

Guidance: Hepatitis C prevention, diagnosis and treatment in prisons in England



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Abbreviations

BBV Blood borne virus

CCG Clinical Commissioning Group

DBS Dried blood spot test

HCV Hepatitis C virus

HJIP Health and Justice Indicators of Performance

MDT Multi-disciplinary team

NHSE NHS England

NICE National Institute for Health and Care Excellence

NOMS National Offender Management Service

ODN Operational Delivery Network

PCR Polymerase chain reaction test which tests for active current infection

PHE Public Health England

Foreword

My favourite days are those where I can tell someone that they no longer have hepatitis C. I have seen the transformative effect this has on peoples' lives and it's what inspires me to go to work each day.

I know that prisons can be a challenging environment for healthcare provision but, when you normalise and embed the offer of a blood borne virus test to all people in your prison and get an effective hepatitis C pathway running, you will save lives. This guidance shows what an ideal hepatitis C prison service should look like to give prison healthcare teams, secondary care and CCGs a blueprint to work towards locally.

The prevalence of hepatitis C amongst people in prison is so high that healthcare teams can't address it alone – it needs to be everybody's business. The Governor, senior staff, prison officers, healthcare team, substance misuse staff all need to understand what hepatitis C is, the transmission risks and the fact that it is curable. Through training and education, we can end the stigma that too often puts people off getting tested or treated.

Getting an effective hepatitis C service running in a prison takes time, commitment and investment, but the prison and surrounding community will reap the health benefits in the long term. If someone enters prison with hepatitis C and can be released hepatitis C-free, then that is a really positive health outcome for their time inside.

I hope this guidance will help prison healthcare teams, substance misuse staff and prison leadership to work closely with their local specialist secondary services to build good relationships and effective services. My message to you is simple: it can work and you will save lives.

Jayne Dodd

Hepatitis Specialist Nurse for Prisons, Pennine Acute Hospitals Trust

Hepatitis C Prison Pathway – Quick checklist for commissioners and managers

Do you have a BBV lead within your prison (usually a nurse with a special interest)?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 7
Are all consenting eligible people in your prison offered BBV testing as per the opt-out testing programme?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 8
Do you offer dried blood spot BBV tests and ensure that any HCV antibody positive samples are reflex tested for HCV PCR to confirm active infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 8
Are all BBV test results provided to patients personally with advice about treatment and prevention given to those testing positive, and advice about avoiding future infection to those testing negative?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 8
Do you have a clear treatment referral pathway for anyone testing positive with a BBV?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see appendix 2
Are people diagnosed with hepatitis C able to access treatment within the prison under the auspices of their Operational Delivery Network, without being escorted out for routine appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 9
Are all staff trained to an appropriate level in BBV awareness?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 13
Do you have accessible information on BBVs available and promoted to all people in prison?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 10
Does your substance misuse team work closely with the health team to diagnose BBVs, spread harm minimisation messages and reduce stigma?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 12
Does your care pathway include close links to local specialist services, substance misuse services and GP services, with agreed referral protocols, to ensure continuity of care for anyone released diagnosed with a BBV?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see appendix 3
Are your healthcare teams coding testing, diagnosis and/or treatment for Hepatitis B, Hepatitis C or HIV using appropriate READ Codes on SystemOne?	<input type="checkbox"/> Yes <input type="checkbox"/> No – see section 14

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1 Target audience

This document is aimed at prison healthcare managers, prison healthcare teams, prison governors, prison substance misuse teams, health and justice commissioners, specialised commissioners, operational delivery networks and clinical commissioning groups.

2 Policy statement

NHS England (NHSE), the National Offender Management Service (NOMS) and Public Health England (PHE) published their National Partnership Agreement in 2013 which sets out their shared strategic intent and joint corporate commitments in the commissioning, enabling and delivery of healthcare services in adult prisons in England.

The National Partnership Agreement listed 12 priorities for 2013/14, one of which was: ***'To work together to design and deliver an appropriate 'opt-out' model of testing for BBVs by April 2014, in collaboration with other non-statutory partners (e.g. National AIDS Trust and the Hepatitis C Trust).'***ⁱ

In their National Partnership Agreement for 2015-16, NHSE, NOMS and PHE reiterated this commitment, describing opt-out testing for BBVs as a 'high priority' and stating that they will ***'Continue to implement an 'opt-out' policy for testing for blood-borne viruses (BBVs) and development of care pathways for those found to be infected.'***ⁱⁱ

3 Aim

The aim of this document is to provide commissioners and prison healthcare teams with practical guidance regarding the implementation of opt-out BBV testing and related hepatitis C care pathways, which can be adapted and used by any prison that needs to develop, revise or update their services.

This guidance will assist in providing prison healthcare staff with the relevant information, training requirements and agreed procedures to:

- Educate and inform patients about hepatitis C
- Offer confidential testing to all consenting eligible people in prison on an opt-out basis
- Provide advice about prevention and/or treatment when indicated
- Arrange follow up with specialist services
- Minimise risk of exposure to and transmission of BBVs
- Ensure access to treatment and care, in custody and in the community and continuity of care from one setting to another (including transfer around the estate as well as from or on returning to the community)
- Assist the effort to reduce stigma

This guidance complements a range of documents produced by PHE to assist stakeholders to introduce the BBV opt-out testing policy, all of which can be accessed on the PHE Health

and Justice PHiPs Team pages: <https://www.gov.uk/government/collections/public-health-in-prisons#improvingtesting-and-treatment-rates-for-bloodborne-viruses>. These include:

- BBV testing in prisons: Cost estimates
- BBV testing in prisons: Q&A for healthcare staff
- BBV testing in prisons: National algorithm for healthcare staff
- BBV testing in prisons: Guidance notes for healthcare staff
- BBV testing in prisons: Flash card for healthcare staff
- BBV testing in prisons: Educational resources for healthcare staff

The HCV Action website hosts contact details for secondary care prison contacts here: <http://www.hcvaction.org.uk/resource/database-secondary-care-prison-hospital-contacts-hepatitis-c-treatment>

4. Population need: hepatitis C

Chronic hepatitis C virus infection can result in progressive liver inflammation, which may progress to scarring (fibrosis and cirrhosis). If left untreated, hepatitis C can lead to mild, moderate, or serious liver disease and in some cases, liver cancer and liver failure. NICE approved treatments are available that can cure the virus in over 90% of patients depending on their genotype and more treatments are expected to come on-stream over the next few years.ⁱⁱⁱ

Currently only around half of the estimated 160,000 people living with hepatitis C in England have been diagnosed.^{iv} Prevalence of hepatitis C is considerably higher in the prison population than in the general population: PHE estimates that around half of injecting drug users in England are hepatitis C positive^v and a Ministry of Justice survey in 2008 found that 40% of people in prison reported injecting drugs in the month prior to entering prison.^{vi}

Hepatitis C is transmitted by blood-to-blood contact. In the UK it is most commonly acquired through injecting drug use through the sharing of needles, spoons, filters, syringes and water. Hepatitis C can also be spread by vertical transmission from an infected mother, transfusion of infected blood or blood products before September 1991, tattoos/medical procedures using un-sterile equipment and sharing razors and toothbrushes with an infected person. HIV infection is thought to increase the risk of transmission. People are often asymptomatic after exposure to the virus and symptoms that are present, such as fatigue, insomnia, flu-like symptoms and skin problems, can often be put down to other causes.

Hepatitis C is a health inequalities issue: almost half of people admitted to hospital with hepatitis C in 2012 were from the lowest socio-economic quintile.^{vii} The exceptionally high prevalence of hepatitis C within prisons makes it an ideal setting to diagnose many of those living with the virus undiagnosed and to initiate them onto a care pathway. This will have a community benefit by addressing issues in under-served populations generally.

Additional to the evident benefits for the individual, there is mounting evidence to suggest that successful treatment of the virus contributes to reducing the transmission of hepatitis C within the population. Therefore, effective prevention measures alongside successful treatment, are effective methods of reducing the incidence of the infection. Tackling hepatitis C will ultimately reduce preventable mortality from liver disease and cancer – both outcomes identified for improvement in the Public Health Outcomes Framework and NHS Outcomes Framework.

5. Outcomes

5.1: National outcomes

Establishing opt-out BBV testing and an effective care pathway for hepatitis C patients will assist towards the following NHS Outcomes Framework Domains & Indicators:

Domain 1 Preventing people from dying prematurely:

This service will improve access to consultant-led infectious disease or hepatology services and will improve assessment and monitoring of patients. If untreated or if patients are not monitored once on treatment there is an increased risk of serious health problems and death.

Domain 2 Enhancing quality of life for people with long-term conditions:

Once patients have access to timely care and treatment, patients will enjoy improved health outcomes. Timely access to hepatitis C treatment cures hepatitis C in most cases.

Domain 3 Helping people to recover from episodes of ill-health or following injury:

This service will significantly support monitoring of patients with hepatitis C and will support recovery. The prison may provide a better support network for individual patients who have limited support networks in the community and this enhances concordance with treatment and reduces chances of failure.

Domain 4 Ensuring people have a positive experience of care:

This service will enhance the patient's health both physically and mentally. Mentally, they are not burdened with a virus which may cause anxiety and depression. Physically, they will not develop chronic liver disease and other health complications.

Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm:

This service will support patients to access screening and treatment, thereby preventing the transmission of the virus to other prisoners or members of the public on release.

5.2: Local outcomes

Establishing opt-out BBV testing and an effective care pathway for hepatitis C patients will assist towards locally defined outcomes, such as:

- All eligible people in prison are offered screening for BBVs

- All people in prison presenting with a BBV will be offered appropriate assessment, care and treatment in accordance with NICE guidance
- All people in prison in need of treatment or who are receiving treatment will be referred to a specialist service on release from prison and their GP will be notified.

6. Principles for commissioners

Commissioners play a key role in ensuring the prison hepatitis C service provides safe, effective care for patients. As described in this guidance document in more detail, commissioners should ensure the key tenants of the prison's hepatitis C service are included in the service specification. These are:

- In line with PHE guidance^{viii}, opt-out BBV testing to all consenting eligible people in prison should be offered within 7 days of a person entering the prison and as a continuous re-offer throughout their stay if appropriate (for example, to be offered by GPs, substance misuse staff on a regular basis).
- Dried blood spot tests (DBST) are the recommended method for opt-out BBV testing as these are easier to perform and less invasive for the client than venepuncture. PCR tests should automatically be performed where a test shows hepatitis C antibodies, to test for active infection and so full results can be given to the patient including advice on the need for treatment and information about risk of transmission of infection.
- The delivery of results, whether positive or negative, should be used as an opportunity to educate the person about the viruses, transmission, prevention and harm minimisation.
- A clear referral pathway to specialist care for anyone testing positive with a BBV should be in place.
- Hepatitis C specialist care and treatment, including diagnostics, should be delivered inside the prison through regular in-reach clinics linked to the ODN, or through prison primary healthcare teams with 'remote support' through the ODN, supported within the prison by a nurse or GP with a special interest in hepatitis C.
- All healthcare staff should receive training in BBV awareness and management, and should disseminate basic awareness training to other prison staff especially custodial staff to enable them to support prisoners.
- All care should be delivered on the principles of a multi-disciplinary team and this may include for people living with HCV infection close cooperation with substance misuse providers and/or sexual health services and/or primary care services including mental health,
- Accessible information on BBVs, their treatment and how to prevent transmission should be promoted to all people in prison through a variety of media, not only printed posters and leaflets but also radio information through the National Prison Radio service. Support through The Hepatitis C Trust's free peer-led helpline specifically for

prisoners only, peer-led support groups and mental health services should be linked to care.

- Peer support should be encouraged and prisons and healthcare commissioners and public health should collaborate to develop and support peer-led health improvement programmes. Examples of successful programmes internationally and nationally are being evaluated by PHE.
- Continuity of care should be ensured through close links between prison healthcare services across the estate and between prisons and their local community hepatitis C services, substance misuse and GP services so that people diagnosed with hepatitis C or on treatment have seamless care if they are moved within the prison estate and when they leave prison.

See section 17 for monitoring, compliance and effectiveness.

7. Accountability

A designated line of accountability is necessary to ensure the effective implementation of opt-out BBV testing and of related care pathways.

Chief Nurse / Head of Secure Environments

- To ensure the effective distribution and implementation of these guidelines throughout all areas and gain assurance regarding implementation
- To appoint a hepatitis C lead (usually a nurse with a special interest) to lead in the implementation of these guidelines
- To ensure all staff participating in screening and treatment have sufficient training and support to enable an effective service
- To monitor the effectiveness of the policy and adapt if necessary
- To establish and maintain communication with local specialists

Prison-based nurse with specialist interest (or other appointed hepatitis C lead)

- To lead on the implementation of opt-out BBV testing and BBV care pathways within the prison
- To lead on the provision of appropriate training in BBVs for all staff
- To ensure care pathways and protocols are up to date
- To maintain a close relationship with the specialist hepatitis secondary care provider

Operational Delivery Network lead

- To ensure that tailored services to meet the needs of the local prison population are available
- To ensure that people in prison receive care equivalent to people in the wider community
- To assess each hepatitis C patient through the multi-disciplinary team process

Senior clinician from the secondary care provider

- To provide treatment and care as per local guidelines and NICE guidelines
- To support primary care and other teams in prisons to deliver care appropriate to their training and role and in line with person-centred care requirements of individual patients

Prison-based substance misuse services

- To appoint a substance misuse BBV lead responsible for coordinating training and care with the health team, in particular the prison-based nurse with a special interest
- To undertake training for all substance misuse staff in BBV awareness and testing
- To offer BBV testing to consenting clients on an opt-out basis and to support re-offer of test if risk behaviours identified since last negative test
- To promote harm minimisation messages

Lead prison pharmacist

- To work with the prison-based nurse with a special interest and the secondary provision prescribers to ensure timely access to all prescribed treatments
- To support patients on treatment to understand their medications, including dosing, drug interactions, side effects or any specific dietary requirements relating to treatment e.g. need to take medications with food or to avoid foods which could interfere with pharmacodynamics of drugs prescribed
- To support patients adhering to prescribed regimens
- To provide support to patients in understanding their infection and how to treat it
- To support infection control and prevention measures including advising about how to access needle and syringe exchange programmes in the community if required/appropriate

All other prison staff

- To undertake training and have knowledge of hepatitis C and other BBVs
- To inform their line manager if any training needs are highlighted
- To provide support to healthcare teams in providing testing or treatment including support patients moving around the prison to health services or out to specialist providers if that is required

8. Testing and referral

8.1 Offering testing

Aim: For BBV testing to become a routine procedure offered by a trained member of staff, using a point-of-care dried blood spot test where possible, to every consenting adult person within 7 days of prison entry as well as supporting testing of prisoners currently incarcerated through offer and re-offer of testing by primary care and substance misuse teams and through awareness events.

Implementation: As per PHE's 'opt-out blood borne virus test algorithm guidance notes' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333059/Blood_borne_virus_testing_in_prisons_process_guidance_notes.pdf), at reception and induction, healthcare should:

- carry out risk assessment and take medical history
- identify patients requiring immediate treatment for BBVs
- avoid interruption to existing BBV treatment and provide medication to those prescribed it on time and without delay
- ensure patients know about the range of services available, including sexual health services
- during induction, basic information should be provided about:
 - o BBV risks, transmission and treatment
 - o HBV vaccination and HBV/HCV/HIV testing and treatment services
 - o Policy on access to condoms and disinfectant tablets
 - o Recommend all consenting eligible* patients a test for HIV, hepatitis B and hepatitis C (HCV antibody, HBsAg and HIV Ab and Ag P24 test) within 72 hours of arrival using DBST or venous sampling. Where a patient is anti-HCV positive **it is important that the same sample is used to test for HCV RNA via PCR.** Samples should be of sufficient quantity that they can be immediately PCR tested following a positive antibody test. No prisoner should receive a positive antibody result without having a PCR result at the same time.
(NB: Healthcare staff should also be recommending testing to EXISTING prisoners not just new receptions)
- suitably qualified healthcare worker to provide a pre-test discussion according to national guidance (the same person should ideally deliver the result). Test to be carried out within four weeks of arrival
- begin super-accelerated HBV vaccination programme (days 0, 7 and 21) ideally when bloods are taken for BBV testing (ideally a fourth dose should be given at one year and a booster at five years)

Prisoners who refuse a test should be re-offered throughout their stay at regular intervals. Testing should be a 'continuous offer' and be re-offered at all available opportunities, for example at hepatitis B vaccination appointments and treatment reviews with the substance misuse service to look at both clinical and psychosocial support requirements.

** Eligible patients: BBV testing should be recommended to all prisoners, including those already in prison unless:*

- they have been tested in the last 12 months and have NOT subsequently put themselves at risk of infection
- they have been tested and are positive
- they are known to be positive for a BBV. For hepatitis B: If a patient has documented evidence of a negative result and have been vaccinated against hepatitis B they do not require further testing for this BBV infection

Options of the different BBV test types are:

Test	Considerations
Dried blood spot testing	<ul style="list-style-type: none"> - Recommended point-of-care test as easy to administer (any staff member can be trained to administer, it does not have to be healthcare staff) and less invasive for clients than venepuncture; - Easy to transport (the samples can be posted via Royal Mail once dried); - PCR and genotype test should automatically be performed on hepatitis C antibody positive samples; - All spots on the kit must be filled; samples take 2 hours to dry. <p>PHE labs supply DBSTs. Contact jane.shirley@phe.gov.uk or jane.shirley@heartofengland.nhs.uk for details.</p>
Oral swab testing	<ul style="list-style-type: none"> - Hepatitis C antibody only - antibody results within 20 minutes but does not test for active infection therefore this is not a recommended method of testing; - Blood will need to be taken via dried blood spot test or venepuncture to confirm active HCV infection via PCR test; - Separate swabs required for HIV testing; - None available for hepatitis B testing
Venepuncture	<ul style="list-style-type: none"> - Venepuncture will be required for confirmatory testing on positive samples and for monitoring response to treatment ; - Requires trained healthcare staff to perform; - Neck venepuncture may be required by a highly trained nurse if veins are difficult to access; - Clients may refuse if needle-phobic.

8.2 Pre-test discussion

Pre-test discussion is vital to the provision of a good service and should include:

- What hepatitis C is and the benefits offered by early detection and treatment
- What the test involves, testing timescale and confidentiality of results
- Assessment of exposure risks and establishing when the last risky activity took place

- Transmission of hepatitis B & C and HIV within the prison environment, including through sharing shaving equipment and advice on prevention
- Implications of a positive result for the individual and their family or close contacts
- Information about implications of leaving hepatitis C untreated
- Support available within the service including primary care nurses, GP, substance misuse services
- It may also offer the opportunity to advise injecting drug users about harm minimisation and to offer them the hepatitis B vaccine

Consent is an essential part of any clinical procedure. Verbal consent should be sought from the patient before routine venepuncture. The procedure should be explained to the patient and the patient should have the opportunity to ask questions and raise concerns.

Prior to performing venepuncture or difficult external jugular venepuncture the practitioner must positively identify the patient by asking them to state their full name, date of birth and prison number and checking these against the request form and the patients' records.

8.3 Post-test discussion and referral

Post-test discussion should be carried out with every patient post BBV screening regardless of the result.

If the result is negative, this is a vital time to reinforce harm minimisation advice.

Depending on the outcome of the test, the post-test discussion can have a number of outcomes (please refer to appendix 2 for the testing flow chart).

9.1 Structure and capacity of service

Hepatitis C treatment and care should be delivered inside the prison under the auspices of the Operational Delivery Network in which the prison resides. This is beneficial for the prison and patients by avoiding costly escorts to hospital for appointments, many of which end as DNAs (did not attend) due to availability of prison staff to escort patients.

The in-reach service should currently include regular clinics as part of a consultant-led service, supported within the prison by a nurse or GP with a special interest in hepatitis C. However, as treatments become easier to administer and manage, prison primary healthcare teams can consider delivering treatment and care directly with 'remote support' through the ODN.

At least one nurse based in the prison should have a special interest in hepatitis C and should receive appropriate in-depth training and ongoing clinical supervision in order to support patients when the specialist nurse is not on-site. This nurse must have dedicated clinical time to oversee the testing and management and care of all patients on the hepatitis C pathway. There should be dedicated administrative support to support the service.

The capacity of the service (i.e. how many people might need to be treated at any one time) will need to be taken into consideration when planning the service. This will determine how frequently the service is required (e.g. weekly / bi-weekly / monthly clinics) as well as determining if and how telemedicine can be used.

The prison healthcare provider and secondary care specialist viral hepatitis team need to be able to communicate electronically and update patient notes and results via SystemOne. It is possible to set up SystemOne to facilitate this in any primary or secondary healthcare setting using an N3 connection. This communication channel is vital ensuring test results are communicated promptly and to enable the management of more complex patients.

9.2 Links to Operational Delivery Networks (ODNs)

The Operational Delivery Networks are responsible for contributing to tailored services to meet the needs of specific vulnerable groups (e.g. prisoners, homeless, current injecting drug users, migrant populations). All patients requiring treatment in the ODN area, including people in prison, will be discussed by the ODN's multi-disciplinary team.

The ODN service specification states that, "specialised HCV treatment services will also be provided to adults in secure environments. Where these services are provided they will be under the auspices of the Specialised Service and funded to the same level as for services for the general population. Where additional costs are incurred and beyond the standard, these costs will be met through a top-up payment by Health and Justice Commissioning Teams. Services provided in prison settings must adhere to the same quality standards and provide an equivalent level of care."

https://www.engage.england.nhs.uk/consultation/specialised-services-policies/user_uploads/hep-c-netwrk-serv-spec.pdf

9.3 Treating patients

People in prison should be offered treatment according to the National Institute for Health and Care Excellence (NICE) guidelines under the auspices of the ODN in which area the prison resides. People in prison should have the same access to medications that those outside the secure environment have.

Treatment is discussed on diagnosis in conjunction with the ODN's MDT. This will include a consultant in infectious diseases or hepatologist and the hepatitis specialist nurse, with reference to all relevant care providers within the prison as appropriate, maintaining confidentiality.

Treatment may be contraindicated for some medical and psychiatric conditions. Current injecting drug users and people who drink excess alcohol are **not** precluded from treatment. However, if this behaviour affects the patient's ability to attend check-up appointments and take prescribed medications appropriately, treatment may be withheld for the patient's safety.

Treatment may have side effects but these can be satisfactorily managed in most cases.

Patients may be referred for, commence and complete treatment whilst in the secure environment. However, due to short sentence lengths this is not always possible. In these cases, it will be necessary to refer to their local treatment centre following release to continue treatment or to initiate treatment. The prison and local treatment centre must develop close links to ensure that patients released are connected with the local health services and offered treatment and care.

Patients undergoing treatment in prison should be on a medical hold for the duration to ensure continuity. Medical hold should start from the moment the decision is made to initiate the patient on treatment until the treatment course is complete.

Where possible, patients on treatment should have easy access to medication, i.e. to be on a health wing. This will avoid the potential issues around access to medication due to lock downs or other issues.

Support is provided by educating prisoners about their illness and through any members of the multidisciplinary team. This can include:

- Consultant team
- Lead nurse for hepatitis C
- GP
- IDTS or substance misuse nurses / GP with a special interest
- Drug/alcohol key workers
- Peer support team
- Secondary care providers
- Health Promotion specialist

9.4 Diagnostic testing

Liver biopsy need no longer be routine in assessing patients for treatment, though it may be advised for some patients.

Fibroscans are routinely performed by viral hepatitis nurse specialists/primary care nurses with special interest and have replaced the more risky biopsy procedure. Mobile fibroscans should be commissioned with the in-reach treatment service. Consideration should also be given to the use of other markers of liver fibrosis such as Enhanced Liver Fibrosis (ELF) and Fibrotest.

9.5 Clearing the virus

When a patient achieves a sustained viral response (SVR), the practitioner giving the treatment result should highlight risks of re-infection and importance of prevention measures to ensure the patient remains hepatitis C free.

10 Information, support and health promotion

10.1 Information

Straight-forward, clear information about hepatitis C, including transmission and treatment options should be promoted to all people in prison. This should be tailored specifically for this audience, for example:

- For male prisons there is an 'Andy Man' handbook series used by HMP Manchester (please contact Jonathan Reed at Sunny Thinking www.sunnythinking.com for details)
- The Health Protection Agency (now part of PHE) and the British Liver Trust have developed an award-winning blood borne virus awareness series available here: <http://www.britishlivertrust.org.uk/publications/blood-borne-virus-awareness-series/>
- Public Health Wales have developed a series of liver health posters and information booklets available here: <http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=60436#lit>

10.2 Support

Patients should be allowed access to The Hepatitis C Trust's dedicated peer-led prison helpline which is on the free global phone list: 0800 9992052, open from 10.30am to 4.30pm Monday to Friday.

Peer support groups and networks should be encouraged and supported. These often work well if set up in the substance misuse wing where there is a culture of peer support.

10.3 Health promotion

The prison healthcare team should develop a health promotion strategy around hepatitis C designed to de-stigmatise the disease, raise awareness of all risk factors and to encourage testing. Peer education is particularly powerful in promoting healthcare messages.

11 Harm reduction

Harm reduction is key to minimising BBV transmission.

Due to the nature of the intra prison setting some community initiatives cannot yet be implemented i.e. needle exchange.

However, nursing teams, GPs and drug and alcohol key workers in prisons can provide education around appropriate needle and syringe cleaning techniques to all injecting drug users and should include highlighting the risks of transmission in sharing razors and illegal tattooing to all.

The BBV testing process provides an important 'teachable moment' to people in prison to educate them about avoiding risks of BBV transmission, both when they are tested and when they receive their positive or negative test result.

Nursing teams, GPs and drug and alcohol key workers should stress the risks of reinfection to people undergoing treatment for hepatitis C.

12 Links to substance misuse and mental health services

BBV awareness, harm minimisation and testing should be a daily part of the substance misuse team's practice.

Ensuring good communications, links and relationships between the hepatitis C in-reach service, hepatitis C lead within the prison, the prison substance misuse and mental health services, and community substance misuse and mental health services is vital in establishing a holistic hepatitis C service and pathway.

Substance misuse key workers should be trained in hepatitis C awareness and testing so they can confidently offer and perform point-of-care dried blood spot tests. They should be part of the MDT team for a hepatitis C patient.

Peer support groups and networks often work well if set up in the substance misuse wing where there is a culture of peer support.

13 Staff training and education

Hepatitis C, especially its treatment, is currently a rapidly evolving field. It is therefore essential that efforts are made to provide all individuals with the most up to date information.

The hepatitis C lead: Hepatitis C lead practitioners within secure environments and community settings should ensure they keep up to date and abreast of developments around hepatitis C services. Hepatitis C leads should receive ongoing clinical supervision through the specialist service provider in order to keep up to date with local developments.

Testing and treatment initiatives should be disseminated by hepatitis C lead practitioners to other members of the healthcare team, to ensure all staff have the opportunity to keep abreast of developments.

Free 'BBV Champions Training' sessions are available throughout 2016 for prison healthcare staff leading on BBV testing and management. For details and dates, please email is-hepatitis-team@is-health-group.co.uk.

The Hepatitis C Trust provides tailored training in BBV awareness and testing. Please contact rachel.halford@hepctrust.org.uk for more details.

Healthcare, substance misuse and mental health practitioners: Due to the high prevalence of hepatitis C within prisons, all healthcare professionals and members of the substance misuse and mental health teams should be encouraged to complete the free RCGP e-learning certificate in '[Hepatitis B and C: Detection, Diagnosis and Management](#)'. This can be accessed through the e-learning link on the RCGP website, under the topic heading 'Health Promotion and Disease Prevention'.

Prison officers and all other staff: To decrease the stigma that surrounds BBVs in many prisons and to achieve a culture change so that BBV testing and treatment is routine, all prison staff should be made aware of basic BBV facts including transmission routes, prevalence and the fact that there are treatments available. This should be embedded in the induction for all new staff and should be given to all current staff through, for example, 'lunch and learn' sessions. See appendix 4 for an example facilitator lesson plan used for awareness sessions for all prison staff and also for prisoners (in groups of 12).

14 Information technology and governance

Healthcare providers in prisons must ensure staff have appropriate training in correct use of health informatics system (SystemOne & HJIPs) and coding using READ codes to allow data to be consistently, accurately and reliably entered, collected and collated. This must include separating out hepatitis C PCR and Ab results.

The prison healthcare provider and secondary care specialist viral hepatitis team need to be able to communicate electronically and update patient notes and results via SystemOne. It is possible to set up SystemOne to facilitate this in any primary or secondary healthcare setting using an N3 connection. This communication channel is vital ensuring test results are communicated promptly and to enable the management of more complex patients.

Both primary and secondary care need to have suitable information sharing agreements in place in order to access each other's systems. As a key restraint to delivery in prison can be access and escort, the need for better information sharing is vital.

15 Approval, ratification and review process

This guidance should be adapted by prisons to suit their circumstances and ratified by the Risk Management and Assurance Group, or equivalent. This policy should be subject to review after two years or in the event of new research, guidance or information.

16 Dissemination and implementation

Once approved, this guidance should be disseminated to all prison and community healthcare departments and staff. It should also be placed on the intranet and prison WIKI.

17 Monitoring, compliance and effectiveness

Compliance with this policy can be monitored through audit of the detection and treatment of hepatitis C. This could include:

- The Proportion of patients with active hepatitis C infection (both HCV antibody and RNA positive)
- Proportion of people diagnosed with active hepatitis C that are seen by a specialist (within the prison or on release) within 18 weeks of their diagnosis
- Proportion of people diagnosed with hepatitis C that are seen by a specialist (within the prison or on release) within 18 weeks of their diagnosis
- Patient surveys of their experiences of care
- Utilising the new Health and Justice Information System (HJIPs) data
- The Commissioner's Providers Performance Management System

Public Health England Health and Justice will maintain national oversight of the diagnosis and treatment of people with BBVs in prisons.

18 Conclusion

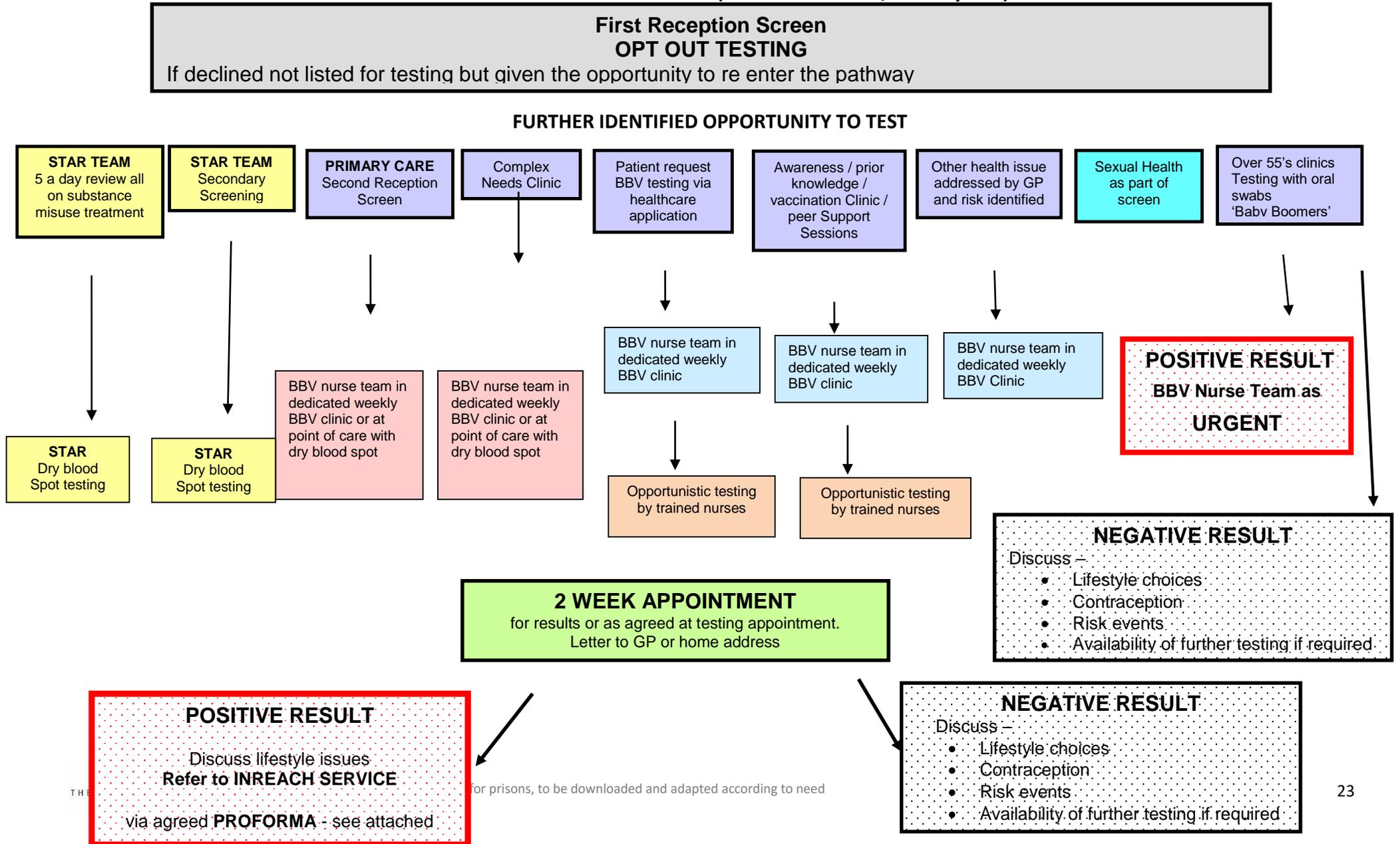
The introduction of opt-out BBV testing across the prison estate has the potential to significantly improve diagnosis rates of hepatitis B, hepatitis C and HIV. It is vital that all prisons have robust pathways in place to ensure everyone diagnosed with a BBV in prison can access specialist treatment and support within prison and that this treatment pathway is continued if they are moved across the prison estate and when they are released into the community.

This guidance details the key components of a prison's hepatitis C pathway to help commissioners, prison healthcare teams, prison and community substance misuse teams, mental

health services, GP practices, specialist care providers and ODN leads to work together to ensure everyone diagnosed with hepatitis C in prison can access specialist care and treatment.

Appendix 1

EXAMPLE BBV TESTING PATHWAY (HMP Manchester / Buckley Hall)



Appendix 2

HMP Manchester / Buckley Hall flowchart
Hep C treatment Pathway

Hepatitis C PCR positive referral received by fax on agreed proforma.

Pennine Acute Trust to register patient
Initial appointment made for Specialist Nurse Clinic within Prison

Initial screen – to include
Mental health issues PHQ9 (if required)
Physical Health issues
Vaccination history
Prior knowledge of the virus
Release date and area
Medication history
Drug and/or alcohol issues
Sexual health
Contraceptive advice
Screen bloods
Blood pressure
Weight & Height

Mental health issue identified

Physical health issues

Refer to Mental health services
within prison health for assessment

Refer to appropriate service or opinion

**APPOINTMENT FOR NEXT
AVAILABLE
PRISON ID CONSULTANT CLINIC**

in - house **FIBROSCAN**
Ultrasound Scan (USS) if necessary at North Manchester General Hospital or local provider

Based on individual assessment - the following may be required prior to commencing treatment

- USS - history of heavy alcohol use for 10 years or above
- Dental referral - are there any outstanding issues
- Optician review prior to starting treatment - fundi check
- Mental Health Assessment – for patients with pre existing condition
- A request from other secondary care provider for their opinion on suitability to treat



Therapy commences whilst in Custody in accordance with NICE guidance



Each patient is discussed fortnightly at a **Multi Disciplinary Team (MDT)** meeting with consultant or other identified medic.

Review of blood results and letters to identify issues that need addressing

Possible inclusion in regime of other injections e.g. GCSF, EPO

Possible addition of more frequent nurse review in cases of:-

- Anxiety
- Abnormal blood results
- Hb below 7.5
- Platelets below 30
- Neutrophil count below 0.7
- Any result that is 50% lower than the previous
- By staff request

Also possible less frequent appointments when patients are managing well with minimal abnormalities in results



UNEVENTFUL TREATMENT PATHWAY



ALTERATION TO REGIME

Appendix 3

Example hepatitis C continuation of treatment pathway (HMP Buckley Hall / Manchester)

Transfer /Release whilst on treatment.

It is essential that once an episode of care commences there are no disruptions to the period of treatment therefore the following are minimum requirements

Transfer out of the area.

- A minimum of 2 weeks is necessary for transfer of care to be arranged.
- Some establishments do not have local providers of treatment.

Release

Release will be prepared for from initial interview.

A local provider will be identified and care will be transferred if patient has commenced therapy

- Minimum requirement to arrange care – 2 weeks
- If less than 2 months left prior to release from initial interview

Release to local area

HMP Buckley Hall/Manchester
Treatment may be continued NMGH if release is in the catchment area Or Transfer care to Manchester Royal Infirmary, Hepatology Department

Release to out of area

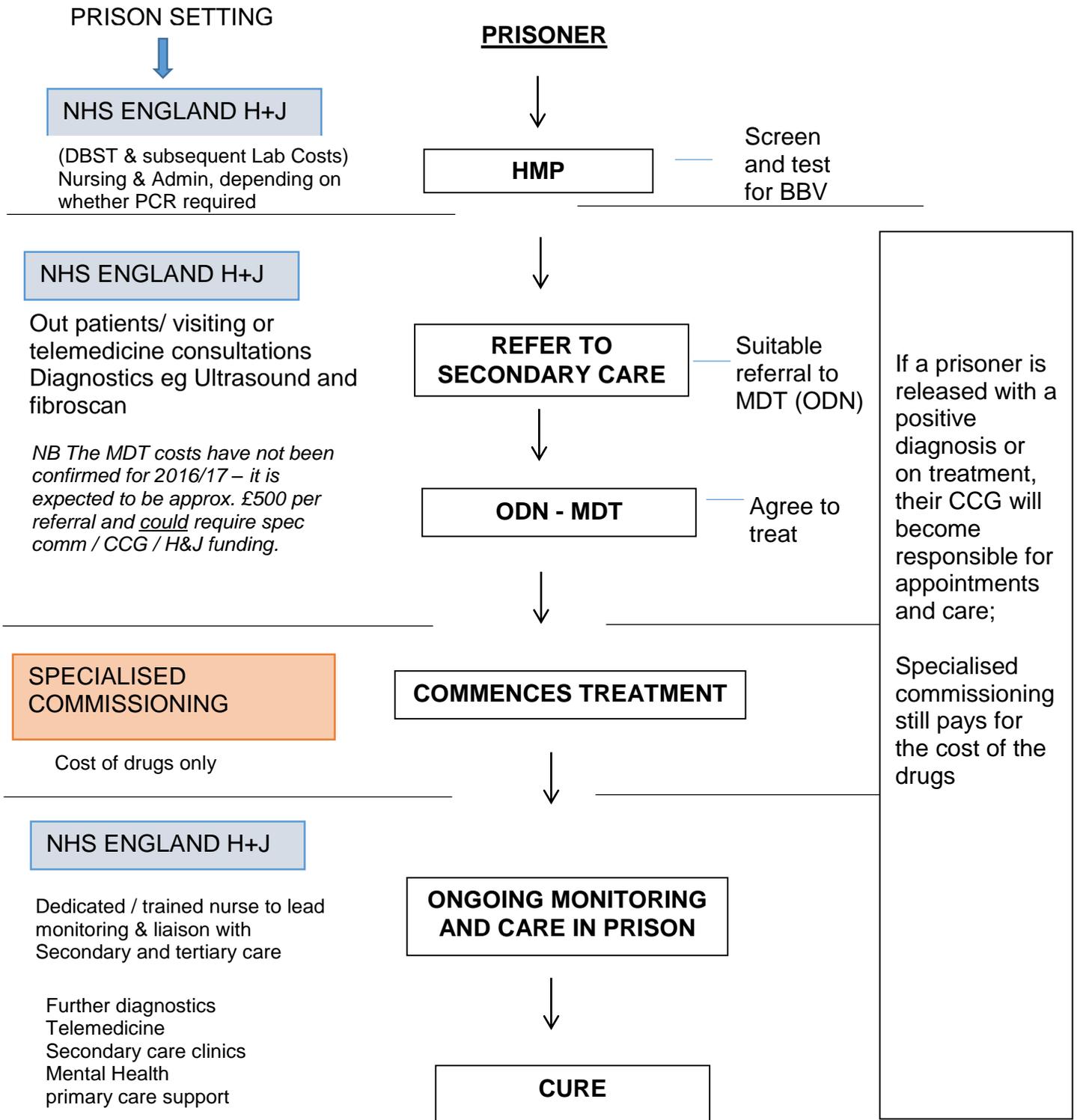
HMP Buckley Hall/Manchester
<ul style="list-style-type: none">• Letter given to patient with results for GP• If treatment has completed, a 6 months post treatment appointment will be given and/or contact details given to patient to arrange own appointment• A minimum of 4 weeks medication will be provided on release

Appendix 4: Facilitator’s awareness training session (adapted according to audience)

Programme: Blood Borne Viruses
Facilitator(s): Trained BBV lead from the health team and/or substance misuse team
Aim and Objectives Target audience: This training can be given at different levels or depth to: senior prison management, prison officers, healthcare teams, substance misuse teams. Aim: To increase basic awareness of the main blood borne viruses, transmission routes and treatment available. Objectives:- <ul style="list-style-type: none">• Have an increased awareness of the main blood borne viruses and how they are transmitted.• Have dispelled the myths.• Be aware of the signs and symptoms of the Human Immune and hepatitis viruses• Treatment options available
Elements to be delivered, suggested timings <ul style="list-style-type: none">• Introduction <i>10 minutes</i>• What are blood borne viruses <i>25 minutes</i>• Understanding of HIV and AIDS <i>10 minutes</i>• Understanding hepatitis and transmission routes, <i>25 minutes</i>• Treatments and support <i>25 minutes</i>• Conclusion <i>5 minutes</i> Training aids used:- <ul style="list-style-type: none">• Visual exercises using internal body organs and the human body.• Brainstorming exercises• Group discussions• Quizzes and games• Health promotional leaflets provided

Appendix 5: Who pays for what in the pathway

Who Pays? – High level flow chart to explain who the responsible commissioner for Hep C services is along the pathway



References

ⁱ NOMS, NHS England and PHE (2013) 'National Partnership Agreement, 2013':

<http://www.justice.gov.uk/about/noms/working-with-partners/health-and-justice/partnershipagreement>

ⁱⁱ NOMS, NHSE and PHE (2014) 'National Partnership Agreement between the National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016'. Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460445/national_partnership_agreement_commissioning-delivery-healthcare-prisons_2015.pdf

ⁱⁱⁱ See SVR rates in the submissions for the NICE technology appraisals TA363, TA364, TA365:

www.nice.org.uk . For up to date information on access to different treatments for each genotype, see

<http://www.hepctrust.org.uk/new-treatments-0>

^{iv} Hepatitis C in the UK: 2015 Report (Public Health England, July 2015):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448710/NEW_FINAL_HCV_2015_IN_THE_UK_REPORT_28072015_v2.pdf

^v Data from the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs suggest that levels of infection in this group are 49% in England (Hepatitis C in the UK: 2015 report, Public Health England)

^{vi} The Ministry of Justice: Duncan Stewart, The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice Research Series 16/08, October 2008:

<http://webarchive.nationalarchives.gov.uk/20100505212400/http://www.justice.gov.uk/publications/docs/research-problems-needs-prisoners.pdf> .

The last Department of Health anonymous survey of BBVs amongst prisoners was conducted in 1997 and showed a hepatitis C prevalence of 7% in male and 8% in female inmates (Prevalence of HIV in England and Wales 1997' para.33 Department of Health 1998; see also Weild, Gill et al 'Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey' Communicable Disease and Public Health Vol 3 No 2 June 2000)

^{vii} The Uncomfortable Truth (The Hepatitis C Trust, October 2013)

^{viii}https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333059/Blood_borne_virus_testing_in_prisons_process_guidance_notes.pdf