Health protection regulations

Consultation report
**Health protection regulations**

<table>
<thead>
<tr>
<th><strong>Policy</strong></th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR / Workforce</td>
<td>Commissioning</td>
</tr>
<tr>
<td>Management</td>
<td>IM &amp; T</td>
</tr>
<tr>
<td>Planning /</td>
<td>Finance</td>
</tr>
<tr>
<td>Clinical</td>
<td>Social Care / Partnership Working</td>
</tr>
</tbody>
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**Circulation List**

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**Description** Response to a consultation which sought comments on proposals for three sets of regulations to be made under the amended Public Health (Control of Disease) Act 1984, taking forward the modernisation of health protection law. The regulations cover notification of hazards, safeguards for individuals and updated local authority powers.

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Health protection regulations

Consultation report
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>5</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>The consultation process</td>
<td>7</td>
</tr>
<tr>
<td>Key findings and future actions</td>
<td>9</td>
</tr>
<tr>
<td>The Health Protection (Notification) Regulations 2010</td>
<td>11</td>
</tr>
<tr>
<td>The Health Protection (Part 2A Orders) Regulations 2010</td>
<td>21</td>
</tr>
<tr>
<td>The Health Protection (Local Authority Powers) Regulations 2010</td>
<td>32</td>
</tr>
<tr>
<td>The costs and benefits of the proposed regulations</td>
<td>40</td>
</tr>
<tr>
<td>Annex A – List of respondents</td>
<td>41</td>
</tr>
<tr>
<td>Annex B – Consultation poster</td>
<td>44</td>
</tr>
<tr>
<td>References</td>
<td>45</td>
</tr>
</tbody>
</table>
Executive summary

Between 8 July and 30 September 2009, we held a formal consultation on three sets of regulations to be made under the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care 2008. These regulations will complement the primary legislation and complete the process of modernising domestic health protection powers in England. The three sets of regulations are:

- **Health Protection (Notification) Regulations**: requirements for doctors (registered medical practitioners (RMPs)) to report cases of infectious disease or contamination which present, or could present, significant harm to human health, to allow prompt investigation and response; similar requirements on diagnostic laboratories in relation to infectious disease.
- **Health Protection (Part 2A Orders) Regulations**: evidence required before a Justice of the Peace (JP) can make an order imposing restrictions or requirements on someone to protect public health; safeguards for people affected by an order, associated matters and reporting of applications for orders.
- **Health Protection (Local Authority Powers) Regulations**: standing powers and duties of local authorities relating to their health protection role, where the judicial oversight of a JP is not necessary.

We invited comments on these regulations, and in particular, responses to specific questions. We received 68 responses, and are grateful to all respondents for their contributions.

The majority of respondents broadly supported the approach taken in the draft regulations. There were however some notable concerns, in particular about the position of people with HIV or other sexually transmitted infections (STIs). Other themes concerned human rights issues; the lists of notifiable diseases and microorganisms; the impact on local authorities’ powers and duties in health protection; and the practical effect on day-to-day health protection measures of increased judicial oversight. We also undertook a further, limited consultation on a provision for local authorities to charge for measures they need to undertake as a result of a JP order.

We have endeavoured to meet respondents’ concerns where possible, and where we have not done so, to explain our reasons. In some instances, we think the issue is better covered in guidance than in regulation, which is currently under development.

Subject to Parliament, we propose that the three sets of regulations should come into force on 6 April 2010, excepting provisions relating to notification by laboratories, which are planned to come into force from 1 October 2010 to allow time for them to prepare for implementation.
The Health Protection Agency (HPA), with the Department of Health, will make available guidance explaining the detail of the new legislative requirements and providing operational advice to assist those who will be responsible for putting the new legislation into practice.
Health protection regulations

Introduction

In July 2009, we began a consultation on three sets of regulations to be made under the Public Health (Control of Disease) Act 1984, as amended by the Health and Social Care 2008. These three sets of regulations will complement the primary legislation and complete the process of modernising domestic health protection powers in England. The three sets of draft regulations are:

- **Health Protection (Notification) Regulations**: requirements for doctors (registered medical practitioners (RMPs)) to report cases of infectious disease or contamination which present, or could present, significant harm to human health, to allow prompt investigation and response; similar requirements on diagnostic laboratories in relation to infectious disease.

- **Health Protection (Part 2A Orders) Regulations**: evidence required before a Justice of the Peace (JP) can make an order imposing restrictions or requirements on someone to protect public health; safeguards for people affected by an order, associated matters and reporting of applications for orders.

- **Health Protection (Local Authority Powers) Regulations**: standing powers and duties of local authorities relating to their health protection role, where the judicial oversight of a JP is not necessary.

We invited comments on these regulations and, in particular, responses to specific questions set out in the consultation paper. For detailed background on the draft regulations, please see the consultation document and accompanying materials, available on the Department of Health website [here](#).
The consultation process

The consultation documents

The consultation document summarised the content of, and the rationale for, the draft regulations. We also produced an accompanying set of draft impact assessments, which assessed the economic, equality, health and legal costs and benefits of the regulations. The production of these impact assessments helped us to formulate the policy underlying the draft regulations.

‘Questions for consultation’ were presented throughout the consultation document, and a form was made available for respondents to use to submit their views. This form included space for general comments on the regulations.

The consultation document, impact assessments, form for response, and the draft regulations themselves were made available on the Department of Health website to view and download electronically. Electronic links to these materials were distributed via e-mail to:

- chief executives of NHS organisations and chief executives of local authorities, for cascade within their organisations (via the NHS Chief Executive’s weekly bulletin, the week);
- public and independent sector clinical microbiology laboratories which test human samples;
- the Health Protection Agency;
- other selected stakeholder organisations (for example, the Chartered Institute of Environmental Health, the Local Authorities Coordinators of Regulatory Services, the Local Government Association, the National AIDS Trust and Liberty).

Consultation activities

Before drafting and consulting upon the regulations, we aimed to capture a wide range of expert input. In particular, a meeting held in early 2009 with a range of stakeholder organisations directly contributed to the content of the draft regulations. Subsequent to this stakeholder meeting, we had informal discussions with health protection consultants from various English regions to gather evidence from front line professionals to inform further policy development. Meetings were also held with two independent microbiology laboratories, including one of the major independent UK providers.

A number of further activities also took place during the consultation period:

- A poster presentation was given at the Health Protection Agency’s annual conference (14-16 September 2009), encouraging individuals to respond to the consultation. A copy of this poster can be found at Annex B.
- The same poster was distributed as a leaflet at the Chartered Institute of Environmental Health’s annual conference (21-23 September 2009).
Health protection regulations

- We had informal discussions with a number of organisations who wished to ask us questions arising from the consultation.

Responses

The consultation closed on 30 September 2009. Sixty-eight responses were received by or shortly after this date. We would like to thank everyone who responded for taking the time to contribute.

A list of those who responded can be found at Annex A. The table below provides a breakdown of the responses received by type of respondent.

Table 1: Breakdown of responses

<table>
<thead>
<tr>
<th>Type of respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health protection professional or organisation</td>
<td>22</td>
</tr>
<tr>
<td>Other health professional or organisation</td>
<td>14</td>
</tr>
<tr>
<td>Local authority, local authority professional or representative organisation</td>
<td>12</td>
</tr>
<tr>
<td>Sexual health/HIV sector organisation</td>
<td>13</td>
</tr>
<tr>
<td>Other third sector organisation</td>
<td>3</td>
</tr>
<tr>
<td>Legal specialist</td>
<td>3</td>
</tr>
<tr>
<td>Member of the public</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
</tr>
</tbody>
</table>
Key findings and future actions

Summary of responses
The majority of respondents broadly supported the approach taken in the draft regulations. There were however some notable concerns, in particular about the position of people with HIV or other sexually transmitted infections. These are discussed in more detail at page 27.

Other major themes concerned the extent to which the regulations and the parent legislation raise human rights issues; the rationale and proposed content of the lists of notifiable diseases and microorganisms; and the impact of the changes on local authorities’ powers and duties in the health protection field. Some concerns emerged about the practical effect on day-to-day health protection measures of the increased emphasis on the need for judicial oversight, which limits the scope for direct local authority action in some areas.

Mini-consultation
The consultation also highlighted that the draft regulations omitted to make provision for local authorities to make a charge for measures they need to undertake as a result of a JP order about a ‘thing’ or premises. We therefore undertook a further, limited consultation involving only those organisations with an interest in this issue. We discuss this issue in more detail and the outcome of the further consultation on page 29.

Our response
We have endeavoured to meet respondents’ concerns where possible, and where we have not done so, to explain our reasons. The following chapters discuss each set of the regulations and summarise how we have acted upon the responses received. In some instances, we think the issue is better covered in guidance than in regulation and will take this into account in our preparation of guidance over the coming weeks.

What happens next
We propose shortly to begin the Parliamentary processes required before the regulations can be finalised. Two of these sets of regulations are subject to the affirmative procedure, which means they must be approved by both Houses of Parliament before they can become law. Subject to Parliament, we propose that they should come into force, together with amendments to the Public Health (Control of Disease) Act 1984 introduced by the Health and Social Care Act 2008, on 6 April 2010. The provisions relating to notification by laboratories (see page 17) are planned to come into force from 1 October 2010, to allow time for them to prepare for meeting the new requirements.
The final Impact Assessment for the regulations will be laid before Parliament with the regulations. We will also publish a final Equality Impact Assessment for the regulations on the Department of Health website.

The Department of Health and the HPA will make available guidance early in 2010 explaining the detail of the new legislative requirements and providing operational advice to assist those who will be responsible for putting the new legislation into practice.
The Health Protection (Notification) Regulations 2010

Respondents

Of the 68 responses from individuals or organisations to the consultation, 64 included comments on the notification regulations. Forty-six responses were made on behalf of organisations (e.g. NHS, local authorities, professional bodies and third sector).

The organisations responding included the Association of Medical Microbiologists, British Medical Association, Chartered Institute of Environmental Health, the Health Protection Agency, the Independent Healthcare Advisory Services, the Justices' Clerks' Society, Local Authorities Coordinators of Regulatory Services, the National Information Governance Board, Royal College of Nursing, Royal College of Paediatrics and Child Health, and the UK Faculty of Public Health. Thirteen sexual health/HIV organisations also responded.

We did not receive any responses from private diagnostic laboratories and the only response from the independent healthcare sector was from the Independent Healthcare Advisory Services.

Specific questions

A: Is the list of notifiable diseases for clinical reporting at Schedule 1 to the draft notification regulations appropriate? If you answered that it is not appropriate, what changes would you make and why?

Responses to this question were as follows:

Yes, the Schedule one list is appropriate - 35
No, the Schedule one list is not appropriate - 16
No reply to this question - 17

Comments were mainly suggestions for additions or deletions to the list, or for modification or definition of items on the list.

The items which attracted most comment were as follows:

Chickenpox
Some organisations and individuals suggested adding chickenpox to the list of notifiable diseases in Schedule 1. The main reasons given were the need for public health action in special cases (e.g. when a healthcare worker has chickenpox and may pose an infection risk
to immunosuppressed patients) and the generation of baseline incidence data, which would be useful if a childhood immunisation programme were to be considered.

The purpose of statutory notification is primarily to enable prompt public health action to prevent and control infection or contamination. There is no need for public health action in the vast majority of chickenpox cases. There are provisions in the regulations for notification of infections not on the list of notifiable diseases that may pose a significant risk to public health (the ‘safety net’ provision). This will require notification of cases of chickenpox that pose a significant risk to public health. We will clarify this in guidance.

Making chickenpox a notifiable disease would have a considerable impact on the workload of both registered medical practitioners (RMPs) and local authority proper officers for little public health benefit. For the above reasons, we do not propose to make chickenpox a notifiable disease at present. However, if universal chickenpox immunisation were introduced in the future and the disease became a rare condition, this position could be reviewed in the light of changing epidemiology of the disease.

- **We do not propose adding chickenpox to Schedule 1.**

**Human influenza caused by a new sub-type of influenza virus**

A number of respondents commented on definition of a ‘new’ strain of influenza, the practicalities of notification when there are large numbers of such cases, and that new strains of the virus are primarily identifiable by laboratories.

Pandemics of influenza are rare (the shortest reported interval between pandemics is 11 years and the longest 41 years) and each one is usually different from others. Arrangements for notification of suspected cases of influenza in the early stages of a pandemic for surveillance and containment purposes may change according to the circumstances of each pandemic, e.g. symptoms, severity of disease, affected population groups and epidemiological factors. Therefore, it would not be sensible to seek to specify standing requirements in regulations, as this would remove flexibility to tailor effective arrangements according to the circumstances.

Notification of all cases during a pandemic will usually cease when the mitigation phase begins, and sentinel clinical and laboratory surveillance is used to monitor the pandemic. Again, this argues for not having a standing statutory requirement for notification.

A ‘new’ strain of human influenza will be identified primarily by reference laboratories, which are required to notify laboratory diagnoses under Schedule 2. If a new strain of human influenza virus emerged before a reference laboratory had identified the virus, doctors would be able to notify such cases, if clinically suspected, under the ‘safety net’ provision if they judged there was a risk of significant harm to public health.
Health protection regulations

We no longer propose that cases of human influenza caused by a new sub-type of the influenza virus should be statutorily notifiable.

- **We propose removing ‘Human influenza caused by a new sub-type of the influenza virus’ from Schedule 1.**

HIV and other sexually transmitted infections

Most sexual health/HIV sector respondents requested that provisions for notification of other infections not listed under Schedule 1 that can pose a risk of significant harm to human health (the ‘safety net’ provision) should be limited to new and emerging diseases. They were concerned that, if this were not done, doctors might notify cases of HIV or other sexually transmitted infections (STIs) unnecessarily.

Some existing diseases that are not notifiable under the proposed list in Schedule 1 of the regulations may need to be notified under special circumstances, e.g. a case of slapped cheek disease (infection with Parvovirus B19) where the person had been in contact with a pregnant woman. The purpose of the safety net provisions for infection and contamination is to capture all unforeseen risks to public health, which is the essence of the ‘all hazards’ approach.

- **We do not propose limiting the ‘safety net’ provision for infections to new and emerging diseases.**

Several other organisations and individuals suggested that HIV and other STIs should be made notifiable. This is unnecessary as genito-urinary medicine (GUM) and HIV clinics deal with at-risk contacts of those with HIV and other STIs and provide health protection advice, as well as offering testing and treatment if indicated.

- **We do not propose adding HIV and other STIs to the list of notifiable diseases in Schedule 1.**

Other comments

Other comments on Schedule 1 included suggestions for addition, removal, modification or definition of some diseases. The main changes suggested are summarised in Table 2 below.
Table 2: Suggested changes to Schedule 1

<table>
<thead>
<tr>
<th>Diseases suggested to be added to Schedule 1</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute meningitis</td>
<td>Acute meningitis will be added to the list and meningococcal septicaemia will replace invasive meningococcal disease</td>
</tr>
<tr>
<td>Lyme disease, Q fever, psittacosis, invasive Hib and pneumococcal disease</td>
<td>These diseases are mainly diagnosed by laboratories and the relevant organisms are included in Schedule 2.</td>
</tr>
<tr>
<td>HIV, STIs</td>
<td>GUM and HIV clinics deal with at risk contacts and provide health protection advice.</td>
</tr>
<tr>
<td>Methicillin-Resistant Staphylococcus aureus (MRSA) and Panton Valentine Leukocidin (PVL) producing Staphylococcus aureus</td>
<td>These infections can only be diagnosed by laboratories. There is already an effective mandatory surveillance system in place, which records all cases of MRSA bacteraemias. Currently there are not sufficient surveillance data and evidence to suggest notification of infections with PVL producing S. aureus would be necessary for health protection reasons.</td>
</tr>
<tr>
<td>Viral food poisoning</td>
<td>Unless there are outbreaks, no health protection action would be required. Outbreaks are routinely reported to the HPA.</td>
</tr>
<tr>
<td>CJD and vCJD</td>
<td>A dedicated surveillance system for this group of diseases exists which triggers any necessary health protection action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diseases suggested to be removed from Schedule 1</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leptospirosis</td>
<td>This disease is mainly diagnosed by laboratories and the causative organism is included in Schedule 2. We therefore propose to remove it from Schedule 1.</td>
</tr>
<tr>
<td>Brucellosis, legionnaires’ disease, malaria, cholera and infectious bloody diarrhoea</td>
<td>The argument put forward for removal of these diseases is that they are always diagnosed by a laboratory. We agree that they cannot be confirmed until microbiological tests are done, but clinical suspicion, particularly in the event of clusters and linked cases, should be notified to the proper officer for immediate control measures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diseases suggested to be modified or defined on Schedule 1</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute viral hepatitis</td>
<td>It was suggested to change the wording to ‘Acute hepatitis (likely to be infectious)’ as a viral cause can only be identified by the laboratory. We propose this be amended to ‘Acute infectious hepatitis.’</td>
</tr>
<tr>
<td>Food poisoning and infectious bloody diarrhoea</td>
<td>Definitions were requested which will be included in guidance.</td>
</tr>
</tbody>
</table>
B: Is there any health protection benefit in primary care trusts (PCTs) receiving from the proper officer of the local authority copies of individual notifications from registered medical practitioners?

Responses to this question were as follows:

Yes, there is benefit - 15
No, there is not a benefit - 20
No reply to this question - 33

We did not receive any response from primary care trusts (PCTs) on this topic. Those who responded positively argued that PCTs would benefit from incidence data for service planning and to be alerted to changing trends and emergence of new diseases. This argument, however, does not apply to routinely receiving copies of notifications about individual cases including patient identifiable information and confidential data, as aggregated data provided by the local authority’s proper officer/HPA would be sufficient for monitoring trends.

Those who commented that PCTs should not receive notifications on individual cases, including the National Information Governance Board, argued that in line with the common law duty of confidentiality and the Data Protection Act, PCTs should not receive copies of individual notifications which include confidential data unless they were directly involved in managing a case, outbreak or incident. Aggregated reports and incidence data would be sufficient for PCTs’ needs.

- We propose to remove the requirement for the proper officer to send a copy of the notifications to PCTs.

C: Is the information to be reported by registered medical practitioners (RMPs), as far as it is known to them, appropriate? If you answered that it is not appropriate, what changes would you make and why?

Responses to this question were as follows:

Yes, it is appropriate - 32
No, it is not appropriate - 16
No reply to this question - 20

Responses included requests for clarification, suggestions for addition of data items to or removal of data items from the notification information provided by the RMP.
The items included in notification by RMPs are not intended to provide all relevant data for further health protection action. Notification provides the basic information about a patient with notifiable disease, so that the proper officer or Health Protection Units can contact the patient or their doctor to initiate further investigations and interventions. Notification also gives an indication of the nature of the disease and urgency of necessary actions.

**Patient’s contact details and contact details of parents**
Several respondents suggested that a contact number (telephone or mobile number) would be necessary to contact the patient and initiate health protection interventions. Contact details of parents would also be required if the patient were a child.

**Recent international travel history**
Some respondents suggested inclusion of recent travel details. It would not be possible to include all travel details on the notification form, but it would be reasonable to expect the RMP to report any relevant overseas travel history (e.g. within the incubation period for the specific infection or where the disease is likely to have been acquired overseas).

**Further items of information**
Some respondents suggested that country of birth, date of arrival in the UK, risk factors for specific diseases, relevant immunisation and other medical history should be added to the notification data provided by the RMP. Although the above information may be relevant in some cases, it could be burdensome for RMP to include all details on the notification form. If necessary, these data can be collected as part of further investigation of the case.

**Ethnicity**
Some respondents commented that ethnicity data may not be relevant to health protection actions or may not be available to RMPs. However, ethnicity data are important for assessing health inequalities and we propose that they should be provided whenever known by the RMP.

**Incomplete notification forms**
A few respondents requested clarification on the validity of notification forms if not all of the above data items are available to the RMP. As stated in the regulations, the RMP is required to provide the information ‘in so far as it is known’ to the RMP. Notifications are valid even if it is not possible to provide all the data items required.

- **We propose to include patient’s contact details, contact details of a parent, and international travel history (if relevant) in the list of information provided by the RMP as part of notification. Ethnicity will remain on the notification form.**
Responses to this question were as follows:

Yes, it is appropriate - 27
No, it is not appropriate - 23
No reply to this question - 18

One professional body commented that the term 'causative agent' needed some clarification because identification of the microbial agent itself may not be carried out for all notifiable microorganisms. Regulations will be amended to clarify that laboratories must notify identification of a 'causative agent' found in a human sample or 'evidence of an infection caused by such an agent', e.g. presence of antibodies to the particular causative agent.

Most respondents made suggestions for deletions and additions to the list, as well as requesting clarification of some details. Table 3 below includes a summary of such suggestions.

Table 3: Suggested changes to Schedule 2

<table>
<thead>
<tr>
<th>Organisms suggested to be added to Schedule 2</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Burkholderia mallei</em> and <em>B. pseudomallei</em></td>
<td>As these organisms can potentially be used as biological warfare agents, they will be added to the list.</td>
</tr>
<tr>
<td><em>Plasmodium knowlesi</em></td>
<td>This is a new strain of plasmodium recently identified in southeast Asia that can cause malaria. It will be added to the list.</td>
</tr>
<tr>
<td><em>Clostridium novyi</em></td>
<td>This will not be added as cases are more likely to be diagnosed clinically and can be reported under the 'safety net' provision.</td>
</tr>
<tr>
<td>HIV, HLTV, <em>Chlamydia trachomatis</em>, <em>Treponema pallidum</em> and other agents causing STI</td>
<td>GUM and HIV clinics deal with at-risk contacts and provide health protection advice.</td>
</tr>
<tr>
<td>Atypical mycobacteria and fungal infections</td>
<td>These can cause serious infections in immunosuppressed individuals, but no routine health protection intervention is required following individual cases.</td>
</tr>
<tr>
<td>Panton Valentine Leukocidin-producing <em>Staphylococcus aureus</em> and <em>Clostridium difficile</em></td>
<td>There is already an effective mandatory surveillance system in place that records all cases of <em>C. difficile</em>, and hospital infection control teams deal with control measures. Currently there is insufficient surveillance data and evidence to suggest that notification of infections with PVL producing <em>S. aureus</em> would be necessary for health protection reasons. We do not propose adding these to Schedule 2.</td>
</tr>
</tbody>
</table>
Health protection regulations

<table>
<thead>
<tr>
<th>Organism(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norovirus and rotavirus</td>
<td>Unless there are outbreaks, no health protection action would be required. Outbreaks are routinely reported to the HPA.</td>
</tr>
<tr>
<td>CJD, vCJD</td>
<td>A dedicated surveillance system for this group of diseases exists, which would trigger necessary health protection actions.</td>
</tr>
<tr>
<td>Other viruses (e.g. Human parvovirus B19, Respiratory Syncitial Virus (RSV), those causing meningitis and encephalitis)</td>
<td>In the majority of cases, no public health action is required. Otherwise cases can be notified under the ‘safety net’ provision.</td>
</tr>
</tbody>
</table>

Organisms suggested to be removed from Schedule 2

<table>
<thead>
<tr>
<th>Organism(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dengue Fever</td>
<td>All viruses known to cause viral haemorrhagic fevers are included in Schedule 2 so this item will remain.</td>
</tr>
<tr>
<td>Clostridium perfringens</td>
<td>Cases associated with food poisoning should be notified.</td>
</tr>
<tr>
<td>Varicella zoster virus</td>
<td>Few cases of chickenpox are confirmed by laboratories, and a virological confirmation is likely to be in serious cases where public health action may be required (e.g. an inpatient in contact with other patients).</td>
</tr>
</tbody>
</table>

Organisms suggested to be modified or defined on Schedule 2

<table>
<thead>
<tr>
<th>Organism(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral hepatitis</td>
<td>All cases (acute or chronic) of hepatitis A, B, C, D and E should be notified. We do not propose any changes to this item.</td>
</tr>
<tr>
<td>Corynebacterium Diphtheria</td>
<td>All strains (toxigenic and non-toxigenic) are notifiable. This will be clarified in the guidance.</td>
</tr>
<tr>
<td>Bacillus cereus and Clostridium perfringens</td>
<td>These are notifiable only if they cause a food-poisoning.</td>
</tr>
</tbody>
</table>

E: Is the information to be reported by laboratories, as far as it is known to them, appropriate? If you answered that it is not appropriate, what changes would you make and why?

Responses to this question were as follows:

Yes, it is appropriate - 33
No, it is not appropriate - 15
No reply to this question - 20

Other additional data

Some respondents suggested that laboratories should send HPA additional information including patient’s occupation, vaccination history, relevant medical history, appropriate disease risk factors and advice given by the laboratory to the clinician. However, it is very unlikely that laboratories would have this information and it would make notification unduly burdensome to obtain it.
We do not propose requesting further information to be sent by laboratories as part of notification.

Ethnicity
Many commented that ethnicity data are not usually available to laboratories and asked for reassurance that provision of incomplete information would not automatically be regarded as an offence. The regulations require the specified information to be provided by laboratories only insofar as it is known to them. However, as these data are important for monitoring health inequalities, they should be reported if known to laboratories.

We do not propose any changes to this item.

Further comments

Notification by nurses and other healthcare professionals
Some individuals and organisations suggested that other healthcare professionals, in particular nurses, should be under a similar obligation as RMPs to notify. The majority of patients with a suspected notifiable disease are seen by a RMP initially or would be referred to them. Including a duty on other healthcare workers to notify may cause confusion as to whose responsibility it is to notify. Guidance will provide advice on situations in which a nurse or other healthcare professional suspects that a patient has a notifiable disease and is not able to bring this promptly to the attention of a RMP colleague. In such circumstances, they can contact the proper officer of the local authority or the HPA for advice.

We propose that only RMPs are to be required by statute to notify under the new regulations.

Timescale
Some respondents requested clarification of notification timescale, e.g. if notifications should be sent or received within three days. Notifications under Schedule 1 should be made so that they are received within three days, unless they are urgent. Guidance will clarify the timescale for notification as well as which diseases should be notified urgently.

Following consideration of consultation responses, we revised the time limit for non-urgent notification by laboratories (under Schedule 2) to seven days, from the original proposed three days, to make it practicable for laboratories.

We propose RMPs should send notification of non-urgent cases under Schedule 1 so that they are received by the proper officer within three days. We propose that laboratories may send notification of non-urgent cases, under Schedule 2, so that they are received by the HPA within seven days.
Fees and offences

Nobody disagreed with removal of the fee and offence connected with notification of diseases by RMPs, although one respondent commented that it might lead to under-notification.

Some individual respondents and a professional body disagreed with laboratories being liable for offences if they failed to comply with the notification requirements without reasonable excuse, and believed such an offence was not necessary, or that other mechanisms could be used, e.g. making notification a condition for laboratory accreditation. However, none of the respondents suggested any other uniform mechanism for enforcing compliance with the notification requirement.

We will clarify in the guidance that the offence applies to corporate bodies that operate laboratories and not to individuals working in the laboratories, unless the laboratory is not operated by a corporate body.

- We propose no changes to the offence for failure by a laboratory to comply with the notification requirements.

Sending new regulations to RMPs

A number of local authorities commented that it was not reasonable to ask them to send the new regulations to RMPs in their area, as they do not have access to a list of RMPs in their area.

- We propose removing the requirements for local authorities and the HPA to send new regulations to the RMPs and laboratories respectively. However, guidance will recommend that local authorities take steps with PCTs to disseminate information to RMPs in their area. The Department of Health will also consider how it can disseminate information to doctors through its bulletins. The HPA will provide information to laboratories as part of guidance.

Electronic notification systems

Several respondents pointed out the need for effective electronic systems to reduce impact on workload for both RMPs and laboratories. The HPA is currently considering this issue and will provide guidance.
Health protection regulations

The Health Protection (Part 2A Orders) Regulations 2010

Respondents

Fifty-two respondents replied to consultation questions on these regulations, or made comments relating to them. They included responses on behalf of NHS organisations, local authorities and professional and third sector bodies. Sixteen responses concerned the relevance of the legislation to people with HIV or STIs. These are discussed on page 27.

The organisations responding included the British Medical Association, the Chartered Institute of Environmental Health, the Health Protection Agency, the Justices' Clerks' Society, Liberty, Local Authorities Coordinators of Regulatory Services, the National Information Governance Board, the Royal College of Nursing, and the UK Faculty of Public Health.

The responses to the consultation questions, and the action we propose to take in each case, are set out below.

Specific questions

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

Responses to this question were as follows:

Yes, they will be helpful - 32
No, they will not be helpful - 7
No reply to this question - 29

Most of those saying the evidential requirements would not be helpful wanted more exacting requirements, in particular, that the regulations should be drafted to exclude cases where the mechanism of transmission was by sexual contact. This is not legally possible. However, we offer a full response to these representations on page 27 below.

One or two respondents were concerned that the requirements for evidence did not make clear that it was for the JP - not the local authority - to decide if a person giving evidence was suitably qualified or not. We have revised the draft regulations to specify only that the evidence-giver must be suitably qualified. While the local authority will need to consider this aspect as part of their preparation of evidence, it will of course be for the JP to decide if, in fact, this requirement is met.
One respondent suggested that details of a person’s symptoms did not allow for the signs, as well as symptoms, of illness and so on to be taken into account. We agree, and propose to revise the evidence requirements to cover both symptoms and signs.

Two respondents were concerned that the wording of the draft regulation about the evidence requirements lacked clarity as to what exactly was required. We propose to revise the wording to address this.

- We propose amendments to the regulations to remove the reference to the local authority’s view of an evidence-giver’s suitability; to include signs as well as symptoms; and to improve the clarity of the wording.

Another respondent was concerned that the draft regulations lacked structure and left too much to the JP’s discretion, with potential human rights implications. We do not agree. The role of the JP in providing judicial oversight of action to protect public health is crucial to protecting human rights. The JP, who will always have access to legal advice, is a public authority under the Human Rights Act and must act in accordance with it. We think the regulations strike the right balance between setting a clear standard for evidence and imposing excessively prescriptive requirements that would constrain the JP’s decision-making. We propose that guidance will emphasise the point that a JP is always free to require more, or different, evidence than that provided under the regulations.

This point is particularly relevant to the issue of who should provide evidence. One respondent pointed out that the Joint Committee on Human Rights has said that all JP orders should be based on objective medical evidence. We have reviewed this issue carefully. It is true that in cases of disease, a person who is medically qualified will be best placed to give evidence about the impact and risk of the disease in question. However, in a case where contamination rather than disease is the issue, a different kind of expert may be needed.

It is our view that, where a person’s liberty or freedoms might be restricted, the need to do so must be reliably shown by the best evidence available and protected by judicial oversight. The qualification of the evidence-giver is obviously crucial to the JP’s decision. The JP will weigh up the suitability of the person, and the evidence overall, in the light of the facts of the individual case. We think this is preferable to setting out rules in legislation that allow no room for the JP’s discretion.

- We do not propose changing this regulation to limit the JP’s discretion.

Some other matters raised, such as the importance of identifying the availability of a hospital place when seeking an order for detention in hospital, will be addressed in guidance.
G: Are the proposed requirements for evidence sufficiently flexible to allow action to protect public health in all circumstances?

Responses to this question were as follows:

Yes, they are flexible enough - 30  
No, they are not flexible enough - 4  
No reply to this question - 34

This question was intended to bring out any concerns about the practicality of the evidence requirements in circumstances where there were gaps in the information available, or in an emergency. No respondent mentioned this. The four who disagreed had disparate reasons for doing so, which we address elsewhere, or will address in guidance.

- **We do not propose any changes to this regulation.**

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

Responses to this question were as follows:

Yes, the list is appropriate - 20  
No, the list is not comprehensive enough - 16  
No reply to this question - 32

Of those disagreeing, six respondents wanted dependent children to be affected persons. We have sympathy with this view, because it is indeed possible that a child could be personally affected by an order imposed on a parent or person on whom they were dependent. However, designation as an ‘affected person’ confers on that person the right to apply for variation or revocation of the order. We do not think this is practicable in the case of a child (certainly if the child is in one of the younger age groups) and could impose additional burdens on the courts. We propose to rely on local authorities’ good practice in taking the needs of dependent children into account when applying for an order.

Other respondents who disagreed wanted people who might represent a person who was the subject of an order to be an ‘affected person’. With the exception of a person who is a ‘decision-maker’ (see below), we feel that this is inconsistent with the meaning of the phrase in the legislation - an ‘affected person’ must, by definition, be personally affected. We do not think it is right to stretch the meaning of ‘affected person’, and therefore do not propose a change here. However, a person who is a decision-maker for a person under the Mental Capacity Act 2005 (with lasting or enduring power of attorney, or appointed by the Court of Protection, with authority to act in respect of an order) should be able to act in relevant respects as if they were
Health protection regulations

that person. The regulations as drafted did not preclude a decision-maker from applying for variation or revocation of an order, but we propose to make the regulations explicit on this point in the case of an order relating to a person.

- We will therefore specify in the regulations that a decision-maker with relevant authority under the Mental Capacity Act 2005 is an ‘affected person’, in relation to orders about a person.

As set out in the consultation document, we propose also to specify that the next of kin is an affected person where an order is made about a body or human remains.

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?

Responses to this question were as follows:

Yes, the list of next of kin is adequate - 29
No, the list of next of kin is not adequate - 7
No reply to this question - 32

This question relates only to the particular circumstances where a JP makes an order in respect of a dead body, or human remains. Three respondents suggested that a person who had had power of attorney over a person’s affairs while they were alive should be included; two others said that anyone the person had themselves nominated when alive should be covered. We sympathise with these points but have reservations about how they would work in practice. A power of attorney ends on the death of the person in respect of whom it was made, and it is also the case that someone who had that role might be, for example, a financial adviser and not as close to the person as a family member in the ‘next of kin’ list. As for someone nominated by the person while alive, any nominee would have been appointed for another purpose - there is no process for nominating a generic ‘next of kin’, and it is inconceivable that someone would nominate a next of kin in the context of a JP order about their body after death.

- We do not propose any changes to this regulation.
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?

Responses to this question were as follows:

Yes, the proposed requirements are adequate - 30
No, the proposed requirements are not adequate - 7
No reply to this question - 31

Most of the respondents who thought the proposed requirements were inadequate were concerned that persons with parental responsibility should not automatically be notified of an application for an order relating to a child, as this would not always be in the child’s best interests. We agree that this could be the case in certain very rare circumstances. Therefore, although we think that in practice the need for this provision is unlikely, we propose to amend this regulation so that a local authority is not required to notify a person with parental responsibility if there are exceptional circumstances that would make notification not in the child’s best interests.

One respondent suggested that consideration be given to the use of independent advocates, although it is not clear what role they envisaged for them in this context. We do not think it would be feasible or proportionate to introduce independent advocacy to these regulations.

A linked issue raised by some respondents in the context of notification concerned the question of a time limit for making the notification. We cannot specify a time limit in the regulations, as the enabling legislation does not provide the necessary powers to do so. We propose that guidance will cover this issue.

- We will amend this regulation so that a local authority is not required to notify a person with parental responsibility if there are exceptional circumstances that would make notification not in the child’s best interests.

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?

Responses to this question were as follows:

It is desirable - 37
it is not desirable - 1
No reply to this question - 30
There was a clear consensus that a provision of this kind was desirable to protect vulnerable people. Some respondents argued that local authorities should not be allowed to charge for any services they provide arising from this duty. We do not agree, because it would be inequitable to require services to be free which would be chargeable for people who were not the subject of a JP order.

One or two respondents thought that the duty should apply to all orders, not just, as the draft regulations proposed, those involving detention, isolation or quarantine. However the rationale for a specific duty here is that it arises in circumstances where a person cannot take care of themselves, or of others who are dependent on them, as a consequence of a JP order. We do not think there is a comparable need for a specific duty in relation to any other order.

We do not therefore propose to change the application of this regulation. However, we have found it unnecessary to include a specific power to charge for services, because local authorities may do so in any event under section 93 of the Local Government Act 2003. It is not necessary for this power to be replicated in these regulations.

- With the exception of the removal of a redundant power to charge, we do not propose any changes to this regulation.

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

Responses to this question were as follows:

The proposed contents do require all the relevant information - 30
The proposed contents do not require all the relevant information - 7
No reply to this question - 31

The majority of those who said the proposed contents did not provide all the relevant information wanted the report to include the evidence presented to the JP. We have considered this carefully but have decided that there would be no appreciable benefit in requiring this. The application and order itself will supply all the necessary information to enable the reader to understand why the order was made, and in due course to allow monitoring of the use of orders, which is the purpose of the regulation. There is a further complication in that evidence does not have to be provided in writing, so a requirement of this kind would be difficult to deliver in practice.

Other comments centred on matters which we are confident will be evident from the application and/or the order itself.

- We do not propose any changes to this regulation.
Other matters raised by consultees relevant to these regulations

Duration of JP orders

The 1984 Act, as amended, restricts the duration of a JP order which imposes detention, isolation or quarantine on a person to a maximum of 28 days (subject to extension). Although the Act allows regulations to limit the period of other orders in the same way, we had not proposed to make such regulations. However, two respondents argued that all orders should be limited in duration by regulations, and not left to a JP’s discretion.

We accept that there could be implications for the human rights of a person who might be the subject of an order imposing other restrictions or requirements under the Act, and therefore that there is a case for setting a limit to such an order by regulation. We propose to make a regulation imposing a maximum time limit of 28 days on all orders affecting a person that are not already limited under the Act, subject to the usual process for extension.

We do not think that there is a need to apply this restriction to an order about a thing or premises; here the argument for legislation to limit duration is less compelling. We propose to leave decisions about duration in these cases to the JP’s discretion.

- We therefore propose to make a regulation imposing a maximum time limit of 28 days on all orders affecting a person, subject to the usual process for extension.

The relevance of the legislation to people with HIV or sexually transmitted infections

A total of 16 respondents commented on this aspect, including the All Party Parliamentary Group on AIDS; the British Association for Sexual Health and HIV; the Children’s HIV Association; the Expert Advisory Group on AIDS; the Independent Advisory Group on Sexual Health and HIV; Liberty; the National AIDS Trust; the Terrence Higgins Trust. A number of other respondents were practitioners working in this field. In addition, the National AIDS Trust cited support from 30 separate organisations, some of whom also responded independently and so are included in the total of 16.

In general, these respondents argued that the regulations should be drafted to exclude people with HIV or other sexually transmitted infections from the scope of the JP order-making powers. Or at the least it was suggested that further requirements be added relating to the evidence to be available to the JP where such infections were at issue.

These respondents’ main concern was that the ‘all-hazards’ approach to health protection could mean that JP powers could be used inappropriately to impose restrictions or requirements on people with HIV or another sexually transmitted infection. They maintained that this would deter people from seeking advice, testing and treatment for sexually transmitted
Health protection regulations

infections; would undermine the responsibility of individuals for their own sexual health; and would risk increasing stigma.

We have considered these arguments carefully. The first point to make is that the current legislation allows JP orders to be used for people with AIDS. However, there are no examples of these powers being used inappropriately - indeed we have only been able to find one example of where they were used at all (in 1985).

Secondly, we cannot exclude any particular kind of infection, or mode of transmission, from the scope of JP orders - the amended Public Health (Control of Disease) Act 1984 does not permit that. However, aside from the legal position, we do not think that it would be consistent with protecting public health to limit a JP’s discretion in the way suggested. We have a number of reasons for this view.

- There could be rare cases where an order, or the option of an application for an order, might be necessary to protect public health. Examples which might arise are:
  - an order might be the best way to get a person with HIV, who is highly infectious as a result of not accepting antiretroviral drug treatment and who is having unprotected sex with several partners, to attend a genito-urinary medicine clinic for information and advice, which could lead to their accepting treatment and/or practising safer sex. (An order can never impose treatment in any circumstances.)
  - a new sexually transmitted infection might emerge in the future - or an existing one mutate - with greater infectivity or virulence, meaning that if an infected person did not act on medical advice a JP order might be needed to protect others. (We do have power to make regulations at any time to deal with a ‘serious and imminent risk’, but this is a generalised contingency provision and inappropriate for this purpose.)

- Most ‘sexually transmitted diseases’ are not in fact exclusively transmitted sexually. It would hamper a JP’s ability to protect public health if a disease were placed outside the scope of an order merely because it was capable of being transmitted sexually, regardless of the actual mode of transmission in the particular case.

- Some respondents suggested that the criminal law is the right way to deal with any instances of recklessly or intentionally infecting others. However, we believe that the option of a JP order provides a better public health response as it can be introduced far more quickly.

This is not to make light of the real concerns expressed to us about the potential impact of the new legislation. We want to address these concerns. It should firstly be understood that a JP order is subject to strict criteria which mean that one cannot be made unless there is no alternative way to achieve the desired health protection outcome. And we are already proposing a high standard of evidential requirements, set out in the regulations, to apply to all
infections or contamination. The effect is that the powers can only be used as a last resort in exceptional circumstances, and that they could not be used as a form of ‘social control’ as some respondents feared. We will make this even clearer through:

- **guidance** - we have invited some organisations who responded on this aspect of the regulations to participate in the production of operational guidance for local authorities covering, for example, the steps that should be taken before considering an application for an order; the circumstances when an application for an order would not be appropriate; and the relevance of the evidential requirements to people with HIV or sexually transmitted infections.

- **monitoring of applications for Part 2A orders** - relevant information from the reports to the HPA of applications by local authorities for orders (to be required under the regulations) will be published annually. (The amount of detail to be published would be limited to ensure an individual’s anonymity and confidentiality is not compromised.) This will ensure transparency and allow the use of the orders to be monitored.

### Local authority powers to charge for action taken by them as a result of a Part 2A order

This matter was not covered in the consultation, but was raised by a major organisation in this field as being of some importance to effective public health protection. We accept this contention. The 1984 Act, as amended, does not make provision for a JP to apportion the costs of measures, or for local authorities to make charges in these circumstances. We do not therefore have powers to provide for this under health protection legislation. However, regulations can be made under local government legislation to allow local authorities to make charges in specific circumstances, and we therefore proposed to use this legislation for this purpose.

We conducted an additional, smaller scale consultation of key organisations with an interest, as follows:

- Chartered Institute of Environmental Health;
- Local Authorities Coordinators of Regulatory Services;
- Local Government Association;
- Association of British Insurers;
- Confederation of British Industry;
- Federation of Small Businesses;
- Liberty;
- The UK Faculty of Public Health;
- James T H Button & Co, Solicitors.
Health protection regulations

We proposed that local authorities should be able to make a reasonable charge for reimbursement of costs they might incur if it fell to them to carry out any measures required under a JP order relating to things or premises (for example, if an owner or tenant was unwilling or unable to do so). We suggested that this would be a fair provision which would allow local authorities to recoup costs of taking measures, and that the need to use this provision would arise only very rarely, so that the overall impact on business interests or individuals would be unquantifiably small.

We asked the consultees above if they agreed that local authorities should be able to make such a charge; whether there were any circumstances in which such a charge should not be made; and we invited any further comments on the issue.

We received five responses, from the Chartered Institute of Environmental Health; the Federation of Small Businesses; James T H Button & Co, Solicitors; the Local Authorities Coordinators of Regulatory Services (whose response was also made on behalf of the Local Government Association); and the UK Faculty of Public Health.

Four of the five respondents agreed that local authorities should be able to levy a charge. One pointed out that this power would remove a possible disincentive for local authorities to take the necessary action. The Federation of Small Businesses was concerned that the proposals should not impose an undue burden on a small business affected, though they recognised that the need for use of this power would arise only rarely.

Three of the five respondents thought that there were circumstances where a charge should not be made. They argued that this should depend on the individual’s or business’s ability to pay, and the culpability or otherwise of the person or business in question. The Federation of Small Businesses was naturally concerned that a business should not be harmed by being subject to a charge, especially if the business had not been at fault.

We recognise these concerns and agree that the particular circumstances applying should be taken into account. However, it would be very difficult to specify in regulations all the circumstances in which charges should or should not be made. We also consider that while it is a matter of natural justice that the person at fault should pay, it is not always possible to say where (if anywhere) the fault lies; and in any event it would pose difficulties in practice to allow a local authority to levy a charge on this basis. We do not think that there is any viable alternative to allowing a charge to be made against the person who is the subject of the order. We propose to make the power to charge discretionary, so local authorities can take into account the particular circumstances of the case. We are assured that local authorities have local policies to deal with questions such as when it is not appropriate to levy a charge. We will consider whether our guidance on the regulations might reinforce good practice in this area, with particular regard to the issues raised in this consultation.
One respondent was concerned that costs should include the ‘establishment’ costs - such as for staff time involved in arranging or overseeing the necessary works. We agree that these costs should be included, subject to their being reasonable in the circumstances. We also propose that the charge should not exceed the actual costs (i.e. including the staff costs if appropriate) incurred.

- **We propose to make a regulation (under powers in local government legislation) allowing local authorities to levy a discretionary charge where they take the action required as a result of a JP order about things or premises. The regulation is to require the charge to be reasonable in the circumstances, and it is not to exceed the actual costs incurred.**
Health Protection (Local Authority Powers) Regulations

Respondents

Forty-eight respondents replied to consultation questions on these regulations, or made comments relating to them. They included responses on behalf of NHS organisations, local authorities and professional and third sector bodies. As in relation to Part 2A orders, a number of responses were from bodies or organisations concerned with sexual health or HIV.

The organisations responding included the British Medical Association, the Chartered Institute of Environmental Health, Coroners’ Society of England and Wales, the Health Protection Agency, the Justices' Clerks' Society, Liberty, Local Authorities Coordinators of Regulatory Services, the National Information Governance Board, the Royal College of Nursing, the Royal College of Paediatrics and Child Health, and the UK Faculty of Public Health.

The responses to the consultation questions, and the action we propose to take in each case, are set out below.

Specific questions

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? If not, how long should the time frame be and why?

Responses to this question were as follows:

Yes, it is a suitable timeframe - 25
No, it is not a suitable timeframe - 6
No reply to this question - 37

Of the respondents who felt that five days was not a suitable timeframe for review, some suggested a slightly longer, and some a slightly shorter timeframe. The majority of respondents answering this question felt that five days was a suitable timeframe for a review, while those that did not were divided as to whether a longer or shorter timeframe was more appropriate. There was some confusion about whether ‘days’ were working or calendar days. The draft regulations specify that the review must take place within five working days of a first request for a review being made by a parent.

- We do not propose any change to this regulation.
N: Will the requirement for a local authority to review a notice to keep a child off school work fairly in practice? If not, what changes should be made to the requirement?

Responses to this question were as follows:

Yes, it will work fairly in practice - 25
No, it will not work fairly in practice - 5
No reply to this question - 38

Out of the 30 respondents who answered this question, the majority (25) agreed that this requirement would work fairly in practice. Those who did not agree felt that the review would not be undertaken with the appropriate degree of independence. We do not propose to set out a detailed and independent mechanism for these reviews in regulations, which we think would be disproportionate given the numbers likely to be affected. We have considered specifying in the regulations that the review must be conducted by an employee of the local authority who was not involved in the decision to issue the original notice. However, after consultation with a major stakeholder in the field, we believe this would be impracticable. In effect the notice is served by the council as a body, while the small size of some environmental health teams and the way in which they work could make it difficult to identify a person who was genuinely independent of the original decision. In practice, liaison with the other health protection professionals in the HPA and PCT creates an element of independence in both the original decision to serve the notice and in the review.

- We do not propose to add further requirements in regulations to attempt to guarantee the independence of the review.

Other issues raised in relation to the local authority power to keep a child off school

A number of respondents said that local authorities should be able to use this power to keep a child away from other settings, for example, a private nursery. However, the primary legislation only confers the power to make a regulation to enable a local authority to require that a child be kept away from school. We have aimed to keep within the natural meaning of the word, which we take from the Education Act 1996 in which ‘school’ is defined as an educational institution providing primary or secondary education or a maintained nursery school. We cannot therefore extend the scope of local authority powers beyond this definition.

If there is a need for a child to be kept away from any other institution not captured by this definition of school, an application to a JP for an order could be made. This recognises that a degree of independent judicial oversight is appropriate in relation to a requirement to keep a child away from a particular setting other than a school, which might significantly affect the child and the child’s parents’ private life.
Under the draft power to request contact details from the head teacher of a school for the purposes of contact tracing, only the contact details of the children at the school can be obtained. We will ensure that this power to obtain contact details is exercisable when children at a school may have been exposed to a serious infection or contamination from any visitor to the school, as well as from any member of staff or other child.

Several respondents suggested that this power should be widened to allow local authorities to request the contact details of adults as well as children, for example staff and visitors. We do not plan to revise this regulation to allow adults’ contact details to be required. If this were necessary, a JP order could be sought.

Conversely, some respondents argued that far from being too narrow, this power was in fact too broad in its scope. We do not agree, because there are stringent conditions to the use of the power:

- the infection or contamination in question presents, or could present, significant harm to human health;
- keeping the child away from school must be a proportionate response to the risk to others that the child represents.

Some respondents expressed concern about the potential use of this power in respect of children with HIV or AIDS. We think this concern is addressed by guidance the HPA has already produced, which recommends that it is not necessary to keep a child with these conditions away from school. That guidance also covers the circumstances when a child with an infectious disease should stay away from school. We propose that further guidance will be produced to show when it is not appropriate to use these powers to keep a child away from school.

Whenever a local authority issues a notice under these regulations, they will have to ensure that they provide on the notice the details of a relevant contact person, employed by the local authority that issued the notice and able to discuss the notice in question.

- We propose to require that the local authority provide in the notice contact details of a local authority employee able to discuss the case. We do not propose any other change to this regulation.
O: Is there a need for a local authority power for disinfection/decontamination to be retained in an updated form in these regulations? What are your reasons for thinking so?

Responses to this question were as follows:

Yes, such a power is needed - 28
No, such a power is not needed - 1
No reply to this question - 39

The majority of respondents who answered this question argued that this power should be retained and updated, with just one saying that this was not necessary.

Two respondents commented that, where these draft regulations refer to ‘articles’, they should instead refer to ‘things’, in order to achieve consistency with the parent legislation. While we had deliberately used different terminology for simplicity (the definition of ‘thing’ includes human tissue, dead bodies or human remains, animals and plant material) we have amended the language as suggested. Because the power conferred on a local authority to disinfect or decontaminate on request is discretionary, if the local authority received what they thought to be an unsuitable request they could simply decide not to meet it.

- We propose replacing the word ‘article’ with ‘thing’.

Nine respondents argued that local authorities should have the power to require disinfection/decontamination, as well as to carry out disinfection/decontamination at the request of an owner or tenant. Under the framework of the new legislation, if an owner or tenant will not cooperate and disinfection or decontamination is needed to protect public health, the local authority could apply for a JP order. We believe that these arrangements achieve a balance between allowing local authorities to act to protect public health and protecting the rights of property owners through judicial oversight where a local authority wants to act against the owner’s wishes.

As currently drafted, a local authority can only disinfect/decontaminate premises at the request of the tenant if they are reasonably satisfied that the premises will not be devalued because of disinfection/decontamination. One respondent thought that this was not appropriate. However, because this discretionary power can be used by a local authority on the tenant’s request, we are inclined to retain this requirement to offer the owner of the property some protection.

- We do not propose to change this regulation to allow local authorities to require disinfection/decontamination; or to remove the condition that the local authority must be reasonably satisfied that the premises will not be devalued before undertaking disinfection/decontamination.
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? What are your reasons for thinking so?

Responses to this question were as follows:

Yes, such a power could be helpful - 34  
No, such a power is not needed - 3  
No reply to this question - 31

We asked whether a power to request people to do things, with an associated discretionary incentive, compensation or expenses payment, could be useful. The majority of respondents (34) felt that such a power could be helpful. The three respondents who felt this power would not be useful made a number of points:

- paying people money to not put other people at risk was an unsound principle;
- in practice, local authorities are unlikely to pay a compensation payment unless it is mandatory;
- local authorities frequently provide advice and make requests in relation to many areas of public health protection; therefore, this power creates confusion because it does not maintain the clear differentiation between informal advice and legal requirements.

We agree that incentivising people not to put others at risk is not a constructive precedent. We propose removing from the regulations the power to offer incentive payments to comply with requests.

We propose keeping the general request power, along with the power (not a duty) to offer compensation or expenses in line with making a request. We agree that local authorities do not need a power to provide advice, but they do need a power to be able to pay out public money. It seems fair to have the power to compensate someone for complying with a request where financial issues might be a barrier to compliance. Acting promptly to secure voluntary compliance using this power could prevent the local authority incurring a greater financial burden in the long run if a health protection problem were to develop further. However, we do not wish to impose a non-discretionary financial burden on local authorities by making compensation under this power mandatory.

Although it is worth noting that a local authority need not make a request before applying for a JP order, the JP might legitimately ask what steps had been taken to secure voluntary compliance with health protection measures before making an order. Of course, this power does not change the fact that, in the majority of cases, health protection issues can and should be tackled by advising and supporting the person concerned.
A number of respondents who felt that this power could be useful argued that it did not go far enough - they wanted to see a local authority power to require people to take actions with sanctions for non-compliance. This would be inconsistent with the principle that a degree of judicial oversight is required to protect those who might be subject to measures.

- We propose keeping the general request power, but removing from the regulations the power to offer incentive payments to comply with requests.

Local authority powers to restrict contact with or access to dead bodies

No questions for consultation were asked in relation to these powers. However, one respondent commented that a coroner’s jurisdiction concerning dead bodies should not in any way be infringed by these powers. We agree, and are satisfied that this is not the case. We have written to the Coroners’ Society of England and Wales on this issue.

Guidance will also be issued to remind those involved in the use of these powers that they do not, and cannot, impinge on the role of a coroner.

The draft regulations required the local authority to put up a notice near the dead body stating the terms of the prohibition. One respondent argued that the local authority should instead serve the notice on any person having charge or control of the premises where the dead body is located. That person should be required to put up a copy of the specified notice and it should be an offence for any person to remove or deface the notice.

- We propose to amend the draft regulations to require the local authority to serve the notice on the relevant person.

Guidance will also be issued to help ensure that these powers are employed sensitively.

Q: Do you agree that there is no need for an updated power to allow a local authority to arrange for immunisation? If you disagree, please explain why you feel there is a need for this power to be retained and updated?

Responses to this question were as follows:

I agree there is no need for such a power - 22
I disagree: there is a need for such a power - 5
No reply to this question - 41

The majority of respondents who answered this question (22 out of 27) agreed that there was no need to retain this power in an updated form. Some respondents argued that this power should be retained just in case, but we do not envisage a situation where a local authority
Health protection regulations

would need to use this power because immunisation is an NHS sphere of responsibility, as many other respondents pointed out.

- **We do not propose to carry forward a power to allow a local authority to arrange for immunisation.**

**Keeping a food handler off work**

The Public Health (Infectious Disease) Regulations 1988 allow a local authority to require a person to ‘discontinue any occupation associated with food’ in order to limit the spread of an infectious disease.

In the consultation document, we suggested that this power should be replaced by JP order-making powers and the power for local authorities to request people to take action (or to refrain from action) to protect public health. We also cited the Food Hygiene Regulations 2006 as providing safeguards.

Some respondents argued that this 1988 power should not be lost, and that the 2006 Regulations were inadequate for the purpose of preventing an infected food handler from working because the prohibition is only enforceable by the Food Business Operator (FBO). This means that if the food handler did not tell the FBO about their condition, the FBO would not be in a position to take action. Some respondents suggested allowing local authorities to issue an immediate ‘stop’ notice barring the food handler from working pending a JP order. However, the terms of the Act do not allow this. As elsewhere in the updated legislation it would be inconsistent with the principle that a degree of judicial oversight is required to protect those who might be subject to health protection measures. This approach provides a balance between individual rights and the interests of public health.

We therefore propose to proceed as set out in our consultation document, that is, to confer a power on local authorities to formally ‘request’ action to be taken to protect public health (as above), backed by application to a JP if necessary. We believe that the threat of formal action is typically enough to ensure the required action takes place. If a local authority knows that there is an infected food handler working in an establishment, they could make an immediate request of the food handler to stop work and inform the FBO of their condition. In such a case, the request might include a reminder to the food handler of their obligations to inform the FBO under the Food Hygiene Regulations 2006. A food handler who then continues to work in a food-handling environment would be in breach of those regulations. If the request does not secure the desired result the local authority could apply for a JP order if warranted, which should be obtainable in short order.

Some respondents were concerned that there should not be a delay while tests were carried out to confirm the food handler’s condition. The criteria for the exercise of the new powers allow action where an infection or contamination may present significant harm to human health, so confirmation is not always necessary. Of course, there must still be appropriate
Health protection regulations

evidence to support the action. Guidance will provide local authorities with more detail on how to deal with these situations.

- **We do not propose to carry forward a power to allow a local authority to keep a food handler off work.**

**An individual's general responsibility not to expose others to risk**

A small number of respondents commented that they would like to see an offence in regulations to regulate people’s behaviour more generally. A previous consultation\(^2\) already determined that it was not appropriate to have a very general broad offence to try to prevent individuals exposing others to a public health risk. We do not propose to re-open this issue.

The regulations make provision for appropriate offences to apply when a person who is subject to a restriction or requirement in or under the Act fails to comply with that restriction or requirement.

- **We do not propose introducing an offence to regulate people’s behaviour more generally.**
Health protection regulations

The costs and benefits of the proposed regulations

We asked whether respondents agreed with our analysis of costs and benefits of the proposed regulations.

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

Responses to this question were as follows:

Yes, the assumptions in the Impact Assessment appear reasonable - 18
No, the assumptions in the Impact Assessment do not appear reasonable - 8
No reply to this question - 42

The majority of respondents agreed that the assumptions in our Impact Assessment were reasonable. Of those who disagreed, four respondents argued that the impact of the legislation on people with HIV or another sexually transmitted disease had not been adequately addressed in our Equality Impact Assessment (EqIA). They argued that the impact was likely to fall disproportionately on people from black and minority ethnic (BME) groups, men who have sex with men and people with HIV. We have reviewed the EqIA and a revised version addressing this issue will be made available on the Department of Health website.

One respondent suggested that there would be cost benefits in compelling people to accept treatment for serious infectious diseases. We have not attempted to assess the cost benefits as this is not an option we would wish to consider, and indeed the primary legislation expressly prohibits any such provision.

One respondent was concerned that the costs of notifying relevant people of orders could be higher than we had assumed, on the basis that a senior officer would be needed to carry out the work. Two people were concerned that the impact of the notification requirements would be greater than we had said. We have reviewed these areas and are satisfied that the impact of the final regulations will, as far as can be assessed, be in line with the figures in the consultation Impact Assessment.

We have therefore provided an assessment on this basis in our final Impact Assessment to accompany the regulations.
Annex A - List of respondents

Respondents who indicated that they were happy for their information to be shared were:

All Party Parliamentary Group on AIDS
Andrew Collinson, Wycombe District Council
Advisory Group on Hepatitis, Health Protection Agency (HPA)
Antony Hale, Old Medical School, Leeds General Infirmary
Association of London Environmental Health Managers
Association of Medical Microbiologists
Body and Soul
British Association for Sexual Health and HIV
British Medical Association
British Thoracic Society
Chartered Institute of Environmental Health
Children and Young People’s HIV Network, National Children’s Bureau
Children’s HIV Association
Clive Cain, London Borough of Bexley
Cruse Bereavement Care
Coroners’ Society of England and Wales
David Bennett, North Devon Council
Dr Caron Grainger, NHS Coventry/Coventry City Council
Dr Donald Lyon, Department of Microbiology, Crawley Hospital
Dr J K Struthers, Department of Microbiology, University Hospitals Coventry and Warwickshire
Dr Karen Knox, Department of Microbiology, Crawley Hospital
Dr E Ridgway, Department of Microbiology, Sheffield Teaching Hospitals NHSFT
Dr Emma Aarons, St Thomas’ Hospital
Dr Musarrat Afza, HPA West Midlands North Health Protection Unit
Dr Nicole Klynman
Dr Pam Hall, NHS West Essex
Dr Patrick French, Camden Primary Care Trust Sexual Health Services
Dr Ruth Palmer, Department of Microbiology, Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
Health protection regulations

Dr Ruth Hussey, NHS North West
Dr Terry Riordan, Department of Microbiology, Royal Devon and Exeter NHS Foundation Trust
Expert Advisory Group on AIDS
Family Planning Association
A group of professionals in Yorkshire and the Humber working on health protection
Health Protection Agency (HPA)
Hertfordshire and Bedfordshire Environmental Health Heads of Service Group
Independent Healthcare Advisory Services
Independent Advisory Group on Sexual Health and HIV
Infection Prevention Society
Jacqui Bromilow, Chartered Institute of Environmental Health, Buckinghamshire Branch
James T H Button, James Button & Co. Solicitors
Jeffrey Dennis
Joan Cochrane
Justices’ Clerks’ Society
Kate Harris
Leicestershire AIDS Support Services
Liberty
Local and Regional Services, HPA
Local Authorities Coordinators of Regulatory Services
London Borough of Greenwich
Lord Walton of Detchant
Mark Young, NHS Cornwall
National AIDS Trust
National Information Governance Board for Health and Social Care
Nicky Hoyle, NHS Kirklees
Northampton Borough Council
North Central London TB Network
Positively Women
Richard Bendall, Department of Clinical Microbiology, Royal Cornwall Hospital
Robin Smith, Department of Microbiology, Royal Free Hospital
Royal College of Nursing
Royal College of Paediatrics and Child Health
Prof George Kinghorn, Royal Hallamshire Hospital
Health protection regulations

Selina Hoque, Department of Microbiology, Torbay Hospital
Surrey and Sussex Healthcare NHS Trust
Susan Partridge and David Telford, Department of Microbiology, University Hospitals of Morecambe Bay
Terrence Higgins Trust
UK Faculty of Public Health

We have not included the name of one respondent who did not want their information shared.
Annex B – Consultation poster

**Updating Public Health Protection Law**

- Outdated powers in the Public Health (Control of Disease) Act 1984 are to be replaced
- The Health and Social Care Act 2008 provides a new Part 2A for the 1984 Act and other amendments
- Introduces an “all hazards approach”, with more flexible powers and improved safeguards for people who might be affected by them

The Department of Health is consulting on three sets of regulations:

- The Health Protection (Notification) Regulations
- The Health Protection (Part 2A Orders) Regulations
- The Health Protection (Local Authority Powers) Regulations

New Port Health Regulations will follow later.

**This is your chance to respond to the consultation**

Go to the ‘live consultations’ pages at [www.dh.gov.uk](http://www.dh.gov.uk)

The consultation runs until 30 September 2009
References

1. Guidance on Infection Control in Schools and Other Childcare Settings, Health Protection Agency, available at:

2. Review of Parts II, V and VI of the Public Health (Control of Disease) Act 1984: report on consultation, Department of Health, available at: