NICE National Institute for Health and Care Excellence

NICE Pathways

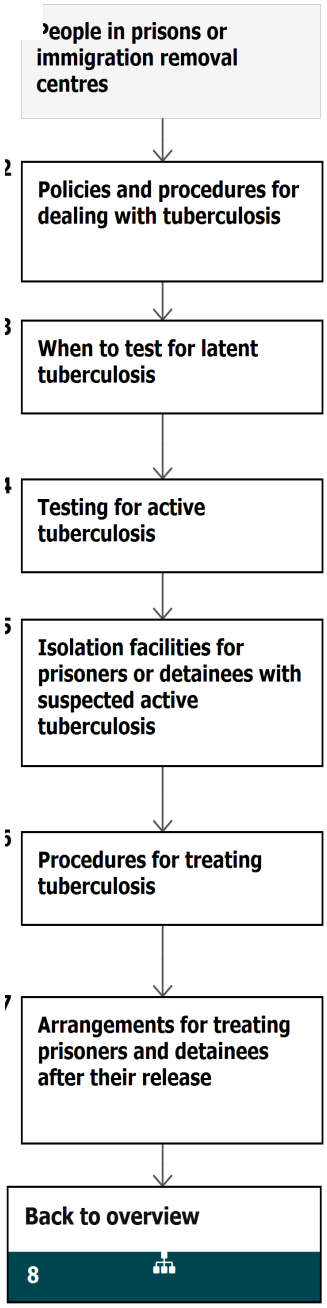
Tuberculosis in prisons or immigration removal centres

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/tuberculosis
Pathway last updated: 06 June 2017

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 People in prisons or immigration removal centres

No additional information

2 Policies and procedures for dealing with tuberculosis

Multidisciplinary TB teams [See page 6], prisons, custody suites and immigration removal centre [See page 7] healthcare services should have named TB liaison leads to ensure they can communicate effectively with each other.

Prison, custody suites and immigration removal centre healthcare services should develop a TB policy by working with the TB control board, and multidisciplinary TB team and the local Public Health England health protection team.

Multidisciplinary TB teams, in conjunction with prisons, custody suites and immigration removal centre healthcare services, should agree a care pathway for TB. This is to ensure that any suspected or confirmed cases are reported to, and managed by, the multidisciplinary TB team.

Multidisciplinary TB teams, in liaison with prisons, custody suites or immigration removal centre healthcare providers, should manage all cases of active TB [See page 6]. Investigations and follow-up should be undertaken within the prison or immigration removal centre if possible.

3 When to test for latent tuberculosis

In high-incidence areas [See page 7] (and at prisons that receive prisoners from high-incidence areas), prison health services should offer an interferon-gamma release assay test for TB to inmates younger than 65 years who are in regular contact with substance misuse services or other support services. This is provided arrangements have been made for this support to continue after release.

Prison health services should incorporate interferon-gamma release assay testing with screening for hepatitis B and C, and HIV testing. They should refer prisoners with positive interferon-gamma release assays to local multidisciplinary TB teams [See page 6] for further clinical investigations. These investigations should be done in the prison if practically possible.

4 Testing for active tuberculosis

Healthcare professionals in prisons and immigration removal centres [See page 7] should ensure prisoners and detainees are screened for TB within 48 hours of arrival.

Prisons with Department of Health-funded static digital X-ray facilities for TB screening should X-ray all new prisoners and detainees (including those being transferred from other establishments) if they have not had a chest X-ray in the past 6 months. This should take place within 48 hours of arrival.

Prison and immigration removal centre health staff should report all suspected and confirmed TB cases to the local multidisciplinary TB team within 1 working day.

Multidisciplinary TB staff should visit every confirmed TB case in a prison or immigration removal centre in their locality within 5 working days.

If a case of active TB [See page 6] is identified, the local Public Health England unit, in conjunction with the multidisciplinary TB team, should plan a contact investigations [See page 7] exercise. They should also consider using mobile X-ray to check for further cases.

5 Isolation facilities for prisoners or detainees with suspected active tuberculosis

In prisons or immigration removal centres [See page 7], everyone with X-ray changes indicative of active TB [See page 6], as well as those with symptoms who are awaiting X-ray, should be isolated in an adequately ventilated individual room or cell. Prisoners and detainees should be retained on medical hold until they have:

- proven smear-negative and had an X-ray that does not suggest active TB, **or**
- had a negative risk assessment for multidrug-resistant TB and completed 2 weeks of the standard treatment regimen (see managing active TB).

6 Procedures for treating tuberculosis

On arrival at a prison or immigration removal centre [See page 7], healthcare professionals should ask all prisoners and detainees (including those being transferred from other establishments) if they are taking TB medication, to ensure continuity of treatment.

All prisoners and immigration removal centre detainees having treatment for active TB [See page 6] should have a named TB case manager [See page 6]. The case manager should be responsible for contingency planning for discharge from prison or detention.

Prisons and immigration removal centres should ensure multidisciplinary TB staff have access to prisoners and detainees who need treatment (for example, by being given security clearance).

All prisoners having treatment for active TB should have directly observed therapy.

7 Arrangements for treating prisoners and detainees after their release

Prison health services should have contingency, liaison and handover arrangements to ensure continuity of care before any prisoner on TB treatment is transferred between prisons or released. In addition, other agencies working with prisoners or detainees should also be involved in this planning.

Prison and immigration removal centre [See page 7] healthcare services should liaise with the named TB case manager [See page 6] (from the multidisciplinary TB team) to ensure contingency plans for continuation of treatment are drawn up for prisoners and immigration removal centre detainees with TB.

Multidisciplinary TB teams [See page 6] should ensure accommodation is available for the duration of TB treatment after the prisoner or detainee's release.

Multidisciplinary TB teams should ensure directly observed therapy is arranged for prisoners or detainees being treated for TB after their release. This should be available close to where they will live in the community.

8 Back to overview

See Tuberculosis / Tuberculosis overview

Involves follow up of a person suspected or confirmed to have TB. It needs a collaborative, multidisciplinary approach and should start as soon as possible after a suspected case is discovered.

Standard and enhanced case management is overseen by a case manager who will usually be a specialist TB nurse or (in low-incidence areas) a nurse with responsibilities that include TB. Depending on the person's circumstances and needs, case management can also be provided by appropriately trained and supported non-clinical members of the TB multidisciplinary team.

Methods of helping someone to overcome barriers to completing diagnostic investigations and TB treatment. Examples of barriers include

- transport
- housing
- nutrition
- immigration status.

A team of professionals with a mix of skills to meet the needs of someone with TB who also has complex physical and psychosocial issues (that is, someone who is under-served). Team members will include:

- a social worker
- voluntary sector and local housing representatives
- TB lead physician and nurse
- a case manager
- a pharmacist
- an infectious disease doctor/consultant in communicable disease control or health protection
- a peer supporter or advocate
- a psychiatrist.

Infection with mycobacteria of the M. tuberculosis complex, in which mycobacteria are growing and causing symptoms and signs of disease. This is distinct from latent TB, in which mycobacteria are present (possibly dormant), but are not causing disease. Symptoms include weakness, weight loss, fever, loss of appetite, chills and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB is in the lungs (pulmonary TB), the symptoms may include a cough, pain in the chest, and coughing up blood.

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Clinical investigations (diagnostic testing) of people identified as having had significant exposure to a case of TB, including tests to diagnose latent or active TB. The aims of contact investigations are to:

- detect active TB earlier to offer treatment and prevent further transmission
- detect latent TB that may benefit from drug treatment
- detect people not infected but for whom BCG vaccination might be appropriate.

A high-incidence country or area has more than 40 cases of TB per 100,000 people per year. Public Health England lists high incidence countries and areas of the UK on its website.

Private or prison-run holding centre for migrants waiting to be accepted by, or deported from, the UK. Also known as immigration detention centre and pre-departure accommodation.

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Glossary

Active case-finding

systematically identifying people with active or latent TB using tests, examinations or other procedures

Adherence

the person's ability or willingness to keep to a treatment regimen as directed

BMRC

British Medical Research Council

BNF

British National Formulary

CNS

central nervous system

Congregate settings

places where people congregate or an institutional setting such as a workplace, prison, hostel, or childcare or educational setting, where social contacts might have had significant exposure to TB

Contacts

a person who has spent time with someone with infectious TB

Disseminated TB

blood-borne spread of TB that may or may not be accompanied by chest X-ray or high resolution CT changes

Extensively drug-resistant TB

resistance to at least isoniazid and rifampicin, 1 injectable agent (capreomycin, kanamycin or amikacin) and 1 fluoroquinolone

Extrapulmonary TB

active TB disease in any site other than the lungs or tracheobronchial tree

FFP

filtering face piece

GCS

Glasgow coma score

IV

intravenous

Latent TB

infection with mycobacteria of the M. tuberculosis complex in which the bacteria are alive but not currently causing active disease (also known as latent TB infection)

Multidrug-resistant TB

TB resistant to isoniazid and rifampicin, with or without any other resistance

Neonates

child aged 4 weeks or under

Outbreak

there is no robust, widely accepted threshold for an outbreak of a disease, but in practical terms an outbreak is the occurrence of an unusually high number of cases in associated people, in a small geographical area, or in a relatively short period of time

Prisons

any state prison establishments, including young offender institutions

Prison

any state prison establishment, including a young offender institution

Rapid access

in the context of TB services, timely support from a specialist team

Social contacts

someone who has had contact with a person with infectious TB but has not been in prolonged, frequent or intense contact

Treatment interruption

a break in the prescribed anti-TB regimen for 2 weeks or more in the initial phase, or more than 20% of prescribed doses missed intermittently

Sources

Tuberculosis (2016) NICE guideline NG33

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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