Guidance for 2014/15 on responding to cases or outbreaks of seasonal flu in prisons and other prescribed places of detention within the criminal justice system in England
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NHS England area teams  
PHE Centres health protection teams  
Immigration removal centres healthcare teams  
Other Prescribed Places of Detention healthcare teams |
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1. Introduction

This guidance is for Prisons, Immigration Removal Centres (IRCs) and establishments of the Children and Young People secure estate (CYP), referred to as prisons and other prescribed places of detention (PPDs). It has been developed by Public Health England’s (PHE’s) Health and Justice Team in collaboration with the Respiratory Diseases Department, Centre for Disease Surveillance and Control, Colindale. PHE would like to thank colleagues from NHS England, the Youth Justice Board, the Home Office and the National Offender Management Service for their expertise and support in developing the guidance.

PPDs within the criminal justice system are at risk of outbreaks of seasonal flu due to large numbers of vulnerable individuals, some of whom will be in clinical risk groups, living at close quarters. Previous experience has demonstrated the importance of high vaccine coverage among appropriate people in prison and other detention centres and staff 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 criminal justice system 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 than the community because:

- 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 admissions, discharges and transfers
- access to healthcare facilities within prisons could be limited if demand is high
- prisoners have a higher prevalence of respiratory illness (including asthma), immunosuppression (eg due to HIV infection) and other chronic illnesses than their peers in the community

A key element of reducing the impact of influenza in the prison sector 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.

A key principle in managing cases or outbreaks of seasonal flu is that people in prescribed places of detention 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.

Flu is an unpredictable disease and although last winter, 2013-2014, was less severe than some of the recent seasons, this must not lead to complacency and undermine our preparedness to respond to a more severe flu season. Flu is an unpleasant but self-limiting illness in most healthy people. Nevertheless, it is capable of causing severe illness, such as bronchitis and pneumonia, and death in some individuals, particularly if they belong to identified high risk groups. Therefore, high vaccine up-take among individuals for whom vaccination is recommended (Appendix 1) continues to be a priority this year as per previous years.

2. Recommendations for action

2.1 Preparation

Prisons and other Prescribed Places of Detention (PPD) should agree clear arrangements with their PHE health protection teams (HPT) and NHS England area teams to ensure the institutions know how to:

- recognise possible outbreaks and report them quickly
- access public health advice and support, both in and out of office hours
- 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.

The public health principles guiding action within prisons and other prescribed places of detention are the same as those in the wider community, ie:

1. Vaccination of risk groups and staff groups who work with those in high-risk groups (Appendix 1).
2. Prompt diagnosis (either clinical or laboratory depending on circumstances);
3. Ensuring effective and appropriate care for the ill;
4. Preventing transmission where possible;

2.2 Vaccination of risk groups and staff working with vulnerable people

People in high-risk groups who need to be considered for seasonal influenza vaccination as listed in Appendix 1. This section details considerations of risk groups and other groups to be considered for vaccination in the specific setting of prisons and other places of detention. For more detailed information on seasonal influenza vaccine, indications, contraindications and recommendations, see the Green Book, chapter 19 Influenza.

2.2.1 New flu vaccination for children – implications for prisons, IRCs and CYP establishments

In 2012, the Joint Committee on Vaccination and Immunisation (JCVI) recommended that the seasonal flu programme should be extended to include all children aged 2 to under 17 years. A phased introduction of the childhood influenza programme started on 1 September 2013. In the first year of the programme, a nasal flu vaccine was offered to all two and three-year-old children, primary school children in seven plot areas and children in at risk groups aged two years and under 18 years.

This year (2014-2015) the programme has been extended so that the flu vaccine will be offered to all two, three and four-year-old children, the primary school children in the 2013/14 pilot areas, children in at risk groups aged two to under 18 years and children in years seven and eight in secondary schools in twelve pilot sites.

Given the age groups involved, it is possible that prisons, IRCs and CYP establishments may have some individuals who are eligible for this vaccination. The situation will change over the next few years as the full programme is implemented with institutions such as Secure Training Centres (hosting 12 to 17 year old), Secure Children Homes (hosting 10 to 17 year old) or young offender institutions (YOIs) having some of their younger inmates (15 to under 17 years old) eligible for vaccination as part of the target group, in addition to those in the at risk groups already mentioned.
2.2.2 Vaccination targets and coverage in prisons and other prescribed places of detention

Vaccination uptake targets established by the Department of Health for the 2014/15 season are to:

- reach an uptake of 73.4%, (with an ambition of 75%) for those aged 65 years and over
- prioritise improvements in vaccine uptake over and above last season in those with chronic liver (42.9% up-take in 2013-14) and neurological disease, including people with learning disabilities (49.2% in 2013-14), which were the lowest up-takes reached nationally amongst the different risk groups (see table below)

Table 4: Flu vaccine uptake by clinical risk group in 2012/13 Influenza vaccine uptake in patients aged six months to under 65 at risk, by clinical risk group 2012/13

<table>
<thead>
<tr>
<th>Risk group</th>
<th>six months to under two years Vaccine uptake (%)</th>
<th>two years to under 16 years Vaccine uptake (%)</th>
<th>16 years to under 65 years Vaccine uptake (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic heart disease</td>
<td>23.7</td>
<td>27.2</td>
<td>55.2</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>28.5</td>
<td>41.1</td>
<td>51.7</td>
</tr>
<tr>
<td>Chronic kidney (renal) disease</td>
<td>40.5</td>
<td>37.6</td>
<td>56.3</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>34.5</td>
<td>36.0</td>
<td>43.0</td>
</tr>
<tr>
<td>Patients with diabetes</td>
<td>44.3</td>
<td>61.6</td>
<td>68.6</td>
</tr>
<tr>
<td>Patients with immunosuppression</td>
<td>36.1</td>
<td>44.7</td>
<td>55.0</td>
</tr>
<tr>
<td>Patients with chronic degenerative neurological disease (incl. stroke/TIA, cerebral palsy or MS)</td>
<td>18.6</td>
<td>28.2</td>
<td>50.8</td>
</tr>
</tbody>
</table>

The 75% flu vaccine coverage in prisons and other prescribed places of detention is an ambition, as outlined in the national flu immunisation letter.
Table 1 shows vaccine coverage for 2013/2014 in the 122 establishments in England:

Table 1: Vaccine uptake among prisoners 65 years and older in England 2013/14

<table>
<thead>
<tr>
<th>% of establishments</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>51% (61/119*)</td>
<td>Excluded as less than 10 people eligible for vaccination</td>
</tr>
<tr>
<td>21% (12/58)</td>
<td>Achieved Department of Health ambition of 75% or greater (includes those achieving 74% and above)</td>
</tr>
<tr>
<td>52% (30/58)</td>
<td>Achieving coverage between 55% and 74%</td>
</tr>
<tr>
<td>28% (16/58)</td>
<td>Achieving 54% coverage or less</td>
</tr>
</tbody>
</table>

Source: ImmForm

*3 prisons out of the 122 (2%) did not provide any data on flu vaccination

Table 2: Vaccine uptake among prisoners under 65 years in at-risk groups in England 2013/14

<table>
<thead>
<tr>
<th>% of establishments</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% (6/119*)</td>
<td>Excluded as less than 10 people eligible for vaccination</td>
</tr>
<tr>
<td>3% (4/113)</td>
<td>Achieved Department of Health ambition of 75% or greater (includes those achieving 74% and above)</td>
</tr>
<tr>
<td>26% (30/113)</td>
<td>Achieving coverage between 55% and 74%</td>
</tr>
<tr>
<td>71% (80/113)</td>
<td>Achieving 54% coverage or less</td>
</tr>
</tbody>
</table>

Source: ImmForm

*3 prisons out of the 122 (2%) did not provide any data on flu vaccination

The above figures indicate that, notwithstanding what was achieved last year, further efforts are needed to achieve this year flu vaccination ambition of 75% coverage.

NOTE: Both offer and uptake of seasonal flu vaccine should be recorded for prisoners and detainees on SystmOne.
2.2.3: Staff groups and seasonal flu vaccine:

Healthcare staff with direct patient contact in prison and other prescribed places of detention should be offered flu vaccination by their employer similarly to healthcare staff in the community. Vaccination ambition for healthcare staff in prison, IRCs and other detention centres is 75%. Healthcare staff should be encouraged to be vaccinated to protect the health of vulnerable people in their care and to avoid sickness absence in the healthcare workforce.

Non-healthcare staff working in prisons and other prescribed places of detention who have close contact with prisoners/detainees with flu in order to provide health and/or social care for them will be offered seasonal flu vaccine this year (October – November 2014) as per last season, via the NOMS programme.

Data on seasonal flu vaccine coverage for staff fulfilling a health and social care role in prisons, last season showed an average coverage of 21%, indicating that further improvement is required to achieve the 75% ambition.

Source: NOMS OH service

2.2.4 Accessing vaccine supplies

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

Vaccine supplies for Adults

Healthcare providers in prison and other PPDs should routinely order vaccine supplies, directly from influenza vaccine manufacturers well in advance of seasonal flu vaccination programmes (i.e. in the spring) in order to secure supplies. Order quantities are estimated on the basis of the previous year’s vaccination programme and any additional adjustments based on the current detained population. Information about manufacturers with whom orders can be placed each year is given in the Green Book chapter 19 Influenza. These orders are supplied later in the year just prior to the Autumn vaccination programme.

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 or PDP.

Patients under 18 years

As mentioned in section 2.2.1, some places of detention may have patients under 18 years that are eligible for influenza vaccination. For these patients influenza vaccination falls under the national childhood immunisation programme. Live attenuated influenza vaccine (Fluenz Tetra®) has been purchased centrally for children aged two to 17 years in risk groups. For both healthy and at risk children under 18 years of age where Fluenz is unsuitable an inactivated trivalent vaccine (Sanofi Pasteur MSD Split Virion BP) or Fluarix™ Tetra will be supplied. These vaccines should be ordered as per the usual mechanisms for the routine childhood immunisation programme via immform (https://www.immform.dh.gov.uk/) and are distributed by Movianto UK (Tel: 01234 248631) as part of the national immunisation programme.

2.3 Diagnosis

- prison officers, IRC staff & other custodial staff as well as healthcare staff should be aware of the symptoms of influenza-like illness (ILI) and of the need to report possible cases promptly during the winter flu season
- during the winter flu season, the majority of single cases will be diagnosed by healthcare staff on clinical grounds only:
  - Measuring patient temperature is recommended as ascertainment of high temperature (>38°C) is a criterion of PHE case definition
- during suspected outbreaks of flu in custodial settings, 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 prison:
  - if any positive results is returned by the laboratory, no further testing is required

2.4 Treatment and care

- The use of antivirals for prophylaxis and treatment of influenza according to NICE guidance remains an integral part of influenza control measures in prisons and other close institutions within the criminal justice system. Public Health England has published additional guidance on the use of antivirals titled Guidance on antiviral agents for the treatment and prophylaxis of Influenza (October 2014).
Symptomatic care should be offered, including bed rest and oral fluids with paracetamol or ibuprofen as clinically indicated;

Treatment with antivirals: as with all other settings, there should be “a low threshold for treatment” with antivirals for people in high risk groups (Appendix 1) who become symptomatic;

Antiviral prophylaxis of close contacts: Cellmates of 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.

2.4.1 Accessing supplies of antivirals

Prisons and other PPDs should include ordering and patient supply of antivirals within routine plans for treating cases of seasonal flu. These plans need to take account of the need for patients to access antivirals within 24-48 hours of symptom onset. All supplies of antivirals to patients should be recorded in the clinical record.

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 (ie the pharmacy contracted to provide medicines to the prison or PDD or an out of hours pharmacy) or by using over-labelled stock supplies\(^1\) 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\(^viii\): 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.

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

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\(^1\) 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.
• 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

2.5 Prevention of transmission of infection

Prisons and other detention centres should be advised that:

• during the winter flu season, prisoners/detainees with ILI should be diagnosed early and isolated to prevent further spread
• prisoners/detainees with ILI should be promptly assessed and isolated on their own or cohorted with other cases as soon as possible
  o where demand for isolation exceeds capacity, consideration should be given to cohorting, with appropriate risk assessment of suitable cohortees, and the need for prisoner movements in, out and around the prison should be reconsidered with a view to reducing these movements
• hand and respiratory hygiene infection control measures should be re-emphasised to help minimising the spread of the infection (for both people in detention/prison 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 cellmate(s)/close contacts 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 prisoners 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
• during the winter flu season, prison officers, IRC staff, other custodial staff and healthcare staff with ILI should be strongly advised to stay away from work and be managed by their GP if they are in specific risk groups;
  o if staff become ill at work, they should be isolated until they can be sent home
  o 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)
If there is a large outbreak of influenza in a prison or other detention setting, cases among staff should be reported to the HPT at the PHE centre as well as cases among prisoners/detainees.

2.6 Outbreaks within prisons and other prescribed places of detention

If a prison, IRC or other custodial setting within CYP develops a sudden rise in the number of cases of suspected seasonal influenza the HPT, governing governor and NHS England commissioner should consider whether a formal outbreak control team meeting is required to consider:

- operation status of the Centre/Prison re: transfers in and out/regime restrictions etc.
- whether antiviral prophylaxis is required, who should receive it and how;
- if not already carried out, ensuring that testing for seasonal influenza is carried out;
- cohorting prisoners and trying to ensure, within the practicable constraints of the service, that staff either deal with prisoners who are symptomatic or asymptomatic but not both;
- consideration of need, in special circumstances, ie prolonged outbreaks, and following national expert advice, to offer vaccination to those not ill, prisoners and staff, to stop chain of transmission;
- managing hospital admission if required;
- communication and media issues.
Appendix 1: List of high-risk groups

From PHE, NHS England and Department of Health, Flu plan, winter 2014-15, April 2014:

- people aged 65 and over
- all pregnant women at any stage of pregnancy
- people (aged six months or older) 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 5
    - chronic liver disease
    - chronic neurological disease, such as Parkinson’s disease or motor neurone disease
    - diabetes
    - splenic dysfunction
    - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
Appendix 2: Command, control, co-ordination and communication in outbreaks of infection in prisons

Where closing reception departments or stopping transfers out is being considered the following must take place:

- the outbreak control team (OCT) should consider whether closure should be to reception departments, or transfers out only, i.e. is there an unaffected part of the establishment that can be used so the establishment can continue to accept new prisoners, thus maintaining NOMS’ service to the courts and other prisons?
- the OCT should consider full or partial closure necessary they must, via the governor, obtain from the population management unit (PMU) an impact assessment of closing to receptions and transfers*
- the assessment will outline the resulting population pressures from such action and state the approximate time period for which closure of the establishment can be sustained
- the impact assessment must be considered by the OCT before deciding on whether to recommend to the Deputy Director of Custody (DDC) to close
- only the DDC 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 DDC wishes to 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 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 DDC 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 DDC should then maintain or withdraw his/her decision to close the establishment to receptions and transfers
• again, should the PMU assessment determine that continuing closure is unsustainable, any decision to extend closure must be made by the director of public sector prisons (or duty director in urgent out-of-hours circumstances)

Figure 1: The command, control, co-ordination and communication in outbreaks of infection in prisons and other places of detention
Guidance on responding to cases or outbreaks of seasonal flu 2014/15 in prisons and other places of detention within the criminal justice system in England

References

i Department of Health. Immunisation against infectious disease, 2006, updated September 2013

ii JCVI statement on the annual influenza vaccination programme – extension of the programme to children, 25 July 2012

iii Department of Health, PHE and NHS E; Flu plan, winter 2014-15

iv Ministry of Justice (MoJ) Seasonal flu notice to NPS 15 September 2014; Seasonal flu notice to Governors 9 September 2014

v Department of Health. Immunisation against infectious disease, 2006, updated September 2013

vi NICE. Guidance on the use of antiviral drugs for treatment of influenza (Technology Appraisal Guidance No. 168) and Guidance on the use of antiviral drugs for the prevention of influenza (Technology Appraisal Guidance No.158)

vii PHE guidance on use of antiviral agents for the treatment and prophylaxis of influenza Version 4.1: January 2014

viii NICE. Good practice guidance Patient Group Directions August 2013
http://www.nice.org.uk/guidance/mpg2
ix HPA. Infection control precautions to minimise transmission of Respiratory Tract Infections (RTIs) in the healthcare setting. 12 January 2012 Version https://www.gov.uk/government/publications/respiratory-tract-infections-infection-control