UK Health Security Agency

Why update TB guidance for secure settings now?

Dr Chantal Edge – National Lead for Health and Justice Health Equity and Inclusion Health, UKHSA

Burden of disease

- TB numbers increased by 13.6% in England in 2024 compared to 2023 – the largest annual increase since national surveillance began. England remains just under the WHO threshold for a low TB incidence country but at current rates of increase it will pass this threshold by the end of 2025
- We have seen a rising tide of TB in secure settings
- TB incidents more than doubled in prisons between 2023 and 2024
- People with a history of imprisonment have a TB rate four times higher than the general population.

Burden of disease

- TB is curable and deaths from TB in the UK are rare.
- However, UKHSA data shows people with TB with a history of imprisonment are **70% more likely to die** than those without.
- Between November 2024 and July 2025 there have been **three deaths** in English prisons due to TB.
- Two of these prison deaths were only identified on post-mortem

Challenges with TB management in secure settings

- TB screening on entry to secure settings can miss cases
- Differing approaches to active case finding during outbreaks
- Considerations for staff including personal protective equipment and active case finding
- Uncertainty over the role of latent TB screening
- Achieving continuity of care on release

Out of date guidance and evidence

Secure settings public health TB guidance was last updated in 2013

- Evidence was out of date
- New innovations are available
- New challenges have become apparent to TB management in secure settings

General appetite from across all stakeholders to revisit and review TB guidance

Approach

A multi-agency stakeholder group was convened in May 2024 with aim to review the evidence on TB management in secure settings and update the relevant guidance

Settings covered in the updated guidance:

- Prisons and young offender institutions (YOIs) with residents aged 18 and above
- Approved premises (APs)
- IRCs and residential short-term holding facilities (maximum stay for 7 days) and residential holding rooms (maximum stay for 96 hours)

UK Health Security Agency

A Case Tuberculosis in a Prison in England.

Dr Martin Dedicoat PhD
Tuberculosis Unit, UKHSA

23rd October 2025

UK Health Security Agency

Guidance

Management of tuberculosis in secure settings in England

Updated 9 October 2025

Applies to England

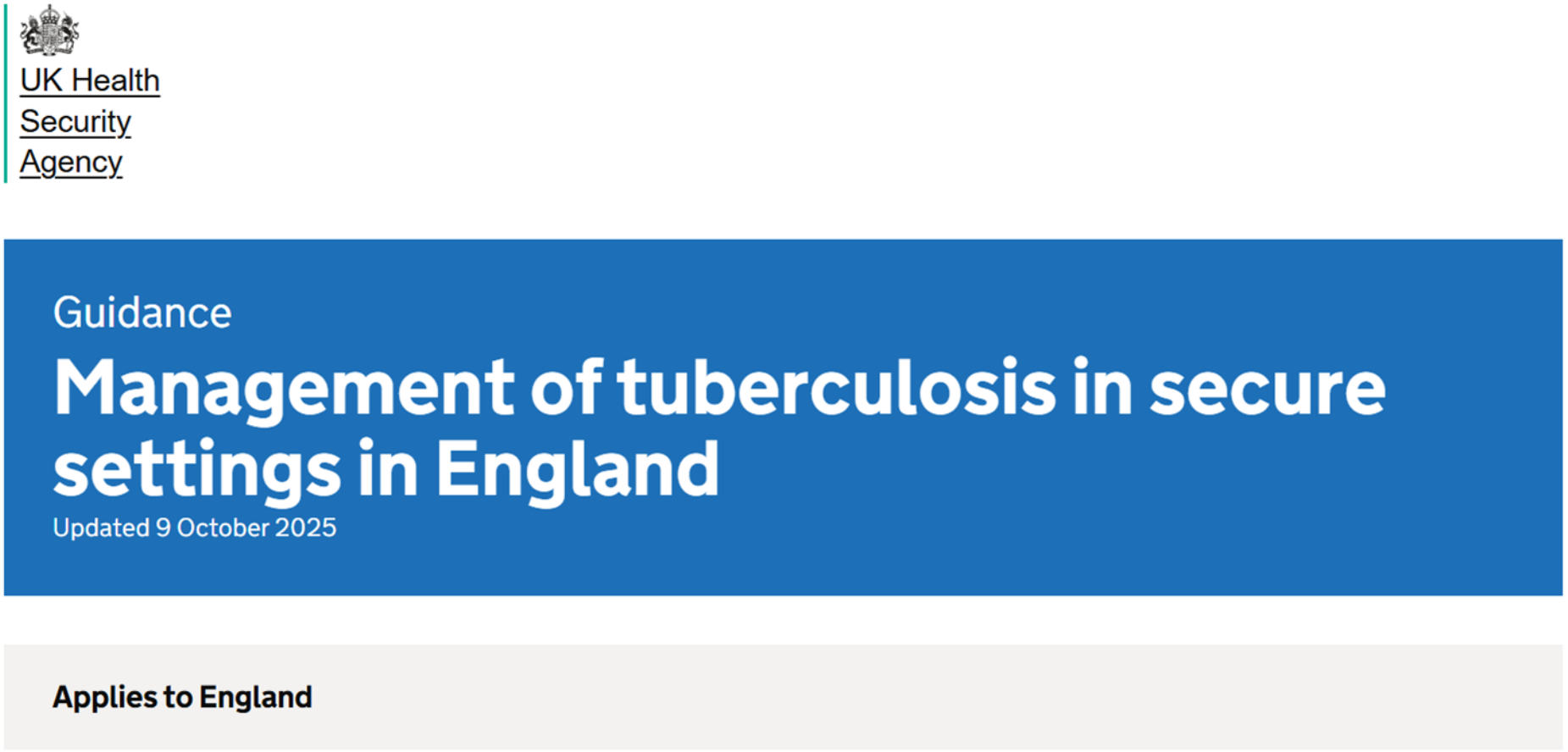
TB Case in a Prison

- 24 year old man admitted to hospital with 5 month history of cough, fever, sweats and an x-ray suggestive of cavitatory tuberculosis
- Patient was currently an inmate at a YOI
- 600 inmates

Index case

- Patient had been ill for 5 months with fever, cough, weight loss and sweats
- Had been assessed as having anxiety
- Was on 24 hour bed watch
- Initial sputum sample smear positive and culture positive in under 10 days
  - TB PCR positive RPoB mutation negative

What could have been done better at this point?



8. Residents with symptoms compatible with TB disease on arrival at a secure site or develop during their stay

The secure setting healthcare doctor or nurse should assess any resident in a secure setting with any of the following symptoms:

- history of a cough
- coughing up blood
- unexplained weight loss
- high temperature
- drenching night sweats
- swollen lymph nodes
- loss of appetite
- tiredness
- backpain

If an individual is identified as having any of the above the symptoms, they should be promptly referred to the local NHS TB service. If the individual is coughing up fresh blood or is clinically unstable, urgent transfer to a local emergency department should be considered, with staff taking appropriate transmission-based precautions.

Background

- Prison had 600 inmates aged 18-24
- Sentences ranged from 4 years to life
- Split across 9 wings
- Each wing had a specialism
- There was some mixing between the wings for sporting and religious activities

- The index case was on a wing where many inmates had drug misuse issues and personality disorders

Issues

- How to manage patient in hospital
- How to manage patient in prison

10. Incident or outbreak management

The UKHSA Management of incidents and outbreaks of communicable disease in secure settings guidance is important preliminary reading relevant to this section.

10.2 Establishing an incident management team (IMT)

Following notification of a TB incident or outbreak in a secure setting, the HPT will conduct an initial risk assessment with the secure setting. The HPT will decide on a course of action which may include providing public health advice or convening an IMT to support with coordinating the incident response. The HPT or IMT will determine the extent of contact tracing, TB screening and other actions as necessary.

Screening

- Staff
- Inmates

Investigation

- Collecting data around inmates

Index Case

- Patient returned to prison on treatment
  - But was not supervised
  - May have mixed with others

- Initial contact tracing – 13 contacts identified
  - Cell mate – IGRA positive
  - 11 other possible contacts identified amongst inmates – all IGRA negative
  - 1 officer identified as did bed watch – IGRA positive

9. Directly observed treatment (DOT)

By default, DOT is recommended in all secure settings and most residents in secure sites will receive their treatment this way. However, there are instances where DOT could reduce TB treatment adherence in some individuals in secure sites if it is prohibitively prescriptive about when the resident needs to present themselves to healthcare. In these cases, individualised patient risk assessments and tailored plans made with the patient about how they will receive their medication can be used to optimise treatment completion.

Tuberculosis Cases – Subsequently Detected

Case	Date of clinical onset	Symptoms	Wing	Culture specimen type	CXR	Site of disease	Treatment outcome
1	May	Cough, chest pain, weight loss, night sweats	A	Sputum	UL, cavitation	Pulmonary	Completed
2	January	Dry cough	A	Pleural fluid	Pleural effusion, LL	Pulmonary, pleural	Completed
3	March	Dry cough	A	Pleural fluid	Pleural effusion, LL	Pulmonary, pleural	Completed
4	April	Chest pain	A	Pleural fluid	Pleural effusion	Pleural	Completed
5	May	Night sweats	A	Sputum	LL	Pulmonary	LTF
6	May	Night sweats	A	Sputum	LL	Pulmonary	Completed
7	August	Fever, headache, convulsions	B	CSF	Normal	Meningitis	Completed
8	August	Parotid swelling, cough	A	Pus	Left hilum, UL	Pulmonary, EP	LTF
9	March	Cough, weight loss, night sweats.	A	Sputum	UL, cavitation	Pulmonary	Current
10	November	Parotid swelling, weight loss	A	Pus, sputum	UL	Pulmonary, EP	Current

Contact Tracing Extended – Wing A

- 159 inmates identified as exposed
  - 82 had been released or moved at time of screening
- 101 staff identified as exposed

- 77 inmates offered screening
  - 27 (35%) inmates IGRA positive – all completed treatment
  - 5 refused
- 101 staff offered screening
  - 10 (10%) staff IGRA positive – all completed treatment
  - 6 refused

Inmates who had moved on

- Only 51/82 (62%) of this group were located and screened

- 19/51 (37.5%) were IGRA positive
- 16 people started treatment
- Completion could not be confirmed in any

- Cases 8,9&10 were amongst the 31 dispersed contacts who were not located and screened

Screening on Wing B

- Screening was extended to wing B as cases were detected here in inmates transferred from wing A

- 4/96 (5%) inmates were IGRA positive
- 4/50 (8%) staff were IGRA positive

Summary of Cases

- 10 active cases of tuberculosis diagnosed over 36 months
- 64 cases of tuberculosis infection diagnosed

Issues with Outbreak Management

- Poor intelligence on inmate mixing
- Very high turn over of inmates
- Poor record keeping as to where people are

Treatment of TB Infection in Prison

- Issues
  - Arranging to see patients in clinic
  - Supervision of treatment
  - Drug interactions
  - Ensuring completion
  - Prison transfers

- All above could be discussed at IMT and arrangements made

Lessons Learned (or restating the obvious)

- Suspect tuberculosis in people with a prolonged cough!
- Inmates are at increased risk of having tuberculosis even if they do not have other risk factors
- Tuberculosis spreads quickly in congregate settings

Lessons Learned

- Act quickly if there is a case of infectious TB in a prison
- Visit the prison to gain intelligence about routes of transmission
- Consider doing clinics in the prison
- Supervise patients in prison on TB treatment
- Use observed chemoprophylaxis

Lessons Learned

- Conduct frequent staff awareness training around identifying and managing tuberculosis

- Consider having a TB nurse linked to the prison to facilitate
  - Patient management
  - Staff training
  - Act as a link for prison healthcare staff

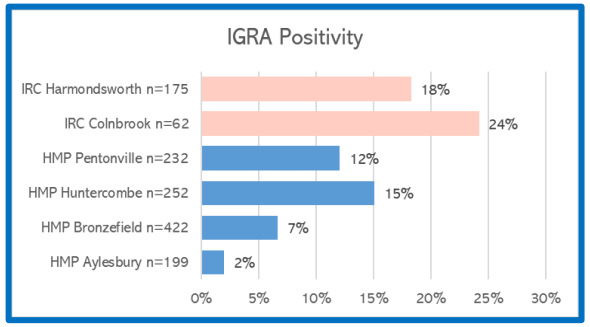
UK Health Security Agency

Overview of TB Guidance on Management of Tuberculosis (TB) in secure settings in England : Public Health Priorities

Launch of TB Guidance on the Management of Tuberculosis (TB) in secure settings in England
23rd October, 2025 11:00–12:30

Dr Anjana Roy
Consultant in Public Health – UKHSA National Health and Justice Team

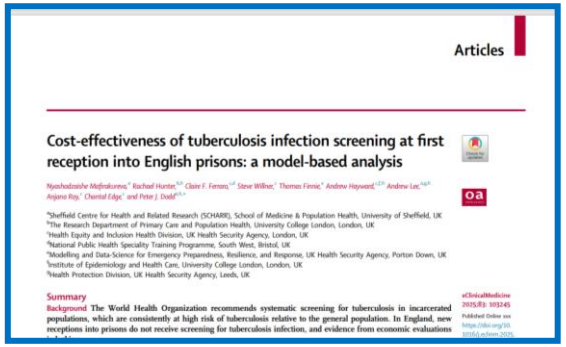
TB Guidance in secure settings informed by:



Evidence Gathering

- Bio-behavioural multi-pathogen survey (BBS) on infection prevalence.

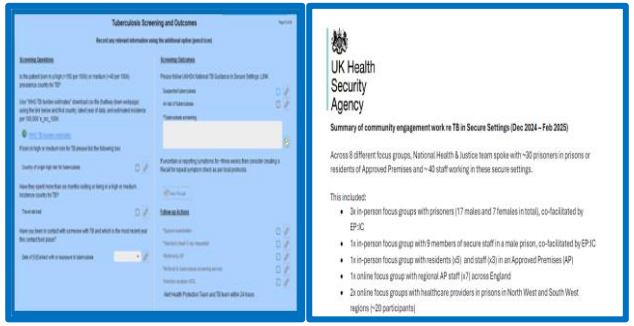
- LTBI modelling in secure settings commissioned with University of Sheffield.


Articles

Cost-effectiveness of tuberculosis infection screening at first reception into English prisons: a model-based analysis

Summary

Background The World Health Organization recommends systematic screening for tuberculosis in incarcerated populations, which are consistently at high risk of tuberculosis relative to the general population. In England, new receptions into prisons do not receive screening for tuberculosis infection, and evidence from economic evaluations


Tuberculosis Screening and Outcomes

UK Health Security Agency

Summary of community engagement work re TB in Secure Settings (Dec 2024 – Feb 2025)

Across 8 different focus groups, National Health & Justice team spoke with ~30 prisoners in prisons or residents of Approved Premises and ~ 40 staff working in these secure settings.

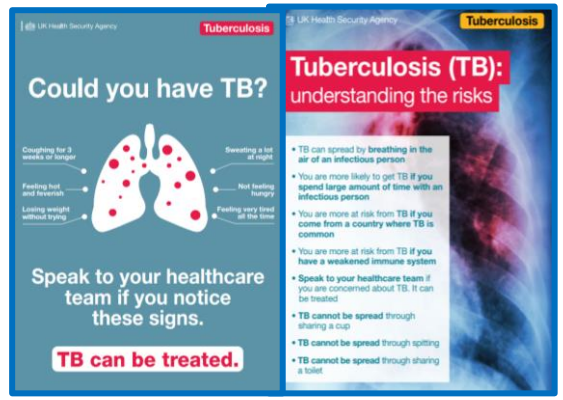
This included:

- 3x in-person focus groups with prisoners (17 males and 7 females in total), co-facilitated by EPIC
- 1x in-person focus group with 9 members of secure staff in a male prison, co-facilitated by EPIC
- 1x in-person focus group with residents (x5) and staff (x3) in an Approved Premises (AP)
- 1x online focus group with regional AP staff (x7) across England
- 2x online focus groups with healthcare providers in prisons in North West and South West regions (~20 participants)

Task & Finish Groups

- Clinical Reference Group: T&F group gathered evidence to update TB identification & management (UKHSA-led)

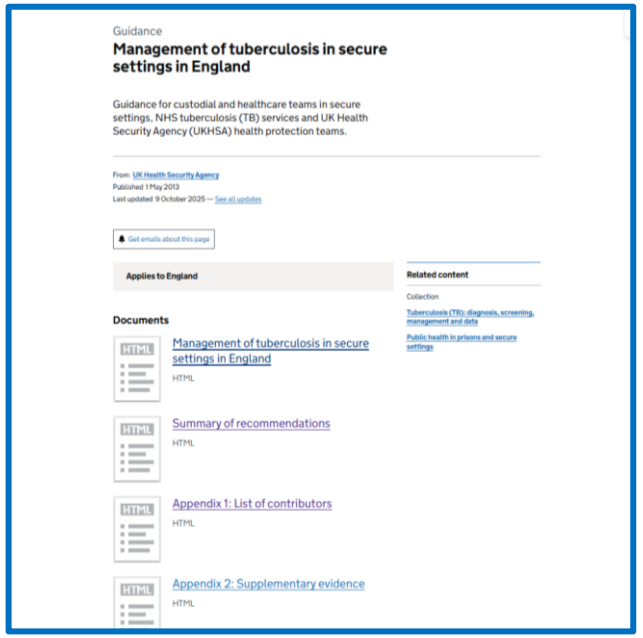
- TB Awareness T&F : Raised awareness in prisons (H&J HP network).



Consolidation: Work of T&F groups now taken forward by the **TB Group for PPDs**

Management of tuberculosis in secure settings in England - GOV.UK – Structure of Guidance

Landing pages


Guidance

Management of tuberculosis in secure settings in England

Guidance for custodial and healthcare teams in secure settings, NHS tuberculosis (TB) services and UK Health Security Agency (UKHSA) health protection teams.

From: UK Health Security Agency
Published 1 May 2013
Last updated 9 October 2025 — See all updates

Get emails about this page

Applies to England

Related content

Collection

Tuberculosis (TB): diagnosis, screening, management and data

Public health in prisons and secure settings

Documents

HTML Management of tuberculosis in secure settings in England
HTML

HTML Summary of recommendations
HTML

HTML Appendix 1: List of contributors
HTML

HTML Appendix 2: Supplementary evidence
HTML

[Management of tuberculosis in secure settings in England]

Guidance main text


Home > Health and social care > Public health > Health protection > Health surveillance and reporting programmes > Management of tuberculosis in secure settings in England

UK Health Security Agency

Guidance

Management of tuberculosis in secure settings in England

Updated 9 October 2025

Applies to England

Contents

1. Outline and purpose of guidance
2. What has changed
3. Who this guidance is for
4. What this guidance covers
5. Background
6. Roles and responsibilities
7. Testing or screening of people arriving in secure settings for TB disease
8. Residents with symptoms compatible with TB disease on arrival at a secure site or develop during their stay
9. Directly observed treatment (DOT)
10. Incident or outbreak management
11. Infection prevention and control
12. Occupational health provision for staff
13. Continuity of care following release, transfer, removal or deportation
14. Improving the awareness and knowledge of TB in secure settings
15. Latent TB testing
16. References

1. Outline and purpose of guidance

This guidance is intended to support the collaborative approach to prevention, diagnosis and management of tuberculosis (TB) in secure settings.

This guidance is evidence based and developed through expert opinion agreed by a multiagency group established within the Health and Justice Transform NHS England (NHSE) Clinical Reference Group, chaired by the UK Health Security Agency (UKHSA), and including partners from His Majesty's Prison and Probation Service (HMPPS), NHSE, Home Office, NHS TB services, NHS-commissioned providers of secure setting healthcare services, and people with lived experience of imprisonment. See full list of contributors in Appendix 1.

This guidance covers multiple settings which are listed in the section Who this guidance is for, below. These settings will collectively be referred to as 'secure settings'. Those who are resident in these settings, including prisoners in prisons and detained individuals in immigration removal centres (IRCs), will be collectively known as 'residents'. Those who are responsible for non-healthcare actions within these secure settings are referred to as 'governor' in prisons, 'centre managers' or 'director' in IRCs, and 'manager' in Approved Premises; these terms may be used interchangeably.

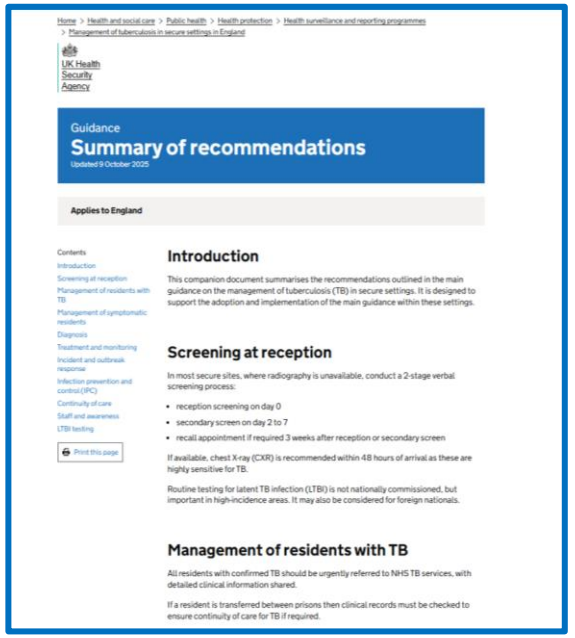
2. What has changed

The previous version of this guidance was in 2 parts:

a) Management of TB in prisons for prison healthcare teams (published in 2013)

b) Guidance for health protection teams (HPTs) on responding to TB incidents and outbreaks in prisons and other places of detention (published in 2014).

Summary of recommendations


Home > Health and social care > Public health > Health protection > Health surveillance and reporting programmes > Management of tuberculosis in secure settings in England

UK Health Security Agency

Guidance

Summary of recommendations

Updated 9 October 2025

Applies to England

Contents

- Introduction
- Screening at reception
- Management of residents with TB
- Management of symptomatic residents
- Diagnosis
- Treatment and monitoring
- Incident and outbreak response
- Infection prevention and control (IPC)
- Continuity of care
- Staff and awareness
- LTBI testing

Print this page

Introduction

This companion document summarises the recommendations outlined in the main guidance on the management of tuberculosis (TB) in secure settings. It is designed to support the adoption and implementation of the main guidance within these settings.

Screening at reception

In most secure sites, where radiography is unavailable, conduct a 2-stage verbal screening process:

- reception screening on day 0
- secondary screen on day 2 to 7
- recall appointment if required 3 weeks after reception or secondary screen

If available, chest X-ray (CXR) is recommended within 48 hours of arrival as these are highly sensitive for TB.

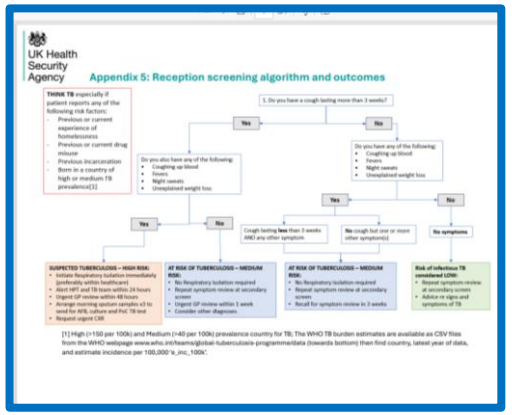
Routine testing for latent TB infection (LTBI) is not nationally commissioned, but important in high-incidence areas. It may also be considered for foreign nationals.

Management of residents with TB

All residents with confirmed TB should be urgently referred to NHS TB services, with detailed clinical information shared.

If a resident is transferred between prisons then clinical records must be checked to ensure continuity of care for TB if required.

Appendix 5: Reception screening algorithm and outcomes


UK Health Security Agency

Appendix 5: Reception screening algorithm and outcomes

THINK TB especially if patient reports any of the following risk factors:
- Previous or current experience of homelessness
- Previous or current drug misuse
- Previous incarceration
- Born in a country of high or medium TB prevalence[1]

1. Do you have a cough lasting more than 3 weeks?

Yes / No

Do you also have any of the following:
- Coughing up blood
- Fevers
- Night sweats
- Unexplained weight loss

Do you have any of the following:
- Coughing up blood
- Fevers
- Night sweats
- Unexplained weight loss

Cough lasting less than 3 weeks AND any other symptom

No cough but one or more other symptom(s)

No symptoms

SUSPECTED TUBERCULOSIS – HIGH RISK:
- Initiate Respiratory Isolation immediately (preferably within healthcare)
- Alert HPT and TB team within 24 hours
- Urgent GP review within 48 hours
- Arrange morning sputum samples x3 to send for AFB, culture and PoC TB test
- Request urgent CXR

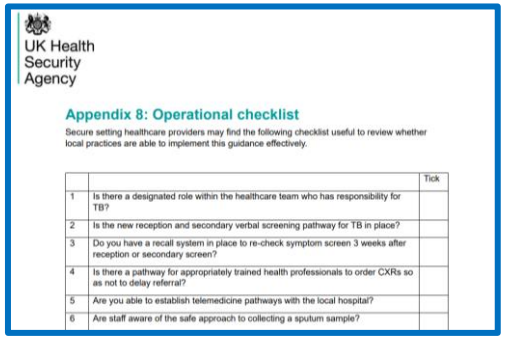
AT RISK OF TUBERCULOSIS – MEDIUM RISK:
- No Respiratory Isolation required
- Repeat symptom review at secondary screen
- Urgent GP review within 1 week
- Consider other diagnoses

AT RISK OF TUBERCULOSIS – MEDIUM RISK:
- No Respiratory Isolation required
- Repeat symptom review at secondary screen
- Recall for symptom review in 3 weeks

Risk of infectious TB considered LOW:
- Repeat symptom review at secondary screen
- Advice re signs and symptoms of TB

[1] High (>150 per 100k) and Medium (>40 per 100k) prevalence country for TB; The WHO TB burden estimates are available as CSV files from the WHO webpage www.who.int/teams/global-tuberculosis-programme/data (towards bottom) then find country, latest year of data, and estimate incidence per 100,000 'e_inc_100k'.

Appendix 8: Operational checklist to implement this guidance effectively


UK Health Security Agency

Appendix 8: Operational checklist

Secure setting healthcare providers may find the following checklist useful to review whether local practices are able to implement this guidance effectively.

		Tick
1	Is there a designated role within the healthcare team who has responsibility for TB?	
2	Is the new reception and secondary verbal screening pathway for TB in place?	
3	Do you have a recall system in place to re-check symptom screen 3 weeks after reception or secondary screen?	
4	Is there a pathway for appropriately trained health professionals to order CXRs so as not to delay referral?	
5	Are you able to establish telemedicine pathways with the local hospital?	
6	Are staff aware of the safe approach to collecting a sputum sample?	

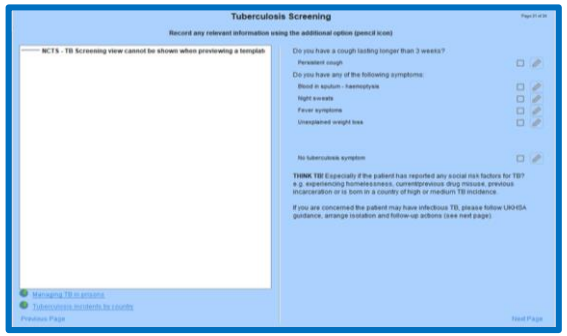
Key Updates TB Guidance for Secure Settings

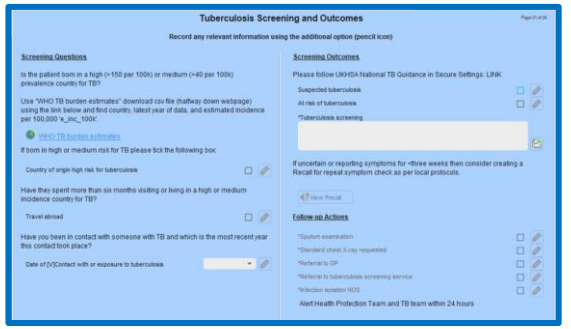
Strengthened Screening in Prisons

- Two-stage verbal TB screening (replaces single reception) screening in the prisons; Reception Screening and Secondary Screening

Table 1: TB verbal screening on arrival – summary

	Reception screening	Secondary screen	Recall appointment
When	Day 0 (within 24 hours)	Day 2 to 7 (within a week of arrival)	3 weeks after reception or secondary screen
Question	Symptom screen for TB. History of current or previous T B treatment	Repeat symptom screen for TB. Full history of previous TB diagnosis and treatment	Repeat symptom screen for TB





- Included RECALL in both reception and secondary screen: Uncertain about symptoms
- Current Treatment: A new section has been added to record whether the individual is currently on treatment to ensure continuity of care
- Follow-up Actions: Sputum examination has been included as it is identified as a very efficient – simple and confirmatory way to diagnose TB

Management of TB on Entry and Transfer in Secure Settings

People Arriving on TB Treatment

- Admit to a single cell if treatment incomplete; inform NHS TB service within one working day.
- Share key details (diagnosis, treatment, adherence, sensitivities) to ensure safe, continuous care.

Transfers Between Secure Settings

- Review records for TB history and current treatment.
- Liaise between healthcare teams to maintain treatment and follow-up contacts.

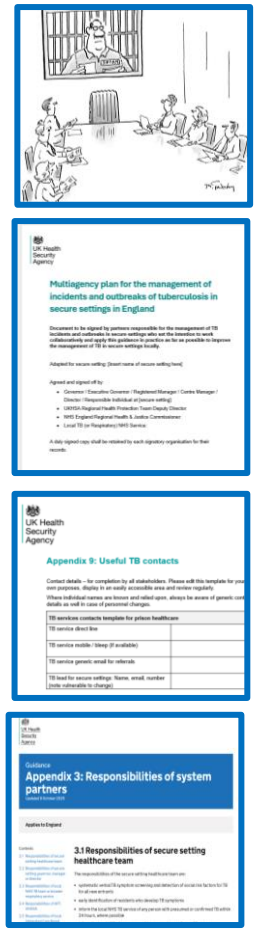
Approved Premises

- No on-site healthcare; residents supported to register with a GP for TB management.

TB Incident or Outbreak Management

Definitions

- **TB Incident:** Any person (staff or resident) with infectious pulmonary or laryngeal TB present in a secure setting.
- **TB Outbreak:** Two or more linked cases (by time, place, exposure, or strain) suggesting recent transmission
- **Close Contact determined by the IMT; usually includes**:
  - Cellmates and immunocompromised residents
  - Individuals sharing activities (education, gym, etc.)
  - Staff or escorts without PPE during contact or transport
  - Visitors, household, or community contacts linked to the case



Case Identified

- **Health Protection Team** conducts an initial **risk assessment** and may convene an **Incident Management Team (IMT)** meeting to coordinate response.
- **Membership (Appendix 9)** and **roles/responsibilities (Appendix 3)** outlined in guidance.
- **IMT determines** contact tracing, screening, and control measures.

Contact Tracing: Identifying additional active or latent TB cases among contacts to assess risk of transmissio

Approach to contact tracing

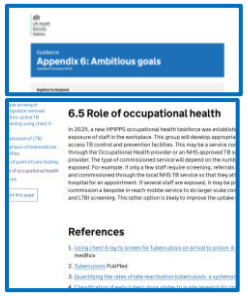
- **Use a risk-based "stone in the pond" approach;** extend tracing if transmission suspected.
- **Extend testing if:**
  - New active TB cases found
  - TB strains cluster on genomic sequencing
  - High LTBI rates or IGRA conversion detected.
- **Prioritise contacts** with **≥8 hrs exposure** (or **4 hrs if immunocompromised**).

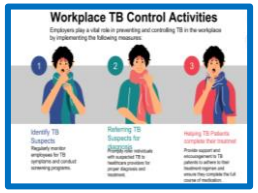
Contact Tracing – Residents

- **Identify and flag** close contacts in SystmOne
- **Tests:** Perform CXR and sputum testing where indicated; test for LTBI (IGRA**)** once active TB excluded.
- **Outcomes:** Refer all positives to the local NHS TB service and update outcomes in clinical records.

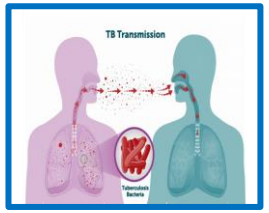
Contact Tracing for Staff and Visitors

Contact Tracing – Staff





- Identify and inform all exposed staff.
- Provide TB information and arrange screening per local pathways.
- Commission TB screening for secure setting staff through occupational health services or equivalent



Contact Tracing – Visitors & Others

- Identify visitor and community contacts; provide TB information.
- Refer to the **local NHS TB service** for clinical assessment and follow-up.

Closure of IMT/OCT

- IMT declares the incident/outbreak over once **all contacts are followed up** and **no ongoing transmission** is detected.

Continuity of Care – Release, Transfer, Removal or Deportation

Planning & Coordination

- Early risk assessment and communication with NHS TB service/HPT.
- Keep records current; use MDTs for transition planning.

Transfers & Release

- Care plan for follow-up and National TB Surveillance System (NTBS) updates.
- Provide 7-day medication; notify HPT; use virtual court if infectious.

Homelessness & Community Care

- Secure accommodation before release.
- Support with DOT/VOT and translated information.

Immigration Removal Centres (IRCs)

- Maintain medical hold; no transfer/deportation while infectious.
- On release, ensure safe housing, care handover, and medication supply.

UK Health Security Agency

Management of TB in Secure Settings in England - Overview of the Guidance - Clinical Management and Care Pathways

23rd October 2025

Emily Shaw
Infectious Diseases Consultant – TB Unit, UKHSA

Residents Reporting Active TB Symptoms

- NICE, 2016: digital CXR all new arrivals <48hrs (if not done <6M) if available (is not).
- Reception verbal screening for TB sx remains mainstay of TB screening in secure sites. Insensitive, but may help identify some individuals who require further testing.
- Secure setting healthcare doctor/nurse should assess any resident w/ any of:
  - Cough
  - Unexplained weight loss
  - Drenching night sweats
  - Loss of appetite
  - Backpain
  - Coughing up blood
  - High temperature
  - Swollen lymph nodes
  - Tiredness

- If clinically unstable -> urgent transfer to ED w/ transmission-based precautions.
- If stable, may be possible to achieve a TB dx in secure setting:
  - reduce diagnostic delay,
  - avoid hospital transfers,
  - reduce the stigma of attending hospital while handcuffed to officers
  - limit staff exposure (during transfers and bed-watch).

Diagnosis I

- Any sx & stable
  - Prompt referral to local NHS TB service
  - Respiratory isolation asap
- PTB suspected – Micro testing:
  - 3 sputum specimens (supervised)
  - Consecutive days, ≥1 early am on waking & pre-breakfast - pulmonary secretions from overnight
  - Transparent, screw-capped, leak-proof containers
  - Request acid fast bacilli smear & culture & for 1 TB PCR. Smear microscopy & TB PCR = rapid & highly sensitive w/ good PPV & available from secure site. Culture is gold-standard
  - High quality=thick w/ sticky material. Poor quality eg saliva may -> false -ve though may still -> +ve TB PCR
  - Labelled w/ date of collection & patient identifiers
  - Sent to local microbiology lab asap (specimen fridge if w/e)
  - Flag samples as important w/ local micro lab and pursue results

Diagnosis II

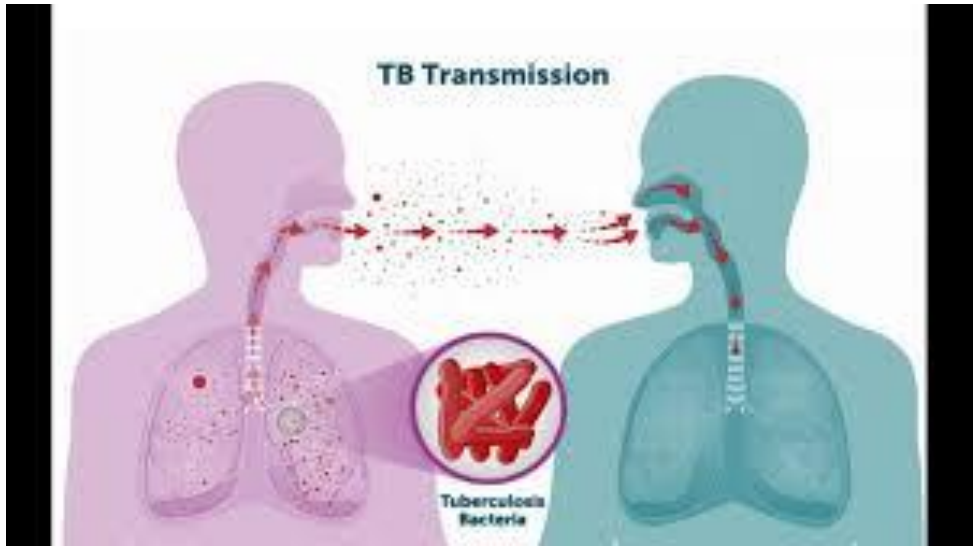
- TB suspected – Radiology
  - CXR asap & FU urgently
  - Ideally w/in secure setting eg mobile or ultra-mobile radiology
  - Otherwise, refer to local radiology department, or done as part of a local NHS TB service assessment.
  - Any resident w/ abN CXR suggestive of TB, regardless of sx/sputum sample results, should be referred urgently to the local NHS TB service
- IGRA tests designed to detect TB infection, not recommended as diagnostic test for active TB disease.

Treatment Adherence & Monitoring

- DOT
  - Patient-centred, enhanced mx approach
  - Aims to improve tx adherence by assigning designated individual - administers, supervises, witnesses & records swallowing of every dose of TB medication by patient.
  - Adherence reduces infectiousness, prevents disease progression & reduces risk of developing DR
  - Report missed doses
  - Should be regularly audited
- By default, DOT is recommended in all secure settings. May be prohibitively restrictive - individualised patient risk assessments & tailored to optimise tx completion.
- Local NHS TB nurse should visit w/in 5 d - assess SEs, clinical issues & adherence. Then agree next FU
- Blood tests for toxicity and SE monitoring

Infection Prevention and Control I

- Consider potentially infectious:
  - Clinical suspicion of pulmonary/laryngeal TB, pending outcome of dx tests
  - CXR compatible with active TB disease, pending dx tests & specialist r/v
  - Confirmed DS PTB until ≥2wks tx, good adherence & absorption & can deisolate
  - Confirmed DS TB & non-adherent or hx incomplete treatment
- Not infectious:
  - Extra-pulmonary TB
  - LTBI, but if untx remain vigilant for sx



Infection Prevention and Control II

- Isolate in a single room/cell w/ hygiene/toilet facilities & door kept shut
- Only essential staff/visitors wearing appropriate PPE. Avoid non-essential contact but meet needs
- PPE: single use, fluid-resistant, fit-tested FFP3 mask (NB facial hair) or powered respirator hood (which comply w/ HSE guidance, decontam schedule & appropriately stored & maintained)
- Secure setting H&S & HC provider responsible for providing IPC resources & training to prevent OH staff exposure. Resident FRSM for indoor movement
- MDR-TB: tf to hospital w/ -ve pressure facilities until de-isolation criteria met
- Assess ventilation systems to ensure air from isolation room not extracted into other areas.
- Hospital bed-watches

Latent TB Infection testing

- No national commissioning for routine LTBI testing in secure settings
- In secure settings, robust CT & testing of close contacts should be priority over routine LTBI screening - greatest overall benefit. Also raise awareness of TB sx & promptly detect active cases
- Measures to routinely identify & manage LTBI cases will be required to reduce incidence & transmission. In this context, active TB needs to be excluded first – should not be using IGRA to screen for active disease.
- May opt to commission locally systematic TB testing, cost-effective may be better in areas of high incidence, or secure settings w/ high proportion of foreign national residents or SRF 'enhanced targeted testing'.
- LTBI testing should only be conducted when clear pathways established for residents & staff who test positive to be mx until tx completed.

UK Health Security Agency

TB – Awareness raising materials for PPD settings.

Ian Palmer – National Health and Justice Team, UKHSA.

Background

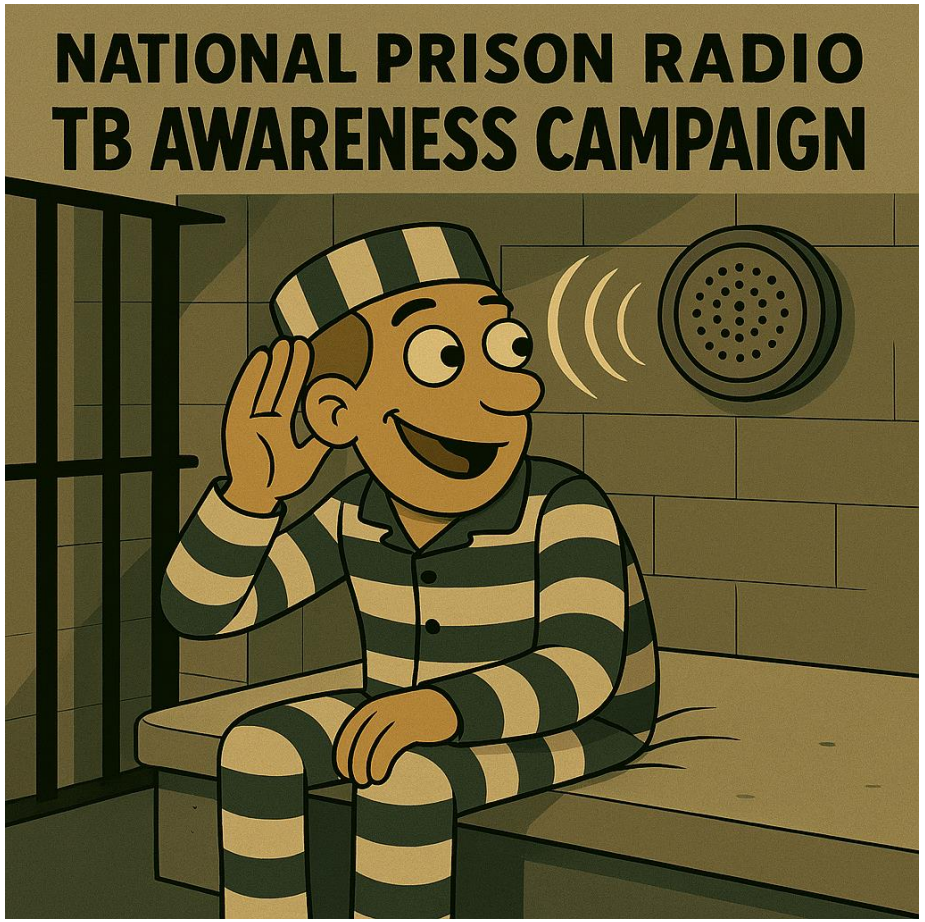
- T&F Group formed at the request of the National H&J Health Protection Network. In response of increasing number of cases in prisons.
- Membership,
  - UKHSA
    - H&J Team,
    - TB Team
    - Regional HP Teams
    - Comms
  - NHS
    - National H&J Team
    - Regional Public Health Leads
  - HMPPS
    - National Public Health Team
    - Comms
    - Health & Safety

- The T&F group concluded October 2025.

Key Objectives

- To improve the awareness of the symptoms and risks associated with TB for those people in prisons and other places of detention (PPD's) by producing a range of communication resources for both prisoners and staff, including Healthcare teams.
- To highlight the importance of treatment continuity post release.

National Prison radio TB Awareness campaign



Prison radio campaign

- Commissioned National Radio Association (NRA) to run a three-month radio campaign. This included a series of adverts that are played regularly between the scheduled programmes. The campaign was extended by a further three months.
- The ads covered, **Symptoms**, **Transmission Routes**, **Treatment** and **Myth busting**
- A longer programme was recorded with interviews with a prison Healthcare Clinical Lead, a prison GP, a community TB Consultant and someone with lived experience of TB.
- The campaign ran from February to August 2024. An evaluation off its reach and effectiveness was carried out.
- A 5 month repeat campaign to run from November 2025 to March 2026

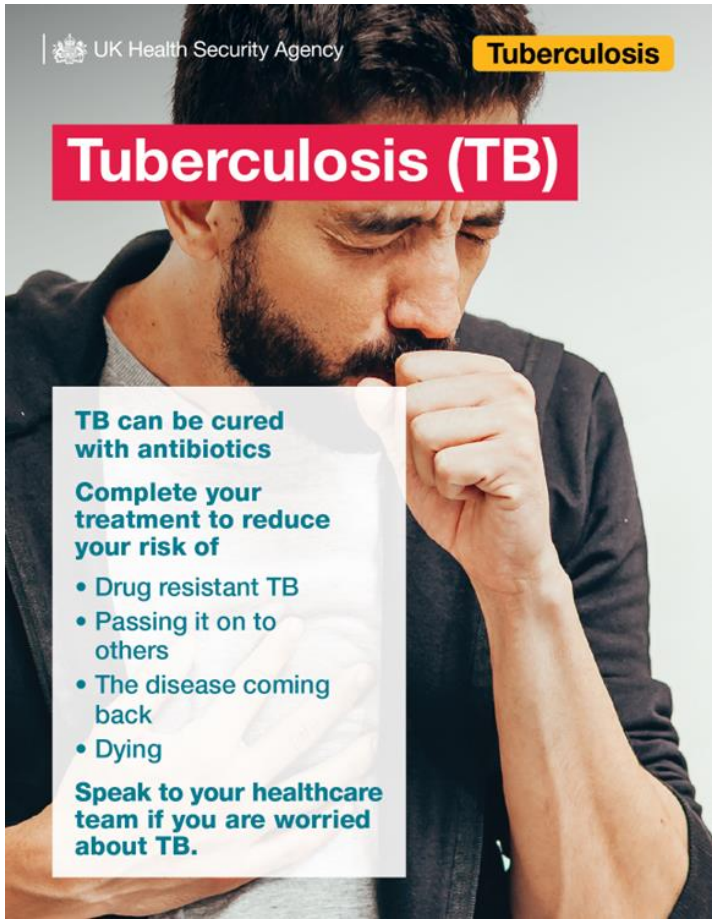
Training webinars for staff

Webinar

- Live webinar event held 26th June 2025
- 285 attendees including operational prison staff and healthcare staff
- Event covered the risks, symptoms, treatment and myths of TB.
- The attendees were asked for their feedback, **89%** said that their understanding of TB had improved.
- A recording of the webinar is available via the WEPHREN website -Webinars and videos • WEPHREN

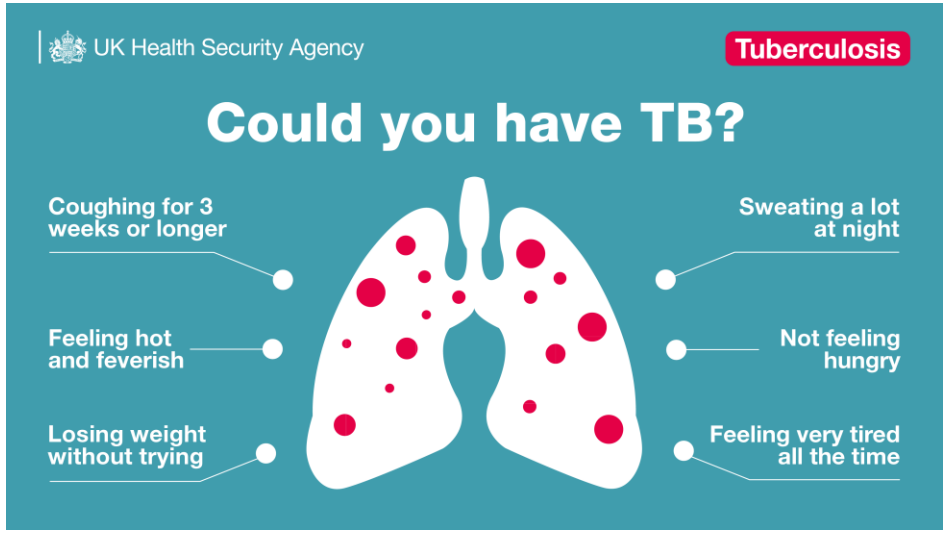
Posters, Leaflets & other Resources

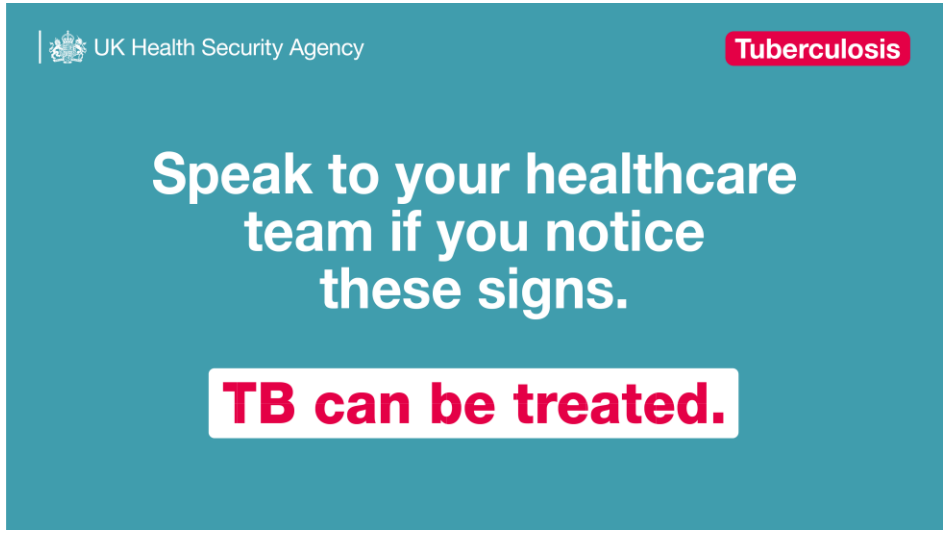
- Developed a number of resources based on existing TB Toolkit graphics.
- Included A4 posters and visuals for TV screens.
- All available on the UKHSA Health & Justice Landing Page. Public health in prisons and secure settings - GOV.UK


UK Health Security Agency
Tuberculosis
Tuberculosis (TB)
TB can be cured with antibiotics
Complete your treatment to reduce your risk of
• Drug resistant TB
• Passing it on to others
• The disease coming back
• Dying
Speak to your healthcare team if you are worried about TB.


UK Health Security Agency
Tuberculosis
Continuing your TB treatment after release
Speak to your healthcare team
about how you will continue your treatment for TB on release

Visuals for 16:9 screens





Next steps

- TB resources and communications will continue to be reviewed and updated
- A short staff training package is being developed
- Exploring opportunities to work with Wayout TV

UK Health Security Agency

NHS England

Case Study- In-reach Chest X-Ray

Rachel Campbell –Public Health-Health & Justice Lead South West

South West Region

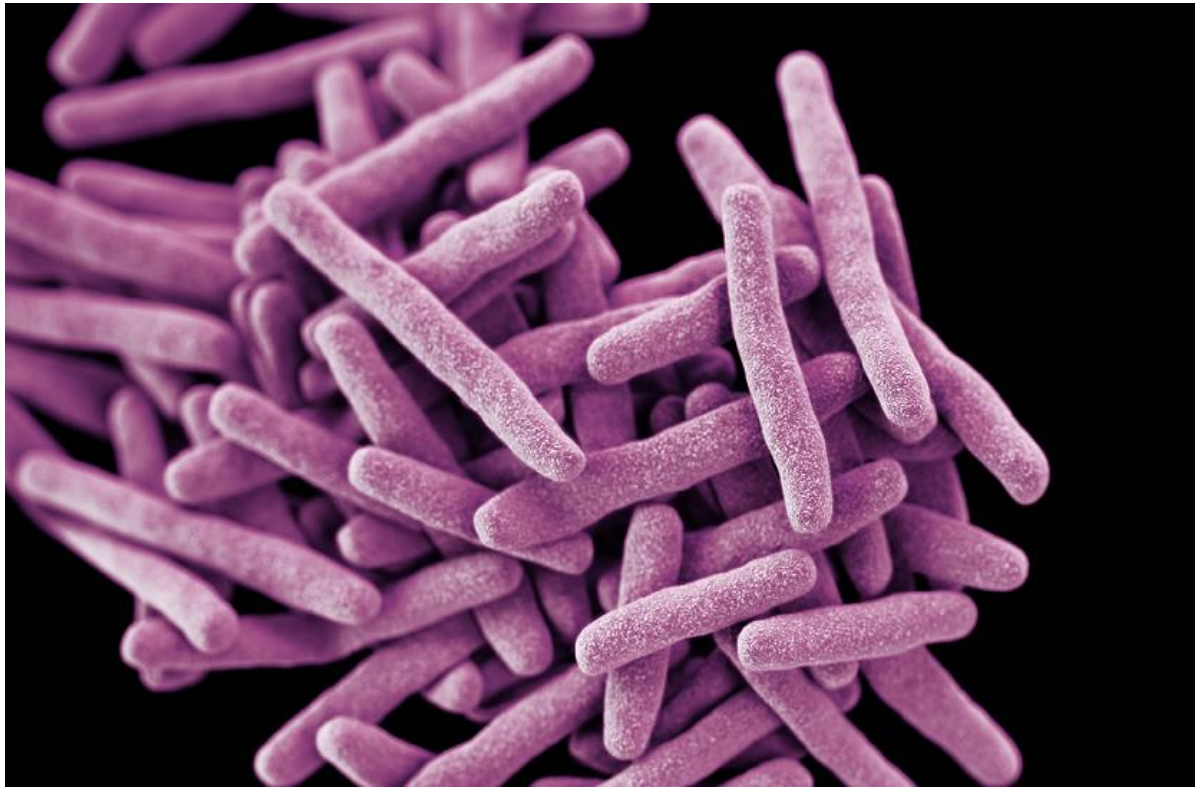
- The South West landscape has diverse rural ,urban and costal communities. Population has a reasonably life expectancy lived without illness in comparison to the National average.
- South West Region has shown a notable increase in Tuberculosis (TB)
- In 2023 incidence was 3.6 per 100,000 population, with 212 cases reported, 29% increase from the previous year
- In 2024 number of notifications was 246 cases, a 16% increase from the previous year
- Region has seen a notable increase in non-UK born cases and in the 15-44 year age group, contributing to the rise
- South West Region still has one of the lowest TB rates, 4.2 notifications per 100,000 population

Low TB Prevalence comes with challenges:

- A low clinical suspicion for TB
- Generalist respiratory staff –Also Managing TB
- Some Community TB Specialist Teams
- Challenges to rapid diagnosis and treatment Rurality poses challenges for accessibility, resourcing and resilience
- Similar challenges for secure prison settings & Justice Pathways

South West Prisons

Prison	Operational Capacity
Prison 1	746
Prison 2	0
Prison 3	512
Prison 4	310
Prison 5	483
Prison 6	447
Prison 7	580
Prison 8	416
Prison 9	398
Prison 10	538
Prison 11	608



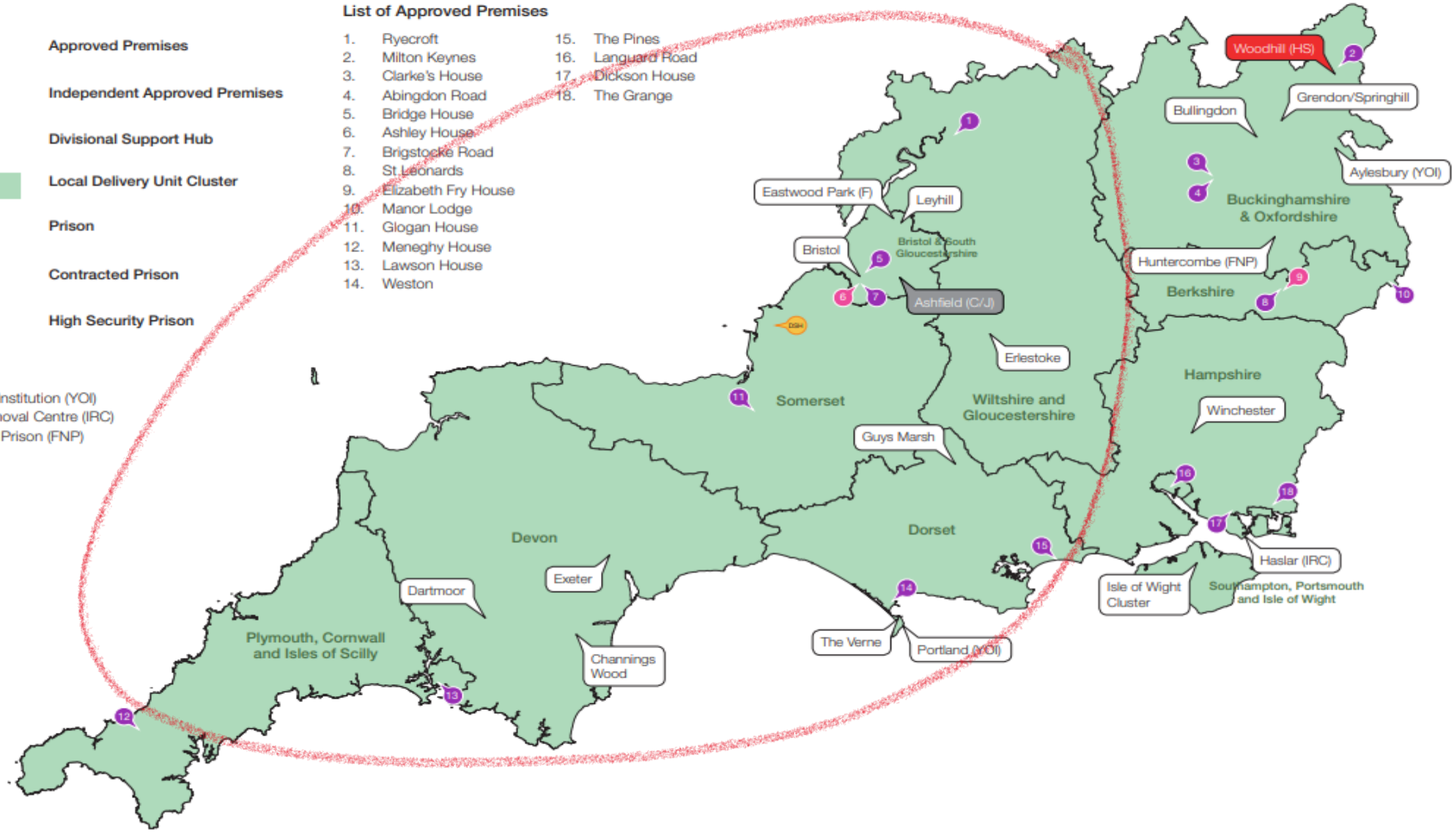
Key

- 15 — Approved Premises
- 8 — Independent Approved Premises
- DSH — Divisional Support Hub
- Devon — Local Delivery Unit Cluster
- Dartmoor — Prison
- Ashfield (C/J) — Contracted Prison
- Woodhill (HS) — High Security Prison

Juvenile (J)
Female (F)
Young Offender Institution (YOI)
Immigration Removal Centre (IRC)
Foreign National Prison (FNP)

List of Approved Premises

1. Ryecroft
2. Milton Keynes
3. Clarke's House
4. Abingdon Road
5. Bridge House
6. Ashley House
7. Brigstocke Road
8. St Leonards
9. Elizabeth Fry House
10. Manor Lodge
11. Glogan House
12. Meneghy House
13. Lawson House
14. Weston
15. The Pines
16. Languard Road
17. Dickson House
18. The Grange



TB Screening

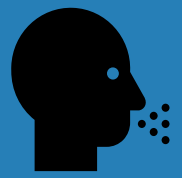
Current Practice

- SEAT Template
- TB Assessment
- CXR Out-reach
- Engage with Respiratory Team (Acute/Community)
- UKHSA

Challenges

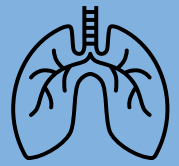
- Prison as a high-risk setting
- Wider complexities
- System Movement
- Rurality
- Respiratory teams (ARI/TB)
- Location & Hospital Link

Case Study-TB

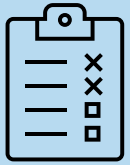


Male early 30's Weight loss, productive cough, night sweats

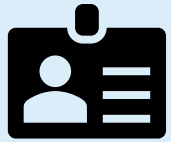
GP Review- Sputum sample. CXR referral



Out Reach Appointment & CXR (Included Pad-Mate)



Results suggest active TB



IMT Contact Tracing & Prison History

Find & Treat

Find & Treat

- Contacts in staff and prisoner group
- Find and Treat option
- **Collaboration with:**
  -NHSE Commissioning
  -Healthcare Provider & GP
  -Acute Respiratory Team
  -UKHSA
  -HMPPS
  -National UKHSA H&J Team
- In-reach option

Bio-behaviour Study Option

- TB/LTBI
- STI
- BBV Testing
- MMR

Opportunity

- Screening of identified contacts
- On-site enabling easier access
- Wider invite across the prisoner population
- Potential to reduce Stigma
- Build relationship with Acute service

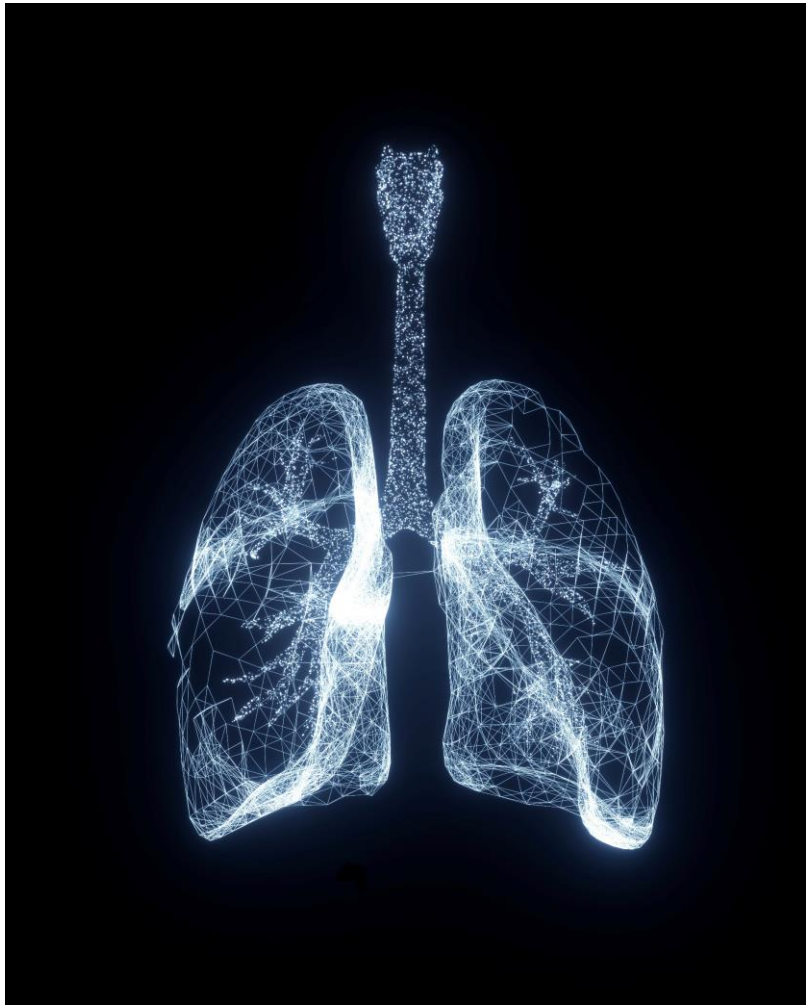
Outcomes & Summary

- Find & Treat on-site for 5 days
- Contacts of the TB case were prioritised
- **Total of 284 individuals engaged with most or all of the testing**
- **Approximately two thirds of the prisoner population screened**
- Reduced Stigma at that point in time
- No new active TB cases identified at that point
- 32 individuals identified with LTBI
- Follow up by telemed
- Acute respiratory team in-reach follow up

- In-reach provides opportunity to manage CXR more efficiently
- Identify/exclude contacts (alongside wider testing need)
- Reducing time, travel and wider security need
- Less disruption broadly
- Anecdotally, reduced stigma
- Work with NHSE/UKHSA Partners to agree cost

Summary

- The Bio-behaviour study did present wider opportunities
- Low number of close contacts
- Wider offer enabled invitation to screen contacts & wider offer
- Opportunity for early intervention
- Prisons are a high-risk setting
- Higher than expected LTBI which required further intervention
- Anecdotally reduced stigma
- Early intervention and prevention



Questions?