Department of Health

Health Protection Regulations

Consultation Response Form

We would prefer this form to be returned to us electronically as an email attachment. The email address for responses or queries is healthprotectionregulations@dh.gsi.gov.uk. You can provide a covering letter by email if you wish.

Postal responses can be sent to:

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Email responses to the consultation will receive an acknowledgement of receipt. Postal responses will not receive an acknowledgement.

The consultation closes on **30 September 2009**.

Telephone contact for enquiries:

020 7972 4048 - Robert Parsons or Janet Whybrow.

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I do not wish my response to be passed to other UK Health Departments (please mark with an 'x').

☐

I do not wish my response to be published in a summary of responses

☐

Please delete as appropriate. I am responding:

- on behalf of an organisation

If you are responding as a professional, please supply the following details:

Name of Profession:

Area of work (please mark with an ‘x’)
NHS
Social Care
Health Protection
Private Healthcare
Third Sector
Regulatory Body
Professional Body
Education
Trades Union
Local Authority
Trade Body
Other (please give details):

If you are responding on behalf of an organisation, please supply the following details:

Name of Organisation: The UK Faculty of Public Health

Area of work (please mark with an ‘x’)

NHS
Social Care
Private Healthcare
Third Sector
Regulatory Body
Professional Body X
Education
Trades Union
Local Authority
Trade Body
Other (please give details):

Health Protection Regulations

Consultation Questions

Please mark your answers with an "x" as necessary.

Chapter 2: The Health Protection (Notification) Regulations

A- Is the list of notifiable diseases for clinical reporting at Schedule 1 to the draft notification regulations appropriate?

The Schedule 1 list is appropriate ( )

The Schedule 1 list is not appropriate (X)

If you answered that it is not appropriate, what changes would you make and why?

It is rather disappointing that there has not been a more fundamental rethink of the list of notifiable diseases. There are two broad groups of infections of public health importance that are either absent or poorly represented viz. sexually transmitted infections and zoonoses. These, and other omissions, are considered in more detail below.

Meningitis
The current list of notifiable disease includes meningitis due to any cause, the new list only refers to invasive meningococcal disease. This means that haemophilus (Hib) meningitis, pneumococcal meningitis and viral meningitis are no longer notifiable.

Invasive Haemophilus influenzae disease sometimes requires urgent action to identify and offer prophylaxis to contacts. Invasive pneumococcal disease and viral meningitis sometimes cause clusters or outbreaks that require public health investigation and action. In addition, Hib and pneumococcal disease are the only vaccine preventable diseases from the routine childhood immunisation programme that are not included on the list.

We suggest the following be added to the list:

- **Invasive Haemophilus influenzae disease**
- **Invasive pneumococcal disease**
- **Viral meningitis**

Childhood exanthemata
These are common and generally mild infections often occurring in clusters or outbreaks. There are two that pose particular risks to either pregnant women and/or immunosuppressed people. These often require a public health response in the form of counselling for exposed

individuals and sometimes exclusion of affected individuals. Patient diagnosis is usually made on clinical rather than microbiological grounds.

We suggest the following be added to the list:

- **Chickenpox**
- **Erythema infectiosum (parvovirus disease)**

Sexually transmitted infection
We appreciate that there is separate legislation concerning the management of patients of sexually transmitted infection. We also note that the only sexually transmitted infection on the current list (ophthalmia neonatorum) has been dropped. However, we believe there are good grounds for incorporating sexually transmitted infections in health protection legislation.

Current surveillance data are poor (with the exception of HIV infection) and inadequate for promptly identifying outbreaks or incidents of public health importance. For example, in recent years there have been several protracted outbreaks of syphilis linked to saunas and other sexual activity venues. The emergence of antibiotic resistant strains, especially in gonorrhoea, also increases the potential for uncontrolled spread of infection. Finally, some diagnoses e.g. syphilis are difficult to make on the basis of laboratory test results alone.

We suggest further consideration be given to making some or all of the following sexually transmitted infections notifiable:

- **Gonorrhoea**
- **Lymphogranuloma venereum**
- **Acute (primary or secondary) syphilis**

Zoonoses
These sometimes occur as common source outbreaks and, even where they occur sporadically, may have implications for public health control measures and advice to the general public. In Wales, there is a specific control programme for hydatid disease. Diagnosis usually requires laboratory confirmation but is often suspected on clinical and/or epidemiological grounds.

We suggest the following be added to the list:

- **Hydatid disease**
- **Lyme disease**
- **Psittacosis**
- **Q fever**

Gastrointestinal infection
This is a difficult category since such infections are very common and most often due to viral gastroenteritis, which usually does not have any major public health implications unless part of on outbreak.

However, food or water borne infection and zoonotic infection may have serious implications and it is important that these are covered by the notification process.

We suggest the following:

- **Food poisoning be defined to make clear that it includes both food and water-borne diseases or intoxications**
- **Acute gastroenteritis be made notifiable if it is considered to be due to animal contact.**

B- Is there any health protection benefit in Primary Care Trusts receiving from the proper officer of the local authority copies of individual notifications from registered medical practitioners?

There is a benefit (X)

There is not a benefit ( )

Comments

This is particularly important for diseases where the PCT are responsible for provision of preventive services e.g. childhood immunisation programme, tuberculosis control services.

For other diseases e.g. food poisoning this is not really relevant or appropriate.

C- Is the information to be reported by registered medical practitioners, as far as it is known to them, appropriate?

It is appropriate (X)

It is not appropriate ( )

If you answered that it is not appropriate, what changes would you make and why?

The current notification form makes provision for extra information to be provided for certain diseases e.g. tuberculosis (organ affected), malaria (parasite type, where contracted), meningitis (causal organism).

It would be helpful if this principle were retained.

The following broad areas of information would be useful:

- **recent travel abroad (past 4 weeks) and country(ies) visited for non-indigenous infections, food poisoning, legionnaires' disease**
- **vaccination history for vaccine preventable diseases**
- **relevant medical history for tuberculosis, acute viral hepatitis, etc.**

D- Is the list of specified microorganisms ("causative agents") for laboratory reporting at Schedule 2 to the draft regulations appropriate?

It is appropriate (X)

It is not appropriate ( )

If you answered that it is not appropriate, what changes would you make and why?

E- Is the information to be reported by laboratories, as far as it is known to them, appropriate?

It is appropriate (X)

It is not appropriate ( )

If you answered that it is not appropriate, what changes would you make and why?

But see comments above in Section C.
The same would apply to laboratory reporting. Details of recent travel abroad and relevant medical history are often included on the test request form, though vaccination history is not.

Chapter 3: The Health Protection (Part 2A Orders) Regulations

F- Will the proposed requirements for evidence to be given to a JP be helpful to the JP?

Yes, they will be helpful (X)

No, they will not be helpful ( )

If you consider that the evidence requirements will be unhelpful, what evidence should be required, in addition to, or instead of, the requirements identified?

G- Are the proposed requirements for evidence sufficiently flexible to allow action to protect public health in all circumstances?

Yes, they are flexible enough ( )

No, they are not flexible enough (X)

If you do not think they are flexible enough, what changes would you make? Please give your reasons.

The clauses in this section mainly concern orders about persons. It is unclear whether the same criteria would be used for orders about things or about premises.

In many outbreak investigations the most pressing need is for information. This may be either information to help identify persons potentially at risk or information about circumstances, procedures, etc. that may have contributed to the outbreak. This often requires someone to provide details about a third party(ies) so that they may be questioned about their exposure and/or alerted to risk. For example, a list of guests at a function, customers at a restaurant, travellers in a coach party, etc.

In such circumstances the 'affected person' may be the owner of the list or a person named on the list. The regulations should be drafted to ensure that these kinds of circumstances are covered, but also to enable the rapid acquisition of relevant information by the investigating authorities.

The clauses in this section are also drafted in such a way that they imply personal risk from person-to-person transmission of infection. Many outbreaks e.g. food poisoning, legionnaires' disease are, however, common source outbreaks where there is little likelihood of onward transmission of infection but it is vital to identify the source rapidly in order to prevent further exposures of individuals to the source of infection.

H- Does the list of "affected persons" in the Act cover everyone who might be personally affected by a JP order?

Yes, the list is appropriate ( )

No, the list is not comprehensive enough (X)

If not, who else should be included?

See comments above. The 'affected person' may be a third party (not yet ill) who is identified as having been exposed e.g. stayed at a hotel that is implicated in an outbreak of legionnaires' disease.

I- Is the proposed list of next of kin who are to have the right to apply for variation or revocation of any JP order applying to a body adequate for this purpose?

Yes, the list of next of kin is adequate ( )

No, the list of next of kin is not adequate (X)

If not, have you suggestions as to what the regulations should require here?

The list does not include individuals without a next of kin who die in an institutional setting e.g. hostel for homeless people. In these circumstances the owner or manager of the institution should perhaps be included.

J- Will the proposed requirements concerning who must be notified of an application for a JP order ensure that those who most need to know are notified?

Yes, the proposed requirements are adequate (X)

No, the proposed requirements are not adequate ( )

If not, have you suggestions as to what the regulations should require here?

K- Is a regulation requiring that local authorities consider the welfare needs of anyone whose liberty is restricted by an order necessary or desirable as an extra safeguard for vulnerable people?

It is desirable (X)

It is not desirable ( )

What are your reasons for thinking so?

L- Do the proposed contents of the report of an application for a JP order cover all the relevant information?

The proposed contents do require all the relevant information ( )

The proposed contents do not require all the relevant information (X)

Comments

It should include the disease or diagnosis which gave rise to the application for an order. Under the terms of Clause 44, this will not necessarily be identified.

Chapter 4: Draft Health Protection (Local Authority Powers) Regulations

M- Do you think five days is a suitable timeframe in which a local authority should be expected to review a requirement that a child be kept off school?

Yes, it is a suitable timeframe (X)

No, it is not a suitable timeframe ( )

If not, how long should the timeframe be, and why?

N- Will the requirement for a local authority to review a notice to keep a child off school work fairly in practice?

Yes, it will work fairly in practice (X)

No, it will not work fairly in practice ( )

If not, what changes should be made to the requirement?

O- Is there a need for a local authority power for disinfection/decontamination to be retained in an updated form in these regulations?

Yes, such a power is needed (X)

No, such a power is not needed ( )

What are your reasons for thinking so?

The local authority will often give advice about disinfection as this is an important aspect of disease control. It is useful to retain this power (and the power to charge) in circumstance where assistance from the local authority is required to ensure that disinfection is properly carried out.

This is most likely to be for disinfection of premises rather than for setting up a 'disinfection station'.

P- Do you agree the local authority power to request co-operation for health protection purposes could be a helpful component of the modernised local authority standing powers for health protection?

Yes, such a power could be helpful (X)

No, such a power is not needed ( )

What are your reasons for thinking so?

This is very helpful. Good communicable disease control often depends on good cooperation and the power to offer compensation or incentives should facilitate this.

Q- Do you agree that there is no need for an updated power to allow a local authority to arrange for immunisation?

I agree there is no need for such a power (X)

I disagree- there is a need for such a power ( )

If you disagree, could you please explain why you feel there is a need for this power to be retained and updated?

This is the responsibility of the health services, in support of the local authority.

Chapter 5 and Impact Assessment: The costs and benefits of the proposed regulations

R- Do the assumptions in the Impact Assessment appear reasonable?

Yes, the assumptions in the impact assessment appear reasonable (X)

No, the assumptions in the impact assessment do not appear reasonable ( )

If not, what assumptions should be used? Please provide evidence for your response.

Please feel free to submit any further comments on these draft regulations below.

<u>Further comments</u>

General comments

We support the principle of flexibility, particularly in relation to health protection orders. Effective communicable disease control can be complex and it is difficult to foresee or anticipate the range of circumstances in which such powers may be required.

It is important that the legislation facilitates rather than circumscribes appropriate control measures, whilst at the same time safeguarding the rights of those affected.

Communication and flow of information

It is important that information about notifications and laboratory reports is promptly communicated to all who need to know. We therefore strongly support the introduction of electronic communication and the provision for urgent oral reporting.

The Consultation Document is not entirely clear about the flow of information particularly in relation to laboratory reporting (Clause 37). It is important that laboratory reports, particularly about food and water-borne disease, legionnaires' disease, etc. are conveyed promptly to the relevant local authority, either directly or via the Health Protection Agency. The diagram has an arrow that implies a flow of information from LA to HPA, but no indication that information also needs to flow in the other direction.