the South for us a strategic leads to assure they were clear about the activity and impact of flu across a wider geography, which in the SW we were able to feed in from the start with the established group and share the template being used for data collection and the checklist was being used across the South. An addition to this was the premise for mass flu vaccination pilot which will be implemented for the season 2019/20.

The positive impact was the engagement for education and training, feedback around challenges for data collection and regular attendance by a sizeable group

From 2018/19 we had already drawn out how the establishments work and interpret things differently, with one area working to the letter and the other flexing the definition to make sure individuals who work with older populations as buddies are included as carers to reduce risk of transmission.

International engagement

International prison health: UK Collaborating Centre for the WHO Health in Prisons Programme

PHE's national Health and Justice team holds WHO Collaborating Centre status, complementing the 10 other WHO collaborating centres PHE holds as part of its international portfolio.

This section highlights the key achievements of the UK Collaborating Centre WHO Health in Prisons Programme in 2018 to 2019, focussing on the central international objectives of supporting policy development through strengthening global health activity with prisons, creating a prison public health dataset for surveillance and intelligence, and building capacity in research and professional development.

Presentations

- International Committee of the Red Cross Prison Research training, Switzerland
- National Monitoring Centre for Drugs and Addiction & the General Directorate of the Prison Service, Czech Republic
- Law Enforcement and Public Health 2018 conference, Canada
- International Counselling in Prisons Network, UK
- ICRC 2nd Asian Prison Health Conference, Cambodia
- Mapping Prison Healthcare Inequalities Worldwide, ICPR and Birkbeck University, UK
- EMCDDA Drugs and Women in Prison, Portugal

Expert groups and evidence submissions

- Penal Reform International – Mental Health for Women in Prison
- UN Study of Children Deprived of Liberty
- PAHO Commission on health inequalities in the Americas
- WHO Health In Prisons Steering Group – Non Communicable Diseases in Prisons
- UNODC – Mother-to-child transmission of HIV in prisons in sub-Saharan Africa
- British Foreign and Commonwealth Office – Medicines management and drug use in prisons for British Overseas Territories

Publications

Tavoschi, L., O'Moore, E.J. and Hedrich, D. (2019).

Challenges and opportunities for the management of infectious diseases in Europe's prisons: evidence-based guidance. *Lancet Infectious Diseases*, 19 March 2019.

Tran, N.T. et al (2018).

Words matter: a call for humanizing and respectful language to describe people who experience incarceration. *BMC International Health and Human Rights*, 18 ⁽¹⁾.

Five Nations' Health and Justice

This year meetings were held in England, Republic of Ireland and Wales. The 5 Nations Collaboration has been working together on a peer-reviewed article on the importance of data, evidence and intelligence and issues to consider in developing a prison health data system.

Leave no one behind: Developing a WHO Health In Prisons Action Plan

At the end of 2017, WHO HIPP welcomed a new WHO programme lead, Dr Carina Ferreira-Borges. This year, the UK Collaborating Centre has been working with WHO and the HIPP Steering Group to develop an action plan for the coming year, promoting prison health as public health and the importance of prison health contributing to addressing the Sustainable Development Goals.

Strengthening coordination of global prison health: 6th Prison Health Conference, Helsinki – March 2019



PHE co-produced and delivered the 6th Prison Health Conference in Helsinki, Finland with WHO Europe and the Finnish government. The conference was opened by Dr. Veli-Mikko Niemi, Director of the International Affairs, Ministry of Health and Social Affairs, Dr. Bente Mikkelsen, Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for

Europe, and Andrea Huber, Deputy Chief, Rule of Law Unit, OSCE Office for Democratic Institutions and Human Rights.

The importance of prison populations contributing to Sustainable Development Goals (SDGs), universal healthcare coverage and human rights framed the conference proceedings.

The conference was attended by 100 senior delegates representing public health agencies, prison health systems, academics working in public health and criminology, clinicians working in prisons, and patient advocates from across the globe including Australia, Azerbaijan, Canada, Denmark, Finland, France, Germany, Ghana, Republic of Ireland, Italy, Latvia, Nepal, Netherlands, Poland, Portugal, Romania, Russian Federation, Spain, Switzerland, Ukraine and UK and the USA.

The conference was also attended by senior officials from UNODC, WHO Regional Office for Europe, Council of Europe, OSCE, EMCDDA, ICRC, Penal Reform International and several international patient advocacy & reform non-governmental organisations.

The conference showcased best practice internationally on management of:

- communicable and non-communicable diseases in prison
- programmes to support continuity of care and transition from custody to community peer-led mentoring and health education programmes
- a quality improvement framework for prison health

PHE and WHO Europe will be working together to publish the conclusions of the Helsinki conference in 2019.

Health in Prisons European Database: a minimum public health dataset for prisons

PURPOSE: To provide comprehensive, consistent and reliable public health data on prison populations and their health needs across WHO European Region Member States and support Member States in identifying areas where preventive and treatment efforts are needed.

The UKCC WHO HIPP has supported WHO to develop the indicator set and survey for the HIPED data collection in 2017 to 2018. This year the UKCC supported WHO in development of country profiles from that data collection. The country profiles for prison health of 38 WHO Europe Member States can be found in this report:

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2019/health-in-prisons-fact-sheets-for-38-european-countries-2019>.

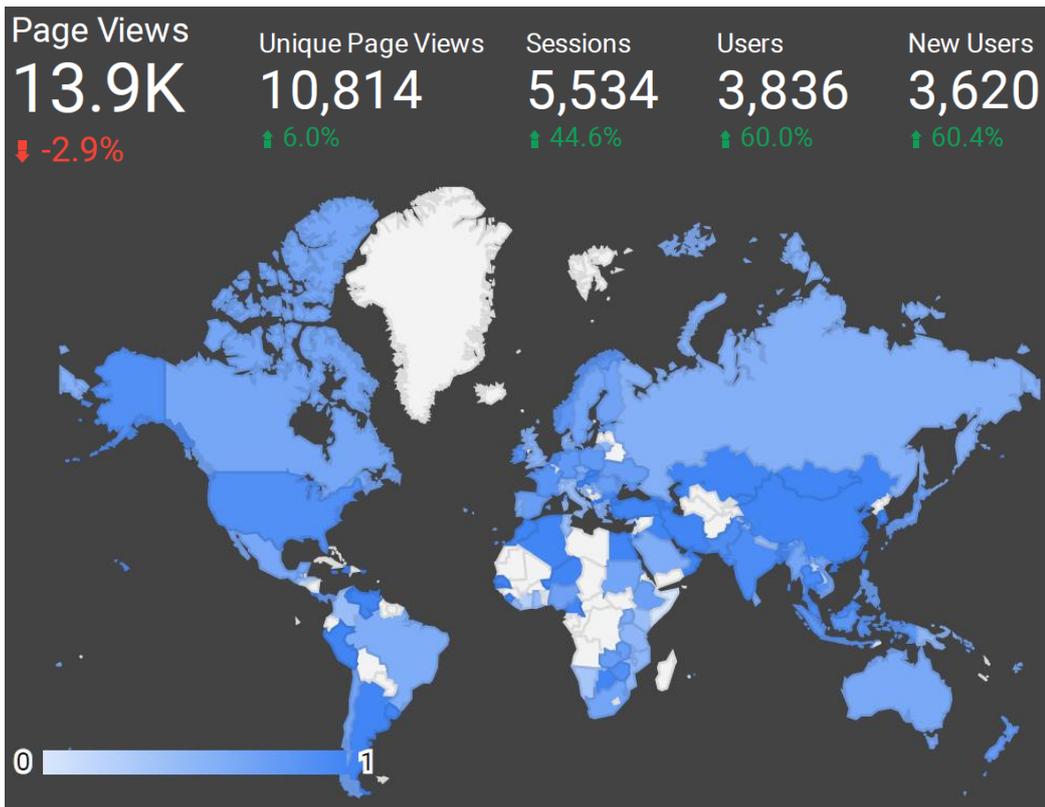
The UKCC is part of the newly formed Technical Expert Group for HIPED with academic institutions and other international organisations to develop the HIPED indicator set and improve data collection for the next iteration of HIPED. The database enables the opportunity for the development of standardised prison health informatics platforms that will help to provide a clear picture of the health of prisoners across Europe and the integration of healthcare programmes as a result

WEPHREN: building international research and professional development capacity

To ensure evidence-based practice in implementing prison health in all policies, as well as to address the challenges of prison health research, PHE has funded the Worldwide Prison Health Research Network (WEPHREN). From April 2018, 427 new members registered with WEPHREN to produce a total of 893 members at the end of March 2019.

Box 3: What is WEPHREN?

WEPHREN is a connected global community, working together to improve the health of all people in prison. Our mission is to improve the health and wellbeing of people in prisons globally by facilitating the development and dissemination of high quality evidence for prison health and health care. Learn more and join this free international network at www.wephren.org (user statistics from 1 April 2018 to 31 March 2019):



In May 2018, WEPHREN’s international Steering Committee gathered at the UN City in Copenhagen, for a workshop on a 3-year plan for WEPHREN’s development. The Committee developed a vision and mission statement for WEPHREN and considered actions on engagement, capacity building and future funding.

In July 2018, WEPHREN celebrated its first anniversary and hosted the inaugural Alex Gatherer Lecture, in memory of Dr Alex Gatherer, a founding member of the WHO HIPP in 1995. The lecture was presented by Professor Brie Williams from the University of California, San Francisco on her experiences in prison health research and implementation into policy and practice.

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