Public Health England

HM Prison & Probation Service

NHS England

Seasonal Flu guidance for 2017/18 for healthcare staff and custodial staff in prisons and other prescribed places of detention for adults in England.

- preventing and responding to seasonal flu cases or outbreaks

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

For queries relating to this document, please contact: health&justice@phe.gov.uk

Published September 2017
PHE publications
gateway number: 2016388

PHE supports the UN
Sustainable Development Goals

Title	Guidance for 2017/18 on preventing and responding to cases or outbreaks of seasonal flu in prisons and other prescribed places of detention
Type	Operational guidance
Author/s	Public Health England: National Health & Justice Team Respiratory Diseases Department, National Infections Service
Prepared by	Éamonn O'Moore National Lead for Health & Justice, Public Health England and Director of the UK Collaborating Centre for WHO Health in Prisons (European Region); Rachel Campbell, Magdalene Mbanefo-Obi & Susanne Howes (PHE Health & Justice Public Health Specialists & Co-Chairs, Health & Justice Health Protection Network); Maciej Czachorowski, Epidemiology Scientist, National Health & Justice Team, Health Improvement Directorate, PHE; Jo Peden, Consultant in Public Health Medicine, Gavin Dabrera, Consultant in Public Health Medicine, Department of Respiratory Surveillance, National Infection Service, PHE.
Other Contributors	PHE: Anita Turley, Julie Mann, Laura Pomeroy, Lipi Begum, Richard Pebody NHS England: Mark Gillyon-Powell, Denise Farmer, Christine Kelly, Christine Cook,; HM Prison & Probation Service: Rupert Baillie, Priscilla Wong; Home Office Immigration Enforcement: Alan Gibson.
Date of Issue **Revised**	September 2014 September 2017
Current Version	4.0 (supersedes 2016/17 guidance
Audience	Prison and YOI Governors and Directors Prison Primary Healthcare Service Providers Prison Occupational Health Services NHS England Health & Justice Commissioners PHE Health Protection Teams and Screening & Immunisation Leads (SILS) Primary Health and Justice Commissioners & providers for the Immigration Removal Centres' Directors & healthcare teams Directors of Public Health
Review Date	August 2018

Contents

Glossary

COPD	Chronic Obstructive Pulmonary Disease
FES	Field Epidemiology Service
HAART	Highly Active Antiretroviral Therapy
HOIE	Home Office Immigration Enforcement
HPT	Health Protection Team
ILI	Influenza-like Illness
IRC	Immigration Removal Centre
JCVI	Joint Committee on Vaccination and Immunisation
MoJ	Ministry of Justice
NICE	National Institute for Health and Care Excellence
NIS	National Infection Service
HMPPS	Her Majesty's Prison and Probation Service
OCT	Outbreak Control Team
PGD	Patient Group Direction
PHE	Public Health England
PMU	Population Management Unit
PPD	Prescribed Places of Detention
PPE	Personal Protective Equipment
PPO	Prison and Probation Ombudsman
PSD	Patient Specific Direction
SOP	Standard Operating Procedure

1 Introduction

This guidance is for healthcare and custodial staff in prescribed places of detention (PPDs) for adults in England (including Prisons & Immigration Removal Centres (IRCs)). It has been developed by Public Health England's (PHE) National Health & Justice Team in collaboration with the Respiratory Diseases Department, National Infections Service Centre for Disease Surveillance and Control. PHE would like to thank colleagues from NHS England, the Home Office Immigration Enforcement (HOIE) and Her Majesty's Prisons and Probation Service (HMPPS) for their expertise and support in developing the guidance. This guidance considers adults in PPDs in England.

Influenza (often referred to as flu), is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs) characterised by a fever, chills, headache, muscle and joint pain, and fatigue[1]. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease with recovery within two to seven days. Flu is easily transmitted and even people with mild or no symptoms can still infect others. The risk of serious illness from influenza is higher among children under six months of age, older people and those with underlying health conditions such as respiratory disease, diabetes cardiac disease or immunosuppression, as well as pregnant women. PPDs are at risk of outbreaks of seasonal flu due to large numbers of vulnerable individuals gathered together in an enclosed setting, some of whom will be in clinical risk groups, living in close quarters. Previous experience has demonstrated the importance of high vaccine coverage among vulnerable people and staff in PPDs in preventing and/or controlling such outbreaks. Further, early recognition and management of outbreaks can minimise both clinical and operational impacts.

Maintaining the operational effectiveness of PPDs is essential to preserving a fully functional youth and criminal justice system, immigration and welfare estate and this makes it desirable to minimise the impact of seasonal flu within these settings.

1.1 Background

Prisons and other PPDs run the risk of significant and potentially more serious outbreaks, with large numbers of cases and potentially a higher rate of complications including mortality because:

[1] PHE, Annual flu programme webpage (updated September 2017) https://www.gov.uk/government/collections/annual-flu-programme

- large numbers of individuals live in close proximity in relatively crowded conditions, often with high degrees of social mixing during activities.
- the population is constantly turning over with new receptions, releases and transfers;
- access to and capacity within healthcare facilities in PPDs could be limited if demand is high and transfer out to hospitals for assessment or care is complicated with demands on custodial staff for bedwatch/escort services;
- individuals in prison have a higher prevalence of respiratory illness (including asthma) immunosuppression (e.g due to HIV infection) and other chronic illnesses such as cardiovascular disease, diabetes or liver disease, than their peers in the community.
- increasing numbers of older prisoners: The Ministry of Justice Prison Population Projections 2017 to 2022[2], indicate that both the absolute number and proportion of the prison population in age groups 50, 60 and 70 years are set to increase in England & Wales. Causes include more people aged 50 years and over being sentenced than being released and longer custodial sentences for those in the older age groups. Prisoners aged 50 years and over have a high level of physical health needs which may put them at risk of complications of infection with influenza: 93% of prisoners over the age of 50 years have at least one physical health condition or long-term condition and 82% had a physical condition that was moderate or severe in nature[3].

A key principle in managing cases or outbreaks of seasonal flu is that people in PPD should receive healthcare equivalent to people in the wider community including access to antiviral treatment, although the means of delivering such healthcare may differ from community models.

An essential element of reducing the impact of influenza in the prisons and other PPD is a whole setting approach to the prevention, early identification and notification of illness, and prompt access to treatment including anti-virals.

Vaccination of those in high risk groups is an essential component of preparation for seasonal flu prevention. Therefore, high flu vaccine up-take among individuals for whom vaccination is recommended[4] ,(see Appendix 1).

[2] The Ministry of Justice, Prison Population Projections 2017 to 2022 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/639801/prison-population-projections-2017-2022.pdf

[3] Hayes et al (2012) The health and social needs of older male prisoners. International journal of geriatric psychiatry 27 (11) 1155-62 https://www.psych.ox.ac.uk/publications/522474

[4] DH, PHE and NHS England,National flu immunisation programme plan (March 2017) https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan

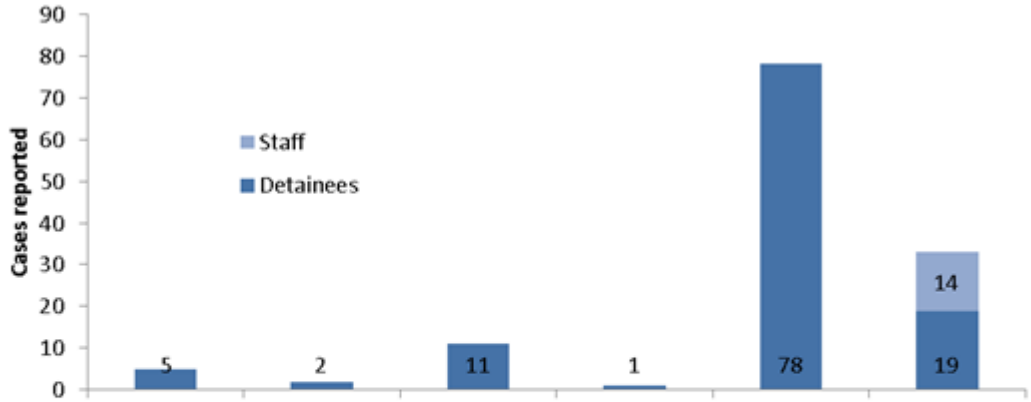
All staff, (including custodial staff), should play a key role in the early recognition of potential cases[5] and report the information quickly to healthcare who must then ensure they report this to their local PHE Health Protection Team (HPT)[6] promptly.

Another key element of reducing the impact of influenza in PPDs is by social distancing measures – reducing the contact between exposed and non-exposed people. This will require isolation of those with symptoms where possible, or cohorting groups of people with symptoms if cases exceed isolation capacity.

Flu is an unpredictable disease and the impact on PPDs is hard to predict. Surveillance data on the number of outbreaks and their impact is collected centrally by the National Health & Justice Team and this helps to inform realtime operational response as well as support planning and preparation.

The 2016/17 flu season showed a lower number of reported flu outbreaks from the previous year with six outbreaks of influenza being notified to the PHE National Health and Justice Team[7] (five in prisons and one in an IRC: see **Figure 1** below).

Figure 1: Notified influenza outbreaks in the secure and detained estate (England; 2016/17 flu season) by facility type, region and notification date. *IRC = immigration removal centre.*
Source: National Health and Justice Team, PHE.



Flu A confirmed (detainees)	0	2	8	1	4	10
Hospitalised (detainees)	0	2	0	1	4	0
Deaths (detainees)	0	0	0	0	1	0

[5] Diseases that healthcare teams in prisons and other secure settings should report to PHE (April 2015) https://www.gov.uk/government/publications/diseases-that-healthcare-teams-in-prisons-and-other-secure-settings-should-report-to-phe

[6] Contact details of local health protection teams can be found at https://www.gov.uk/guidance/contacts-phe-regions-and-local-centres#region

[7] PHE Health and Justice Annual Review 2016/17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/642924/PHE_Annual_Report_1617V2.pdf

Influenza A was confirmed in samples taken from cases in five of the notified outbreaks. In total, seven detainees from three discrete prisons were hospitalised subsequent to their infection with one prisoner later dying in hospital (Figure 1). We continue to see 'late' seasonal flu outbreaks: influenza outbreaks were reported into early April of the preceding, 2015/16, flu season[8]), and in 2016/17 nearly all outbreaks were notified in the one month period from early February to March 2017. Uncharacteristically for any setting in England, community or otherwise, one large outbreak affecting detainees and staff in an IRC was reported at the height of summer (early August 2017: see Figure 1).

[8] PHE Health and Justice Annual Review 2015/16
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565232/health_and_justice_annual_review_2015_to_2016.pdf

2 Recommendations for action

2.1 Preparation

The public health principles guiding action within prisons and other PPD are the same as those in the wider community i.e.:

- vaccination of risk groups (people in prison/IRCs/other PPDs and staff – operational as well as healthcare staff) (see Appendix 1)
- vaccination of healthcare staff working in PPDs according to national guidance[9]
- vaccination of custodial & detention staff who provide equivalent of a social care function to prisoners/detainees ill with flu in their cells/rooms[9]
- prompt diagnosis (either clinical or laboratory depending on circumstances including whether an outbreak situation)
- ensuring effective and appropriate care and access to anvirals for individuals who are ill
- preventing transmission where possible

PHE recommend that healthcare teams appoint a Flu Lead to oversee implementation of the preparations including the seasonal flu vaccine campaign. It is strongly advised that this includes holding a register of people in the defined risk groups, (see Appendix 1), those offered vaccine, and those vaccinated, allowing an estimate of vaccine coverage to be calculated for the whole season or for points in time when there is an active outbreak. These data need to be regularly updated throughout the flu season. An example of this is presented in the PHE Audit of Influenza Vaccination Programme in London Prisons (2014/15)[10].

Prisons and other PPDs should agree clear arrangements with their PHE HPT and NHS England Health & Justice Commissioners to ensure the institutions know how to:

- order vaccine supplies in good time prior to the annual vaccination period plan and co-ordinate vaccination of eligible individuals
- recognise possible outbreaks and report them quickly, (see Multi-agency contingency plan for disease outbreaks in prisons)[11]

[9] PHE, **Influenza: the green book, chapter 19 (updated 28 August 2015)**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456568/2904394_Green_Book_Chapter_19_v10_0.pdf

[10] PHE Audit of influenza (flu) vaccination programme in prisons in London 2014/15
https://www.gov.uk/government/publications/flu-vaccination-in-prisons-in-london-programme-audit

[11] Multi-agency contingency plan for disease outbreaks in prisons, January 2017
https://www.gov.uk/government/publications/multi-agency-contingency-plan-for-disease-outbreaks-in-prisons

- access public health advice and support, both in and out of office hours[6]
- rapidly access viral testing (and processing of swabs) to support the need for timely diagnosis and "low threshold to treat" policy for at-risk groups
- access antiviral medication

Each outbreak should be risk-assessed and managed on a case-by-case basis.

2.1.1 Seasonal flu vaccination for patients

The objectives of the influenza immunisation programme are to protect those who are most at risk of serious illness or death should they develop influenza and to reduce transmission of the infection, thereby contributing to the protection of vulnerable patients who may have a suboptimal response to their own immunisations. To facilitate this, healthcare teams are required to proactively identify all those for whom influenza immunisations are indicated and to compile a register of those patients for whom influenza immunisation is recommended. Sufficient vaccine can then be ordered in advance and patients can be invited to planned immunisation sessions or appointments.

Influenza vaccine should be offered, ideally before influenza viruses start to circulate, to:

- all those aged 65 years or older (for definition please see the annual flu letter for the coming/current season)
- all those aged six months or older in the clinical risk groups shown in Appendix 1

Additional groups to be considered for vaccination in prisons: 'older prisoners'

In addition to the usual risks groups, it is proposed that in prisons particularly, an additional group of older people may be considered for vaccination. In prisons, people aged 50 years or older are defined as 'older prisoners', in comparison to the community where the term 'older adults' usually refers to those aged 65 years and above.

The proportion of the over 50s in the prison population is the fastest growing defined cohort in prisons in England[12]. Emerging evidence suggests that an individual entering prison aged 50 years is physiologically ten to fifteen years older than their counterpart in the community.These older prisoners often have a greater burden of disease. This evidence supports the opportunistic vaccination of older people in prison who may not ordinarily meet eligibility criteria for flu vaccination. Prison healthcare teams may wish to consider proactively reviewing people in prisons who may be offered flu vaccination once the vaccination of those normally eligible has been completed. The North West Flu Plan for Prisons 2017/18, recommends vaccinating those aged 55 years and above in

[12] T. Wangmor et al Aging Prisoners' Disease Burden: Is Being Old a Better Predictor than Time Served in Prison? . Gerontology 2015. https://www.karger.com/Article/FullText/363766#ref5

prisons. This could help reduce the risk of flu transmission to vulnerable individuals who do not necessarily fit the high risk criteria or age group.

N:B If providers undertake to vaccinate people between 50 and 64 years of age, and these people do not meet the national criteria for vaccination, the national PHE template cannot be used. Where providers vaccinate this cohort, the provider or local commissioners will need to develop and arrange authorisation of a separate PGD. Alternatively prescriptions can be used instead for these patients.

2.1.2 Seasonal flu vaccination for staff

Different establishments across the custodial estate will have various occupational health arrangements for custodial and healthcare staff and it is important to include staff vaccination as part of preparation. Heathcare and social care staff (or those undertaking equivalent roles[9]) should be offered the seasonal flu vaccine in order to protect vulnerable patients in their care and avoid operational impact due to staff sickness absence. It is strongly recommended that as part of any establishment's flu strategy there is clear information on vaccine coverage in all appropriate staff groups, healthcare and custodial.

Healthcare staff with direct patient contact in prison and other PPD should be offered flu vaccination by their employer similar to healthcare staff in the community. This should form part of the organisations' policy for the prevention of transmission of flu to help protect patients, and service users as well as staff and wider groups and should link directly to the organisations Occupational Health Policy.

Non-healthcare staff working in prisons and other prescribed places of detention that have close contact with prisoners/detainees in order to provide health and/or social care for them should be offered seasonal flu vaccine this year (September 2017–February 2018) as per last season. Flu vaccines will be delivered by the HMPPS Occupational Health provider in public prisons for HMPPS employees. For the 2017/2018 flu season, probation service staff who fall into this category should acquire the vaccine via primary care or a pharmacy with the cost being reimbursed via HMPPS expenses claims procedure for the staff member.

2.1.3 Vaccination targets, coverage and recording in prisons and other prescribed places of detention

Vaccination uptake targets established by the Department of Health for the 2017/18[4] season are:

- actively offer flu vaccination to 100% of all those in eligible groups
- vaccination of at least 75% of those aged 65 years and over
- vaccination of at least 75% of healthcare workers with direct patient contact
- vaccination of at least 55% of those in all clinical risk groups and maintain higher rates where those have already been achieved – ultimately, the aim is to achieve at least a 75% uptake in these groups given their increased risk of morbidity and mortality from flu

Both the offer and uptake of the seasonal flu vaccine should be recorded for people in prisons, IRCs and other PPDs. Healthcare providers are encouraged to hold a register so that they can identify all patients eligible for the flu vaccine. They are also encouraged to update the patient eligibility register throughout the flu season as this will help with coordination of the local flu vaccination programme. It should also be recorded on SystmOne, paying particular attention to the inclusion of women who become pregnant and patients who enter at risk groups during the flu season.

Last year, PHE's sentinel flu surveillance across nine prisons in England, yielded a flu vaccine uptake rate of 57% of eligible consenting prisoners[13]. SystmOne data is also used to populate a seasonal flu vaccine uptake indicator included within the Health and Justice Indicators of Performance (HJIPs). Data for this indicator will be gathered in the upcoming flu season (2017/18).

2.1.4 Accessing vaccine supplies

Healthcare providers access influenza vaccines in the same way as GP practices as detailed in Chapter 19 of the Green Book[9]

Vaccine supplies

Healthcare providers in prison and other PPDs should routinely order vaccine supplies, directly from manufacturers well in advance of the flu season (i.e. in the spring) in order to secure supplies. They should ensure that the number of vaccines ordered are sufficient for the size of the population at risk based on past and planned performance

[13] Data sourced from PHE Health and Justice Team. Twelve prisons were asked for data but only nine responded.

and expected demographic increase to ensure that everyone at risk is offered flu vaccine. These orders are supplied later in the year just prior to the autumn/winter vaccination programme. A list of the influenza vaccines available in the UK is published ahead of the influenza season in the annual flu letter for England[4]. Information about manufacturers with whom orders can be placed is documented in the Chapter 19 Green Book[9]

In the event of an outbreak of seasonal flu, additional influenza vaccine stock can be sourced from the following in priority order:

- vaccine manufacturers
- pharmacy Service providers contracted to provide pharmaceutical services to the prison/PPD

Administration of influenza vaccines

Influenza vaccines can be be administered via a prescription for the vaccine. Alternatively to support vaccination of several people as part of nurse or pharmacist-led vaccination clinics a Patient Group Direction (PGD) can be used in line with legislation and NICE Guidance[14].

NHS England clinical and PHE leads within individual NHS England regions or localities usually authorise a flu vaccine PGD that can be shared and used by GP practices and health and justice providers within that locality/region.

In the event that providers cannot access a local NHS England authorised PGD, the PHE template PGD for the vaccine (available here[15]) can be used by providers to either authorise within their organisation (i.e. in NHS Trusts) or to gain NHS England authorisaiton for its use in the health and justice sites (i.e. private healthcare providers).

N.B. Please note that prisons which have healthcare commissioned by HMPPS (i.e. private prisons) must have the PGD authorised by the prison director/governor and not NHS England.

[14] NICE. Good practice guidance Patient Group Directions August 2013 http://www.nice.org.uk/guidance/mpg2
[15] PHE template for PGD (flu vaccine) https://www.gov.uk/government/publications/intramuscular-inactivated-influenza-vaccine-patient-group-direction-pgd-template

2.2 Diagnosis & Recognition of a case

It is important that all staff (custodial as well as healthcare) are aware of the symptoms of influenza-like illness (ILI) and of the need to report possible cases promptly during the winter flu season to healthcare. Custodial staff often have the most contact with prisoners/detainees and are therefore well-placed to recognise increasing number of cases. Employees with signs and symptoms of ILI should seek advice from their GP and inform their line manager and OH.

During the winter flu season, the majority of single cases will be diagnosed by healthcare staff on clinical grounds only based on the following clinical signs & symptoms and recognition of a case[16]. Testing may be considered especially if an outbreak is suspected.

Prompt action is necessary if ILI is suspected. A useful case definition for flu cases is provided in Table 1 below - *this case definition may be modified once an OCT is called*:

Table 1: Influenza (Influenza virus), clinical criteria for case definitions
Source: European Centre for Disease Prevention and Control, EU case definitions[16]

Sudden onset of symptoms
AND At least one of the following four systemic symptoms: • fever or feverishness • malaise • headache • myalgia
AND At least one of the following three respiratory symptoms: • Cough • Sore throat • Shortness of breath

During suspected outbreaks of flu in prisons, secure settings and other PPD, **testing** to confirm the presence of the influenza virus **should be given high priority when dealing with the first few cases (up to five) in the secure setting: if any positive results are returned by the laboratory, no immediate further testing is required.**

[16] European Centre for Disease Prevention and Control, EU case definitions **http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012D0506&qid=1428573336660&from=EN#page=16**

2.3 Treatment and care

Symptomatic care should be offered, bed rest and oral fluids with paracetamol and/or ibuprofen as clinically indicated;

The use of antivirals for prophylaxis and treatment of influenza according to NICE guidance[17,18] remains an integral part of influenza control measures in prisons and other closed institutions within youth and criminal justice system and children placed on welfare grounds. Public Health England has published additional guidance on the use of antivirals[19].

As with all other settings, there should be "a low threshold for treatment" with antivirals for people in high risk groups (see Appendix 1) who become symptomatic

Antiviral prophylaxis of close contacts

Adults (or children) sharing a room with a confirmed case (or clinically confirmed in an outbreak) of seasonal flu, who are themselves in high risk groups (see Appendix 1) and who have not been previously vaccinated with current seasonal influenza vaccine, should be offered antiviral prophylaxis provided this can be started within 48 hours from last exposure with oseltamivir or 36 hours for zanamivir[vi]. This advice applies even if the outbreak happens outside the period when flu is circulating in the community when antivirals use in the community is permitted by the NHS under NICE Guidance. Consideration should be made for those high risk contacts for whom vaccination is contraindicated, or in whom it has yet to take effect and those who have been vaccinated with a vaccine that is not well matched to the circulating strain of influenza virus, according to information from PHE. During outbreak control team (OCT) meetings there may be consideration of other factors such as severity of illness/hospitalisations or case fatality rate to inform discussion about wider offer of antiviral prophylaxis. This discussion should include consultation with experts within the National Infection Service as well as the National Health & Justice Team, (see Section 2.5 on convening OCT).

2.3.1 Accessing supplies of antivirals

Prisons and other PPDs flu plans should include details of the ordering process and supply of antivirals. These plans need to take into account the need for patients to

[17] Guidance on the use of antiviral drugs for the prevention of influenza (Technology Appraisal Guidance No.158) https://www.nice.org.uk/guidance/ta158

[18] NICE. Guidance on the use of antiviral drugs for treatment of influenza (Technology Appraisal Guidance No. 168) https://www.nice.org.uk/guidance/ta168

[19] Guidance on antiviral agents for the treatment and prophylaxis of Influenza (October 2016) https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents

commence antivirals within 24-48 hours of symptom onset. All supplies of antivirals to patients should be recorded in their clinical records.

There are two routes for patients to access antivirals following a clinical assessment and diagnosis:

1. Individual prescriptions or patient specific direction (PSD): The antiviral can be accessed by sending the prescription to the pharmacy for dispensing (i.e. the pharmacy contracted to provide medicines to the prison or PDD or an out of hours pharmacy) **OR** by using over-labelled stock supplies[20] that allow the prescriber or registered healthcare professional to add the patient name and date to enable a prompt supply to the patient. This should be completed using standard operating procedures (SOPs) developed and ratified by the healthcare provider.

2. A Patient Group Direction (PGD) authorised and handled as per NICE Guidance[vii]: The antiviral must be handed to the patient by the healthcare professional who assesses the patient and makes the PGD supply. The antiviral must be from over-labelled stock and the name of the patient and the date added to the label by the healthcare professional.

   N.B. There is no national PHE template PGD for the supply of antivirals. Providers will need to develop and authorise the PGD in line with the legislation and NICE.

It is important that antivirals are available promptly once cases of influenza are identified. It is recommended that providers always have a stock of antivirals (and an authorised PGD) at the PPD even in the summer months. As soon as a case of flu is identified the amount of stock can be increased in anticipation of further cases.

Where stock supplies of over-labelled antivirals are used plans should include:

- agreement of minimum stock levels based on previous year's use with plans to amend this during an outbreak
- processes to check the antiviral stock regularly to ensure appropriate storage and expiry dates, audit the supplies made and re-order stock should this fall below minimum levels

[20] Over-labelled supplies must be procured from a licenced provider. The label usually has the dose pre-printed on it and allows the healthcare professional to add the patient name and date at the point of supply

Where difficulties in accessing stock supplies are experienced, or a delay in access is anticipated then stocks may be accessible through the local Health Protection Team[6], although this should be a last resort.

2.4 Prevention of transmission of infection

Detailed information on Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings[21] have been published by PHE and can also guide action in prisons and other PPD who should be advised that:

- during the winter flu season, people in prison and other PPDs with ILI should be diagnosed early and isolated to prevent further spread
- people in prison and other PPDs with ILI should be promptly assessed and isolated on their own or cohorted with other cases as soon as possible
- where demand for isolation exceeds capacity, consideration should be given to cohorting, with appropriate risk assessment of suitable cohortees, and the need for the movements of inidviduals in, out and around the prison or secure setting should be reconsidered with a view to reducing these movements
- hand and respiratory hygiene measures should be re-emphasised to help minimise the spread of the infection (for both people in prison/other PPDs and staff working there)
- if a symptomatic case needs to pass through areas where other people are waiting then they should wear a fluid repellent surgical mask
- identify adult or child's close contacts of cases in at risk groups and, if not previously vaccinated with current seasonal influenza vaccine, offer antiviral prophylaxis as indicated above
- in suspected outbreaks, testing of the first five clinical cases should be carried out promptly to establish whether seasonal influenza is the cause of symptoms
- report cases to the local HPT so that advice on the public health aspects of more complex situations can be given
- prison officers, custodial staff and healthcare staff who are assessing adults or children with suspected ILI and coming into close contact (less than one metre) to provide care should wear appropriate personal protective equipment (PPE), as per national guidance[21]
- during the winter flu season, prison officers, IRC staff, other detention staff and healthcare staff with ILI should be excluded to stay away from work and be managed by their GP if they are in specific risk groups;

[21] Public Health England. Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings- October 2016 https://www.gov.uk/government/publications/respiratory-tract-infections-infection-control#history

- if staff become ill at work, they should be sent home immediately or isolated until they can be sent home
- prison and other custodial staff with flu-like illnesses at home should seek medical care in the community using the usual mechanisms (i.e. via their GP if they belong to specific risk groups)
- During an outbreak of influenza in a prison or other PPD, cases among staff should be reported to the HPT as well as cases among prisoners/detainees

2.5 Outbreaks within prisons and other prescribed places of detention

An influenza outbreak can be defined as:

Two or more cases which meet the clinical case definition of ILI (or alternatively two or more cases of laboratory confirmed Influenza) arising within the same 48-hour period with an epidemiological link to the prison or other prescribed place of detention.

If a seasonal flu outbreak is suspected or confirmed, it is recommended that PHE Health Protection Teams convene an outbreak control team (OCT) meeting, (see Multi-agency contingency plan for disease outbreaks in prisons)[11]. This will;

- collectively review information with partners on the extent and severity of infection (including information on patients requiring transfer out to hospital)
- collect and collate epidemiological data on clinical attack rates including wing specific attack rates to guide management of effective control measures
- review and advise on infection control practice
- consider vaccine coverage among prisoners/detainees and staff groups and
- consider role of anti-viral treatment or prophylaxis for cases or contacts including staff

The National Health & Justice Team[22] should be invited to provide expert support and experts from Field Epidemiology Service (FES) and/or the National Infection Service (NIS) should also be considered as contributors to OCT. Detailed guidance on the role of OCTs in prison or other detention settings is available from existing guidance[11].

During an OCT, the following issues need to be considered:

- if not already done, ensuring that testing for seasonal influenza is carried out;
- whether antiviral prophylaxis is required, who should receive it and how including confirmation that a current in-date PGD is in place. A wider discussion regarding who should receive prophylaxis may be required

[22] Reached via health&justice@phe.gov.uk

- operational status of the secure setting re: transfers in and out/regime restrictions
- isolation and/or cohorting prisoners/detainees as part of wider infection control practice
- ensuring that within the practicable constraints of the service, staff either deal with prisoners who are symptomatic or asymptomatic, but not both
- consideration of the need to offer vaccination
- managing hospital admission if required
- communication and media issues

Appendix 1

List of high-risk groups

Department of Health, PHE and NHS England; Flu plan, winter 2017-18, March 2017[4]:

- people aged 65 years or over (including those becoming age 65 years by 31 March 2018)
- people aged from 6 months to less than 65 years of age with a serious medical condition such as:
    - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
    - chronic heart disease, such as heart failure
    - chronic kidney disease at stage three, four or five
    - chronic liver disease
    - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability
    - diabetes
    - splenic dysfunction
    - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment) morbidly obese (defined as BMI of 40 and above)
- all pregnant women (including those women who become pregnant during the flu season)
- all children aged two to eight (but not nine years or older) on 31 August 2017
- three and four year olds as well as children in reception class and school years 1, 2, 3 and 4
- those in long-stay residential care homes or other longstay care facilities
- carers
- others involved directly in delivering health and social care

This list above is not exhaustive, and the healthcare practitioner should apply clinical judgement to take into account the risk of flu exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from flu itself. Flu vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.

Appendix 2

Command, control, co-ordination and communication in outbreaks of infections in prisons other secure settings and those placed for welfare

Where limiting movement through reception departments or stopping transfers out is to be considered, this decision will be taken by the outbreak control team (OCT) and the following must take place:

- the (OCT) should consider whether limiting movement should be to reception departments, or transfers out only, ie is there an unaffected part of the establishment that can be used so the establishment can continue to accept new prisoners, thus maintaining HMPPS' service to the courts and other prisons
- the OCT should consider whether full or partial limitation on movement is necessary, via the governor, obtain from the population management unit (PMU) an impact assessment of change in activity to receptions and transfers*
- the assessment will outline the resulting population pressures from such action and state the approximate time period for which change in activity of the establishment can be sustained
- the impact assessment must be considered by the OCT before deciding on whether to recommend to the Executive Director/Group Director to change activity, limit movement or close
- only the Executive Director/Group Director or above should take decisions on closing prisons to receptions and transfers, given their oversight of a greater proportion of the prison estate, the population of which will be impacted by any decision to close
- if however the OCT and/or the Executive Director/Group Director wishes to limit movement, change activity or close the establishment for a period beyond that which the PMU deems sustainable (and in certain circumstances such action may be not be deemed sustainable for any time at all) then the recommendation must be escalated to the Director of Public Sector Prisons for a final decision
- if an urgent out of hours decision is required it should be made by the Duty Director
- if a decision to limit movement, change activity or close has been taken then at least every three days a further impact assessment of continuing closure must be obtained from PMU
- the assessment should be provided to the Executive Director/Group Director along with up-to-date information as to the current status of the outbreak

"The impact assessment will consider the impact on surrounding prisons of any restrictions on prisoner reception or discharge and the duration for which restrictions are considered sustainable"

- the Executive Director/Group Director should then maintain or withdraw his/her decision to limit movement, change activity or close the establishment to receptions and transfers
- again, should the PMU assessment determine that continuing change of activity or closure is unsustainable, any decision to extend the change of activity must be made by the director of public sector prisons (or duty director in urgent out-of-hours circumstances)

Figure 2: The command, control, co-ordination and communication in outbreaks of infection in prisons and other places of detention
Source: HMPPS