PRISON SERVICE JOURNAL

March 2022 No 259

Special edition:
Recovering from the COVID-19 Pandemic

A public health approach to pandemic response and recovery

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Dr Eamonn O'Moore qualified in medicine from University College Dublin in 1991. He is an expert public health adviser to NHS England, HM Prison and Probation Service, the Department of Health and Social Care, the Ministry of Justice, the Home Office, the World Health Organisation (WHO), as well as several national governments, academic institutions, non-governmental organisations and research organisations. He has written national and international guidelines on managing health issues in prisons and other places of detention; established an international research collaboration to promote evidence-based practice in prisons, and supported the development of national and international health data and intelligence systems in prisons and other justice settings. He has led work for the former Public Health England on public health approaches to serious violence prevention, sexual violence prevention and violent extremism.

This interview took place October 2021.

MM: How did the coronavirus pandemic have an impact upon your organisation?

EOM: The team I led in Public Health England has become almost exclusively focused on managing the pandemic and from 30th September 2021, our work has largely moved into the newly established UK Health Security Agency (UKHSA).

MM: How did you change your service in order to continue during the pandemic?

Much of our routine work was stood down or deprioritised, while we became a seven-day service with on-call, after hours and weekend and bank holiday working.

Teams were responding to outbreak control day and night. This substantially increased the hours people were working and impacted on all sorts of things, like the ability to take leave. While the team aimed to stay ahead of the curve, all too often it was about firefighting. There were many things going on that meant we needed a team dedicated to the pandemic above all other priorities. It has been a huge part of our lives for the last 20 months.

MM: What did you learn from this?

EOM: We have been learning from day one. We swiftly realised that we need to continue to have an array of skills within our public health teams that enable people to have the scientific expertise and clinical expertise to effectively respond to the challenge of a pandemic. This has led to very specific considerations of staffing levels, skill mix and making sure we have got those right.

We have looked at how we prioritise areas of work, with an enhanced focus on health protection and health security. As a result, and reflecting the creation of UKHSA, health improvement functions are transferred to The Office for Health Improvement and Disparity within the Department of Health and Social Care.

The team I now lead has a renewed focus on health protection and health security and this is a team with an appropriate skill mix to make sure we can respond to both the current and any future threats.

This has highlighted how we think about ways to work more effectively with others, whether that be academics, other parts of government, international partners or other stakeholders to ensure we get the best scientific and other evidence to support our work. This will ensure we are able to commission and deliver research to inform our work more effectively, and we also learn from the experiences of others.

MM: Is there anything that you will continue to do that you had started during the pandemic?

EOM: Yes, for sure. We were already doing a lot of work with academic partners and scientists and we will continue to build on these partnerships. The sort of science that informs the modelling of infectious disease impacts on settings like prisons will be vital, and further research into what infection prevention and control practice for these settings need to be will flow from the learning we have had during the pandemic.

We always worked with international partners through the World Health Organisation (WHO) and will

continue to build on that good work. People look to the UK for public health leadership in the area of prison health and we will continue to enhance our leadership role as the UKHSA.

We are continuing to develop our surveillance capability, both nationally and internationally. This will help us understand better any new infectious disease threat on the prisoner population, a population all too often excluded from national surveillance systems. As part of national preparations and national surveillance systems, we have all learnt the lesson that prison populations are both part of the problem and may be part of the solution.

MM: Was there anything that you lost during the pandemic that you felt was particularly valuable?

EOM: We all recognise that because of the priority of the pandemic, some of the public health programmes we have been working on up to that point were deprioritised, for example around hepatitis C. Before the pandemic we were sending in teams known as High Intensity Testing and Treatment Teams or HITT Squads into prisons, to diagnose and then rapidly access treatment for hepatitis C. The programme was making a real contribution towards elimination of hepatitis C, not only in the prisoner population, but also contributing to our national ambition around eliminating hepatitis C by 2025. The programme was completely impacted by the pandemic and we are trying to bring the programme back on stream.

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In March 2020, we held a meeting with Leicester City Council about how we improve access to this programme for people in prison, bearing in mind cardiovascular disease is one of the biggest killers. This programme was designed, among other things, to find early signs of problems and intervene before they became harmful. There were also things we had been doing around screening programmes for cancer and non-cancer conditions impacted by the pandemic. We are thinking about how we can most effectively reboot these programmes, potentially using lessons learned from our pandemic work.

While with hindsight we might have done certain things differently, it is vital to remember that at the time people are dealing with the information currently available at that time. So, on a personal basis, of all the things I lost, I lost a lot of sleep! I lost track of time and I remember often thinking 'what day is it?'. I literally couldn't remember what day of the week it was, as every day increasingly blended into the next during the response.

But we also gained. We have had a huge sense of our value affirmed; we saved the lives of people in prison; we have developed a whole range of relationships and knowledge which will add benefits to our prison work in years to come. Undoubtedly, the interventions we delivered collectively across the prison service with the NHS, Public Health England/UKHSA, our prison families, people in prison; and with our staff, saved lives. At the start of the pandemic we predicted about 2000 people potentially dying from COVID-19 in our prison system. While unfortunately there have been some deaths — and every one of them was a real tragedy — thankfully the number has been much less than our worst-case scenario. Recent data suggests around 150 people in prison died as a result of Covid-19.

MM: How are you planning for the future?

EOM: We are really focused on two things: One is continuing to respond to the pandemic and secondly, we are considering the added challenges of responding to a second Covid winter when we know we will have more than Covid to deal with. We will also need to deal with flu, which can be a challenge.

Our clear objective of getting through this winter means we need to prepare the system. In the longer term, and as we look beyond the pandemic into the post pandemic period, we have got the ambition to — as a currently fashionable phrase would have it — 'build back better'.

We are looking forward to a period of our collective action to put into practice the lessons we learned about surveillance systems, whether about testing protocols, infection, control measures, or guidance, but particularly around getting the science to answer those questions for us, and sharing practice internationally. This is important both for UKHSA and personally, as someone who has worked for many years with the WHO.

MM: Do you expect that the vaccination programme will end the need for further measures?

EOM: The vaccination programme is a hugely important way to reduce the risk of an infection with significant consequences, including hospitalisations and deaths. But as we have seen during this pandemic and other diseases, vaccination alone may not completely reduce the risks. We need to be mindful some measures may be required, continuing forward into what might be the new normal. That could be around things we continue to do with regards to testing people for evidence of infection, or could be about some of the infection prevention and control measures.

Most measures may substantively be stood down, but with flexibility to perhaps be stood up very quickly in response to detected outbreaks. Our efforts will move towards a steady state, where we have minimal measures in place, but the ability to detect an emergent infection that could be the sign of an outbreak, and get on top of that quickly, and for time limited periods only.

MM: Do you think there has been a culture change as a result of the pandemic?

EOM: I think so much has changed in response to the pandemic, some things better than others. Some things we have learnt to do will be things we should continue to do in some way going forward. For example, communicating with a virtual platform, and telemedicine sessions in prisons, have enabled prisoners to have access to our health care specialists in a more accessible, flexible way that doesn't require them to leave the prison. But we also need to get back to a time when people who need to see a doctor face to face can do. We will certainly want to ensure a good balance.

We have also seen benefits to people from virtual visits, helping reduce the impact of a lack of contact with their family in a physical way. Virtual visits mean access to visits more easily, with interaction with their children, and even seeing their normal place of residence as benefits which improves the quality of life in prison and helps to make people feel less isolated.

The national partnership agreement defined our shared ways of working and the way we work together. The pandemic has highlighted the importance of effective partnership working across organisations, reinforced this culture and I think people have seen the value, and I expect it to continue going forward.

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MM: What changes do you think will be made to the services that prisoners receive?

EOM: In general, more personalised approaches to healthcare, physical, mental health and other needs of a person and their social situation. There is more focus on what happens beyond the prison gate, as well as what happens within the prison walls as part of our total package of care.

We will see increasing recognition of the importance of maintaining social relationships, whether between parents and children, between partners, or between other family members, which is part of the rehabilitative journey.

MM: Have prisons become slightly over cautious and will they limit the types of activities that prisoners can do because of the pandemic?

EOM: The prisoner population is much more complex now. Therefore, our prison environments need to change to meet the complexity of needs. I hope that rather than seeing the pandemic and that experience as limiting access to prison regime going forward, it is a good place for us to start to talk about reform, and what a well-run and clean, healthy prison looks like. Not only for infection control, but for developing environments where prisoners feel safe and secure.

I hope this will be a time of great reform. Buildings will have to be much more resilient to infection and this will reflect on how the prison population is managed. How the physical space is managed, and the way it is maintained, the facilities provided to enable people to look after themselves, and their cleanliness and hygiene. These are ideas pioneered long ago by Florence Nightingale.

MM: There have been concerns that the pandemic has intensified social inequality and equity. Have you observed this in prisons?

EOM: Prisons are by their nature, places where people experience health inequalities prior to incarceration and sometimes during incarceration.

There have been some examples of how prison can also be a health opportunity. Sometimes it is sad to say, but prison may be a place where people get better access to structural care through primary and specialist care than they would in the community. There is

evidence that this is the case for some young men who come into prison.

In prison we can screen people for blood borne viruses or sexually transmitted infections, look at diagnosing underlying mental health needs that can then be treated, and make progress addressing physical health needs, like checking blood pressure and cholesterol and so on. Structured health and social care provide opportunities to address health inequalities that existed prior to prison.

The fact that prisons are what they are sometimes meant they have had to experience things differently to the community. You and I may have some choices about how we access Covid testing or Covid vaccination and this is not available in the same way to people in prison. But I firmly believe people in prison should not be structurally excluded from accessing vaccine or testing, or any health and social care services that can be accessed in the community.

There is an opportunity, particularly with the vaccine programme, to really address one great inequality, which is the differential uptake of vaccine across the population reflected in prisoner populations.

We can work with people to engage with them in ways that they find meaningful and make community services part of the solution. There is great benefit in peer workers being part of the solution and exploring how we engage with people in prison. Involving the people who live in that space, who are part of that community, often have the solutions to the problems.

Our mission when working with prisoners is to address health and social care inequalities. We work our hardest to give people opportunities to address health needs, whether covid vaccination or testing, or anything else they really need to get sorted in their lives. We support prisoners by talking to them about vaccines with peer workers who they respect, and they are generally more engaging and open to discuss their experience and views.

MM: From your personal experience, how has this whole journey of the pandemic affected you?

EOM: I have worked harder during the last 20 months than I have ever worked in my life. It has certainly been hugely demanding on me, my family and my life. My partner and I really do not take anything for granted now, some of which I may have done in the past. In ways I never would have imagined I have sometimes found it incredibly emotional and demanding.

The pandemic has also given me renewed energy to really push forward the work about addressing the health needs of people in prison. It has given me extra insights into the ways we might be able to do things going forward. Partnerships have always been there, and I felt really supported by people within my organisation and by people outside of my organisation.

The prison and the public health systems have learnt important lessons that we can never take things for granted. Worlds can change overnight and as systems and individuals we need to be prepared for the unexpected.