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Infection Inside International

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Heightened seasonal flu activity in the English and Welsh secure and detained estate

Unprecedented number of prison & IRC flu outbreaks reported in the 2017/18 flu season

Since January 2018 there have been a significant number of confirmed seasonal flu (A and B) outbreaks in prisons and immigration removal centres (IRCs) in England & Wales, with several outbreaks running concurrently and some for several weeks. In total 18 confirmed outbreaks were reported, two of which were reported in prisons in Wales and three in IRCs. Prisoners, detainees and staff were affected and several hospitalisations resulted from complications due to flu, fortunately no deaths secondary to flu infection were reported (Figure 1). Two outbreaks were also re-opened following recrudescence of flu infection in prisoners and/or staff shortly after the outbreaks were declared closed. Figure 1 provides a longitudinal summary of each outbreak reported along with the number of individuals affected. The cumulative impact of so many outbreaks equated to more than 60 outbreak control team (OCT) meetings being convened to date and has put substantial demands on the prison system as well as responding PHE health protection teams (HPTs), prison healthcare teams and the National Health and Justice Team. However, lessons learned from responding to the demands this season will inform planning for the 2018-19 flu season.

Considerations driving infection control measures during seasonal flu outbreaks in prescribed places of detention (PPDs)

In September, PHE published guidance on planning for and responding to outbreaks of **seasonal flu in prescribed places of detention**[1]. 'Closed settings' (such as prisons, IRCs or even military barracks and boarding schools etc.) are recognised as at high risk of 'explosive outbreaks' of flu and other infectious diseases due to a combination of large vulnerable populations living at close quarters. In immigration detention (and prison) settings, there are usually a higher number of people who fall in 'high risk groups for complications of flu infection' than in peer groups in the community, meaning that the risk of people infected with flu becoming seriously ill and requiring hospitalisation is higher than in other settings. This is also true of many other infectious diseases (eg TB, blood-borne viruses, etc.).

[1] **https://www.gov.uk/government/publications/seasonal-flu-in-prisons-and-detention-centres-in-england-guidance-for-prison-staff-and-healthcare-professionals**

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To prevent and control outbreaks in PPDs, response to flu cases has to be rapid due to the high risk of transmission, which means that clinically suspicious cases should be assessed, swabbed, isolated and if in a high risk group, treated quickly with antivirals. Where there are larger numbers of cases than can be isolated, 'cohorting' of cases is advised. In PPDs, the implementation of these measures is often problematic. We often see delayed presentation, delayed diagnosis (due to issues of access to healthcare and/or swabbing), delayed isolation (due to lack of facilities or challenges from detainees or staff on the basis of normal rules of free association in some settings) and inadequate cohorting facilities. All of these factors mean that by the time the 'first few cases' come to light, the outbreak may already have had significant impact, affecting both detainees and staff.

The key then is to implement rigorous infection control protocols - with effective isolation/cohorting; rapid assessment/diagnosis and then isolation of possible/probable cases; strict application of management of staff (custodial and healthcare) including addressing issues of cross-deployment and 'presenteeism' (ie staff attending work while ill themselves which risks spreading infection across a PPD); and control of 'feeding and seeding' outbreaks ie avoiding new receptions which 'feeds' outbreak by adding new vulnerable contacts and avoiding transfers out to other parts of the estate to avoid seeding new outbreaks across the estate. Advice to 'close' part or all of a prison or IRC to transfers out / new receptions is sometimes modified to take account of capacity within specific places to identify highly defined sections of a building and to consider whether one area is functionally and operationally isolated from the general population sufficiently enough. Often this is not possible because of movement of people and services within specific facilities and between different buildings across its campus.

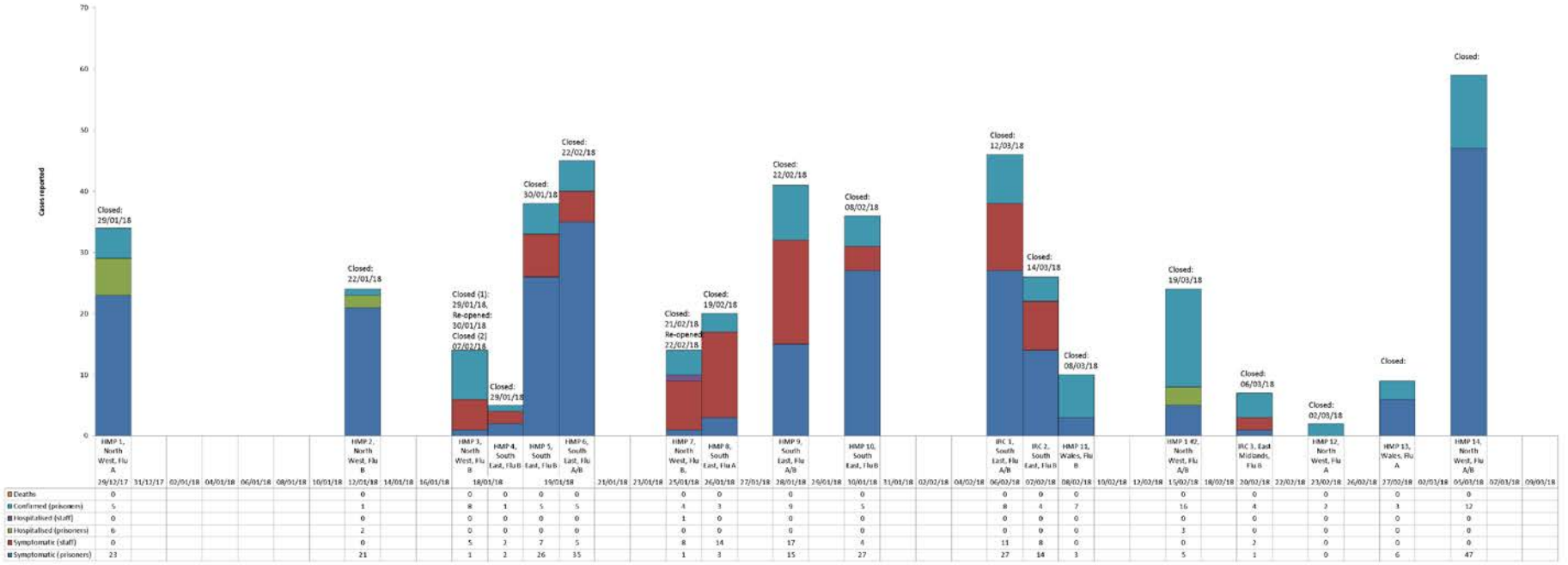
During outbreaks the control team always endeavours to balance effective outbreak control with the operational needs of the PPD to protect health and avoid harm to both staff and detainees. The overall objective is to bring a flu outbreak under control quickly through rapid and effective action. This needs to take account of management of staff as well as prisoners/detainees. Staff should be advised when there is an outbreak that if they become symptomatic with influenza-like illness (ILI) that they should not report for work but inform line managers of illness. If they are themselves in high risk groups for complications of infection then they may require advice from their GP or Occupational Health Adviser. If they become symptomatic at work they should be sent home until fully recovered. To facilitate management of both staff and detainees, accurate and timely information is required to guide actions during an OCT and therefore daily line-listings of new cases provided by prison/IRC healthcare teams to regional health protection teams are necessary. Finally, for vaccine-preventable illnesses such as influenza, prisoners/detainees and staff groups in high risk groups for

complications of influenza infection (see Box 1) should be encouraged to take up offer of seasonal flu vaccine to prevent outbreaks, operational impact and illness.

Box 1: Influenza (Influenza virus), clinical criteria for case definitions ***Source: European Centre for Disease Prevention and Control, EU case definitions***[2]
Sudden onset of symptoms
AND At least one of the following four systemic symptoms: • Fever or feverish • Malaise • Headache • Myalgia
AND At least one of the three respiratory symptoms • Cough • Sore throat • Shortness of breath

[2] **http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012D0506&qid=1428573336660&from=EN#page=16**

Figure 1: Seasonal flu outbreaks in the English prison estate (2017-18) by establishment and date reported by regional health protection teams.



International engagement

Joint WHO Regional Office for Europe, Public Health England and European Monitoring Centre for Drugs and Drug Addiction International Meeting on Health in Prisons

The ongoing work of the WHO HIPP UKCC allows an opportunity for PHE to engage on international aspects of health and wellbeing, both around communicable and non-communicable diseases, strengthening future relationships for further global health activity and the potential to develop public health capacity in other countries.

The WHO HIPP UKCC aimed to produce a conference which provided an opportunity for sharing good practice across regional Member States. The conference topic was drugs and drug related harms deaths in custody, such as HIV, Hepatitis B and C, and tuberculosis. This is an area of key concern with people in prison having higher rates of drug use and injecting behaviours than the general population. People with drug related problems make up a significant proportion of people in prisons; among high risk drug users in the community more than 50% have repeated experience with prison. The likelihood of having contracted an infectious disease is higher among high risk drug users with a prison history than among those who have never been incarcerated and the risk of death by overdose in the first period after prison release is high.

The events were organised through the UK Collaborating Centre, PHE's Events team, the WHO Regional Office for Europe and the EMCDDA. PHE hosted the **meeting website**, arranged registrations for the meeting and the prison visits pre and post meeting, working together with WHO, EMCDDA and the Portuguese Prison Service colleagues to ensure the delivery of the event.

Prison health in all health policies

An action coming out of the conference was that PHE, in collaboration with WHO Europe and the EMCDDA will publish an international statement on the need for prison health to feature in all health and social care policies aimed at policy makers, national and local governmental departments and practitioners in the prison setting. The statement strengthens the acknowledgement of prisons as important settings to address health inequalities as well as of people in prison as a disadvantaged group in terms of health and wellbeing.

Health Protection

National engagement event for blood-borne virus (BBV) opt-out testing in prisons in England, 2017

On November 30th 2017, PHE, working in partnership with NHS England and Her Majesty's Prison and Probation Service (HMPPS), organised an engagement event at the Kia Oval in London to promote the final implementation stage of BBV opt-out testing for consenting eligible adults in prisons in England. The main aim of the meeting was to share lessons learnt from the early phases of BBV opt-out testing implementation in prisons in England and promote good practice in the final stages of implementation. We aimed to replicate a previously successful **function held in Birmingham in May 2015**[3] which had a measurable impact on the early phases of programme implementation.

Event overview

Over 160 delegates from various organisations participated in the event. Speaker presentations reported on the current state of BBV opt-out testing in the English prison estate and highlighted some lessons learnt from programme implementation in early adopter prisons. Leading experts in the fields of prison healthcare, public health and virology as well as patients themselves, were invited to share their knowledge and experience of the current challenges and opportunities for providing BBV treatment and care in prisons. Participants were also encouraged to actively take part in plenary discussions and table-top exercises which focussed on identifying and proposing mitigation strategies for the key barriers to treatment and care of patients with BBV infection in prison. The event programme, which includes the names and topics of invited speakers and lays out the themes around the group exercises, can be found on the event **website**[4].

Looking ahead

PHE, NHS England and HMPPS have committed that by April 2018 the entire prison estate will be offering BBV opt-out testing to new receptions in adult prisons in England. While it was agreed that a lot of progress has been made since the BBV opt-out programme had been introduced back in October 2013, a lot of work still lies ahead. All stakeholders at the event reaffirmed their commitment to collectively work together "to ensure that no one would leave prisons without the offer of a test for HIV, Hepatitis B and Hepatitis C, and, that those found to be infected, would be offered treatment in prison and/or in the community, according to their choice". This will be aim of the BBV

[3] **https://www.gov.uk/government/publications/early-lessons-learnt-from-opt-out-blood-borne-virus-testing-policy-in-prisons-summary-report**
[4] **www.phe-events.org.uk/BBV17**

opt-out programme moving into the future. The key findings from the meeting are summarised online on the National Health & Justice **website**[5].

BBV 'opt-out' testing in London: HMP Wandsworth as a model of good practice

Full implementation of the blood-borne virus (BBV) opt-out testing programme for eligible adults in prisons in England is expected by the end of financial year 2017-18 (ie March 2018). The impact of the programme to date has been marked with formal evaluation showing a seven-fold increase in testing across the English prison estate to more than 29%[6] of all eligible adults. All eight prisons in London currently provide a BBV opt-out testing service. BBV testing in seven of the eight London prisons, namely, HMPs Belmarsh, Brixton, Isis, Feltham, Thameside, Wandsworth and Wormwood Scrubs, moved to a model of opt-out testing from the 1st of April 2017. HMP Pentonville began BBV opt-out testing in December 2015 and was one of the phase 3 'pathfinder' prisons.

NHS England and PHE previously recognised that systems for the detection and management of BBVs within the London prisons almost certainly result in missed opportunities to:

- detect undiagnosed infection with hepatitis HBV, HCV and HIV.
- provide prevention and harm minimization advice to prisoners with negative test results who are at increased risk of infection.
- ensure that all prisoners who are diagnosed with a BBV are rapidly assessed and put onto an appropriate care/treatment pathway.

It continues to be a joint priority with Her Majesty's Prison and Probation Service (HMPPS), PHE and NHS England to monitor opt-out testing for BBVs in prisons. This was always contingent on appropriate care pathways being in place to support those diagnosed with infection.

The London region has rolled out and monitored the early learning of BBV opt-out testing in all eight London prisons through a concerted joint working effort led by the BBV opt-out Steering Group. The group's membership consists of NHS England, PHE, HMPPS, Hepatitis C Trust, NEL CSU (North East London Commissioning Support Unit) Provider Organisations (St Georges Hospitals NHS Foundation Trust, Oxleas Foundation NHS Trust and Care UK) and partners from patient groups and ODNs (Operational Delivery Networks). The initial months of roll out involved embedding BBV opt-out 'as a business as usual' practice within the early days of incarceration and specifically at secondary screening assessment where sufficient time could be spent

[5] **https://www.gov.uk/government/collections/public-health-in-prisons**
[6] BBV opt-out testing in prisons engagement event summary report: *web address TBD*

offering and delivering tests and harm minimisation messages. Currently the Steering Group is focusing on reviewing and refining pathways to treatment and understanding early learning and challenges in referring and retaining patients in treatment.

London specific data and HMP Wandsworth

Collectively, the London region has tested 39% of all new receptions for BBV's in the first half of the 2017/18 financial year. This figure is higher than the national figure of 29% as reported at the latest national BBV Conference.

London region collects data on stages beyond offer and uptake, and this data includes positive tests, confirmation of tests and those referred for treatment. The treatment data is work in progress and the London HPT is now working very closely with colleagues in ODNs to ensure accurate reflection of referral and those accepted onto treatment.

HMP Wandsworth is an excellent example of a healthcare service embracing the BBV Opt Out model despite significant challenges. The healthcare infrastructure within HMP Wandsworth has in recent years, been deemed unfit for purpose. The prison is undergoing major refurbishments in order to be able to respond to an increased turnover of remand prisoners as it becomes a Phase one Reception Prison in the Reform Transforming Prisons Estates Programme, and healthcare facilities is an area that has been identified as requiring significant investment.

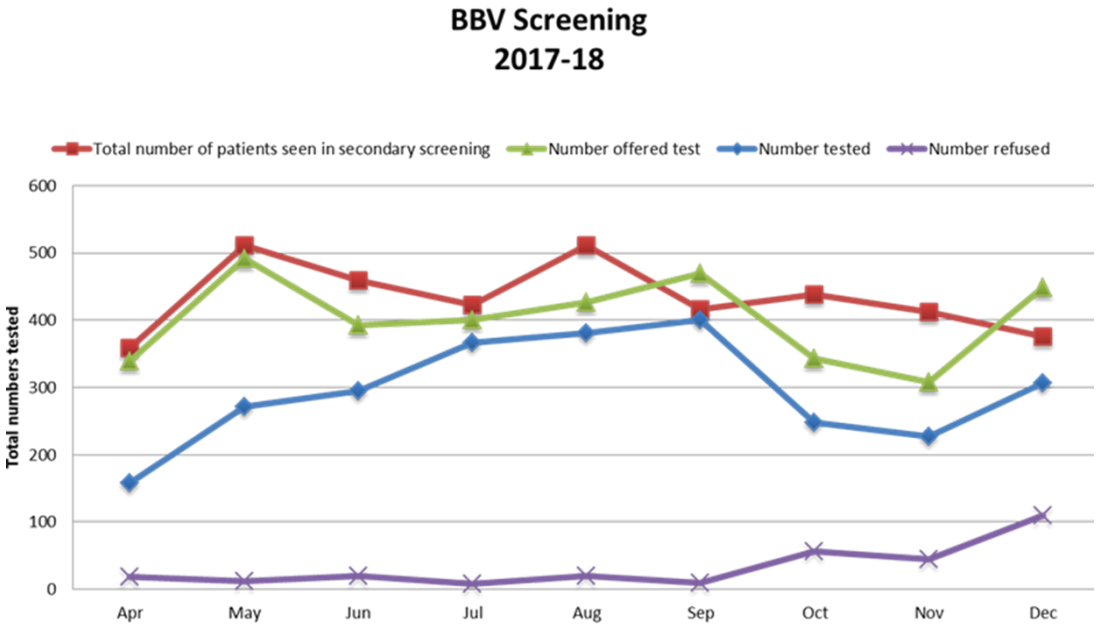
St Georges Hospital NHS Foundation Trust (SGH) holds the contract to deliver healthcare at HMP Wandsworth and has invested resources in appointing a dedicated BBV Nurse. They also provide senior nurse oversight. SGH is unique in using capillary testing (unlike all other London prisons that use Dry Blood Spot testing (DBS). Testing for BBVs at Wandsworth is carried out at the Secondary Screen appointment. The senior nurses monitor offer and uptake of BBV opt-out testing on a clinic by clinic basis at Wandsworth and react to any reduction in numbers with further investigation, review of processes, retraining and reinforcement of opt-out delivery as required.

To date (January 2017), the lead nurse at Wandsworth reports in excess of 150 people tested positive for HCV since 1st April 2017. A number of these are lost due to very short stay in the prison, all positive, however patients are followed up and to date only seven have been totally lost to follow up (suspected extradition/deportation). In the event of a patient leaving the prison, a letter addressed to the individual or their GP is given to the patient detailing their test results, information advising on next steps and harm minimisation messages.

Currently Wandsworth Prisons BBV opt-out testing model is the most comprehensive model within London as not only does this include very high numbers of offer and

uptake of new receptions, Wandsworth healthcare team with the support of the Hepatitis C Trust Peer 2 Peer Programme have also used a targeted approach, for example, all those in the queue for methadone (substance misuse patients) have been given advice and information and offering test there and then whilst waiting their medication – a captive audience. Following a positive result the patient is invited back into healthcare for a further appointment where their diagnosis and treatment options are discussed, hepatology clinics are held within the prison and treatment commences. Wandsworth have embraced the Peer-to-Peer support model provided by the Hepatitis C Trust. This is currently the most advanced Peer-to-Peer example in London due to joint working within the prison and access.

Figure 2: BBV screening at HMP Wandsworth (2017-18)



Health Improvement

Harm Reduction in Prisons: A delegate survey on needle and syringe exchange programmes in prisons

Delegates at the BBV opt-out engagement event convened in November 2017 (see 'Health Protection' section above) were issued a questionnaire to assess behaviours and attitudes to needle and syringe exchange programmes (NSP) in prisons. NSP are part of wider harm reduction strategies in some prison systems in Europe. Studies of these systems have shown some effect in preventing transmission of BBVs, no increase in drug use and no reports of syringes used as weapons.

Thirty-four surveys were returned at the end of the event (out of 160 registered participants). Surveys were completed by individuals involved with prison healthcare from many different perspectives including: prison heads of healthcare, nurses and pharmacists within prisons, hospital consultants, public health professionals and health and justice commissioners.

Survey questions posed

Q1. Do you know NSP are recommended as part of harm reduction strategies by WHO, ECDC and others?

Q2. To the best of your knowledge, has your prison ever considered implementing a NSP?

Q3. Would you consider introducing a NSP in your prison?

Q4. If NSPs were offered in prisons, what do you think would be the best method for providing sterile syringes/needles to offenders?

Q5. Are there any other methods you would suggest for providing sterile syringes/needles to offenders?

Q6. Look back at the barriers you listed in Q2 and Q3. Taking one of the barriers to NSP you consider most significant, what could be done to overcome it?

Results summary

Although only a small sample of delegates returned their questionnaires, these results provide some preliminary evidence surrounding perceived barriers and enablers to introduction of NSP in UK prisons.

Participants mostly knew that NSP are recommended as a harm reduction measure by senior health authorities, however very few reported considering the introduction of prison NSP locally in the past. The main perceived barriers both past and present to NSP in prisons were, staff concerns around safety, offender concerns around safety, concerns around undermining existing drug policy in prison and increasing drug usage in prisons. Suggestions to overcoming these barriers tended to fall into the following subject areas:

- Education and training
- Robust programme monitoring
- Policy level change

- A cultural shift surrounding how drug use in prison is viewed
- Involving prison officers and Governors in service development from the start

Participants selected pharmacy and peer distribution as the most desirable methods of operation for NSP if introduced into local prisons. Other suggestions included making use of existing teams/structures within the prison such as substance misuse services. Participants also raised the need to address safe disposal at programme outset as a matter of priority.

Discussion

Most participants were willing to consider introduction of NSP in their local prison, however they acknowledge that there will be significant barriers to their implementation and acceptance. Addressing these barriers at an early stage, will likely be key to the consideration of NSP within prisons.

Opposition from prison staff (non-healthcare) was perceived to be one of the most important barriers to overcome, in line with previous literature surrounding prison NSP introduction.1-2 Engaging with prison Governors and prison officers at the earliest stage2 would allow commissioners to understand both what an acceptable model could look like, and how best to challenge existing preconceptions of risk with prison NSP.

References

1.Mogg D, Levy M. Moving beyond non-engagement on regulated needle-syringe exchange programs in Australian prisons. Harm Reduction Journal. 2009;6:7. doi:10.1186/1477-7517-6-7.
2. United Nations Office on Drugs and Crime. A Handbook for starting and managing needle and syringe programmes in prisons and other closed settings. July 2014

Research

WorldwidE Prison Health Research and Engagement Network (WEPHREN)

WEPHREN is hosted by PHE's UK Collaborating Centre (UKCC) with the WHO Health in Prisons Programme and supported by The Global Health Network. It is a network for

people interested in prison health, from academics conducting research to practitioners looking for guidance, policy makers looking for best practice and professional development for all. You can access the network's website at www.wephren.org and are encouraged to register and participate in discussions, contributing articles and content and promoting your work. WEPHREN runs themed collections each month and you can access the archive for articles and resources on the website, as well as video interviews with international prison health professionals. Over 2018, WEPHREN will be developing online resources for professional development, accessible through the website and free for all to use. Look out for further announcements; you can follow WEPHREN on Twitter on @wephren.

Events (upcoming)

May:

- **8th to 10th:** Correctional Research Symposium 2018: What is Good Prison Research, Prague: **https://icpa.ca/events/2nd-international-correctional-research-symposium/**
- **14th to 18th:** Commission on Crime Prevention and Criminal Justice Event: Mental Health in Prison, Vienna: **http://www.unis.unvienna.org/unis/en/pressrels/2017/uniscp968.html**
- **24th:** WEPHREN Steering Committee Meeting, Copenhagen: **https://wephren.tghn.org/**
- **25th:** WHO HIPP Steering Group Meeting, Copenhagen: **http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2018/3/who-international-meeting-on-prisons-and-health-recognizing-the-role-of-prisons-in-addressing-health-inequalities**

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