Communicable Disease

Guideline for the Control of Communicable Disease in NHS Lanarkshire

Lead Author	Caroline Thomson	Date Approved	October 2024
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TARGET AUDIENCE	NHSL WIDE, Acute, Health and Social Care Partnerships
PATIENT GROUP	All in patients and outpatients

Clinical Guidelines Summary

This section outlines the elements involved in the control of communicable disease in Lanarkshire. It details the legal responsibilities of the Board for infection control in general and reviews aspects relating to control Infection prevention and control in healthcare settings. It also outlines a suitable structure at provider level for the provision of advice on the management and monitoring of infection prevention and control.
The control of communicable disease is a statutory function for which responsibility is shared by the Health Board and the local authorities within Lanarkshire.
In practice the day to day aspects of communicable disease control are delegated to the Consultant in Public Health Medicine (CPHM) with a main interest in Communicable Diseases and Environmental Health (CD & EH), acting as the Designated Medical Officer.

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Guideline Body

1. INTRODUCTION

This section outlines the elements involved in the control of communicable disease in Lanarkshire. It details the legal responsibilities of the Board for infection control in general and reviews aspects relating to control Infection prevention and control in healthcare settings. It also outlines a suitable structure at provider level for the provision of advice on the management and monitoring of infection prevention and control.
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2. AIM, PURPOSE AND OUTCOMES

To ensure that Healthcare workers consider communicable diseases, report quickly and take appropriate actions to minimise the risk of cross infection.

3. SCOPE

3.1 Who is the Policy intended to Benefit or Affect?

This guideline is designed to safeguard patients, staff and the wider public from the risk of communicable disease.

3.2 Who are the Stakeholders?

The guideline is aimed at all Healthcare staff working in NHS Lanarkshire in particular:

- General Practitioners
- Health Protection Team
- Laboratory Staff
- Infection Prevention and Control Team
- Environmental Health Officers

4. PRINCIPLE CONTENT

The Public Health etc (Scotland) Act 2008 updates the law on public health, enabling Scottish Ministers, health boards and local authorities to better protect public health in Scotland. It will also assist Scottish Ministers to meet their obligations under the International Health Regulations. The Act comprehensively modernises Scotland's public health legislation, ensuring that organisations responsible for protecting public health are

better equipped to protect Scotland from the threat of infectious diseases and contamination. The key aspects of the Act are summarised below:

- Part 1 – Public Health Responsibilities - This Part sets out the duties of the Scottish Ministers, health boards and local authorities to continue to make provision to protect public health in Scotland. Health boards and local authorities are required to designate "competent persons" to undertake functions assigned to them under the Act and which require professional input at a particular level. A duty of co-operation is placed on health boards and local authorities in exercising the functions under the Act, and for them to plan, together, for public health protection.

- Part 2 – Notifiable Diseases, Notifiable Organisms and Health Risk States - This Part replaces the current statutory arrangements for the notification of infectious diseases and the voluntary reporting of organisms by NHS-related laboratories with a statutory notification system. Suspected or diagnosed infectious diseases and health risk states are to be notified by registered medical practitioners and diagnostic laboratories in Scotland that are focused on human infections.

- Part 3 – Public Health Investigations - This Part defines a "public health investigation" and sets out the powers available to investigators who may be appointed by the Scottish Ministers, a health board competent person, Health Protection Scotland (a division of the Common Services Agency for the Scottish Health Service), a local authority competent person or two or more of these bodies or persons acting together. The powers will be available only in defined circumstances and where there are reasonable grounds to suspect that those circumstances are likely to give rise to a significant risk to public health.

- Part 4 – Public Health Functions of Health Boards - This Part replaces many of the powers currently available to local authorities and which relate directly to infected people and assigns them to health boards. It also confers new powers on health boards. Existing powers that are being transferred from local authorities to health boards include: the exclusion of persons from work and school (now extended to cover a wider range of settings); application to a sheriff for an order for a person to be medically examined; and the removal and detention in hospital of a person suffering from a serious infectious disease (now extended to include persons who are contaminated). New powers for health boards include the power to restrict persons' activities in order to reduce the spread of contamination and infection; power to quarantine individuals; and power to require a person to be disinfected, disinfested or decontaminated, in defined circumstances, and where there is a significant risk to public health. With the exception of exclusion orders and restriction orders, all health board powers will be exercisable only where the health board has obtained an order from a sheriff.

- Parts 5 to 10 of the Act cover the Public Health Functions of Local Authorities, provision of mortuaries and post mortem facilities, regulations with relation to international travel, regulation of provision of sun beds, statutory nuisances and other general and miscellaneous provisions, including provision about information disclosure and penalties for offences under the Act.

5. ROLES AND RESPONSIBILITIES

THE ROLE OF HEALTH BOARD

5.1 The main sources of information are official "Notifications" from GP's and hospital doctors to the Health Protection Team and the reporting of cases confirmed by microbiology laboratories. Close liaison with microbiologists and their staff is essential in order to facilitate prompt investigations. Depending on the nature of the individual disease concerned, further investigations are carried out by the Consultant in Public Health Medicine (Health Protection Team [HPT]), in collaboration with local authority Environmental Health Officers and other agencies as appropriate. Other agencies include the State Veterinary Service, the Health and Safety Executive, Water and Drainage authorities, Scottish Government and Health Protection Scotland (HPS).

5.2 These investigations may lead to specific control measures being enforced and to subsequent action by the local authority on the recommendation of the CPHM, in order to prevent further spread or recurrence of infection. This may include the exclusion of food handlers with salmonella from work or the immediate closure of food premises. Close collaboration with a wide variety of agencies is therefore essential to the effective control of communicable disease.

5.3 Prevention of communicable disease also involves the provision of advice and the organisation of immunisation programmes co-ordinated by the CPHM (HPT).

5.4 Board contracts with microbiology services specify the need to maintain the close levels of co-operation established with the Department of Public Health Medicine and the continued need to provide information on communicable disease cases in order to facilitate their control in Lanarkshire

INFECTION PREVENTION AND CONTROLTEAM/HEALTH PROTECTION TEAM

5.5 Local Committees advise their Chief Executive on all matters relating to Infection Prevention & Control. The core remit is to monitor infection within their area and ensure that good infection control practice is maintained.

5.6 Infection Prevention and Control Teams, (IPCT) must establish co-operation between their team and Public Health, to enable the proper control and prevention of infection within healthcare settings and the wider community.

5.7 Environmental Health Officers carry out routine inspections of hospital kitchens and report their findings to management. Responsibility for the correction of faults lies with the relevant managers.

5.8 Members of -IPCT must have the freedom to communicate information on cases or outbreaks of infection to relevant personnel and Public Health in accordance with their professional and legal responsibilities.

OUTBREAK CONTROL TEAMS

5.11 In the event of an outbreak there is a requirement to inform the CPHM (HPT) as identified by the **Hospital Infection Incident Assessment Tool (HIIAT).** Where appropriate the CPHM (HPT) will have a responsibility to inform other relevant personnel. eg. Chief Executive, Director of Public Health, Scottish Government, etc.

5.12 If required, an Incident Management Team (IMT) will be convened by agreement with the Consultant/ InfectionPrevention and Control Doctor and the CPHM (HPT). Chairmanship of the team will be agreed depending on the nature of the outbreak and in line with the Hospital Infection Incident Assessment Tool (HIIAT) (Health Protection Scotland March 2017)

6. RESOURCE IMPLICATIONS

There are no resource implications.

7. COMMUNICATION PLAN

This policy is available on NHS Lanarkshire intranet and external website.

Changes to the guideline will be communicated to key personnel via:

- Email
- Discussion at departmental meetings
- Educational sessions
- Staff Brief

8. SUMMARY OF FREQUENTLY ASKED QUESTIONS

If you have any questions about this guideline or how to implement it, please contact the Health Protection Team to discuss your query.

9. REFERENCES

Hospital Infection Incident Assessment Tool (HIIAT) (Health Protection Scotland March 2017)

Scottish Executive Health Department (2002), The Watt Group Report, Edinburgh, Scottish Executive Health Department.

The Scottish Government (2008), **The Scottish Government's Public Health etc**

(Scotland) Act, Edinburgh, The Scottish Government. https://www.legislation.gov.uk/asp/2008/5/contents

APPENDIX 1

DISEASES TO BE NOTIFIED BY REGISTERED MEDICAL PRACTITIONERS WITH EFFECT FROM 1 JANUARY 2010: NOTIFICATIONS ARE BASED ON REASONABLE SUSPICION AND SHOULD NOT AWAIT LAB. CONFIRMATION

* Anthrax * Botulism Brucellosis * Cholera * **Clinical syndrome due to** E.coli O157 infection **(see Note 1)** * Diphtheria * **Haemolytic Uraemic** Syndrome (HUS) * **Haemophilus influenzae** type b (Hib) * **Measles** * Meningococcal disease Mumps * Necrotizing fasciitis * Paratyphoid	* Pertussis * **Plague** * Poliomyelitis * Rabies Rubella * **Severe Acute Respiratory** Syndrome (SARS) * Smallpox Tetanus **Tuberculosis (respiratory or** non-respiratory) **(see Note 2)** * **Tularemia** * Typhoid * Viral haemorrhagic fevers * West Nile fever Yellow Fever

*It is recommended that those diseases above marked with an * require urgent notification, i.e. within the same working day. Follow up written / electronic notification within 3 days is still required.

Note 1: **E.coli O157**
Clinical suspicion should be aroused by (i) likely infectious bloody diarrhoea or (ii) acute onset non-bloody diarrhoea with a biologically plausible exposure and no alternative explanation. Examples of biologically plausible exposures include:

- contact with farm animals, their faeces or environment;
- drinking privately supplied or raw water;
- eating foods such as undercooked burgers or unpasteurised dairy products;
- contact with a confirmed or suspected case of VTEC infection.

Further guidance is available at:
http://www.hps.scot.nhs.uk/giz/e.coli0157.aspx?subjectid=18

Cases notified as HUS (Haemolytic Uraemic Syndrome) should NOT be notified as "Clinical syndrome due to *E.coli* O157 infection" as well.

Note 2: **Tuberculosis**
For the purposes of notification, respiratory TB or non-respiratory TB should be taken to have the same meanings as the World Health Organisation definitions of **pulmonary TB**

and **non-pulmonary TB** respectively.
Pulmonary TB is tuberculosis of the lung parenchyma and/or the tracheobronchial tree.
Non-pulmonary TB is tuberculosis of any other site.
Where tuberculosis is clinically diagnosed in both pulmonary and non-pulmonary sites, this should be treated as pulmonary TB.

If you are in any doubt about the diagnosis of suspected cases, you should contact the local Health Protection Team for advice.

APPENDIX 2

NOTIFICATION OF HEALTH RISK STATES (HRS)

Why is it necessary to notify suspected 'health risk states'?

The aim of notifying suspected health risk states is to identify diseases or conditions which are not notifiable in their own right but which pose or may pose a significant risk to public health. The definition of 'health risk state' and 'exposure to a health risk state', as provided in the Act is set out in the footnote[1].

Pubic health authorities need to be able to identify and respond quickly to new and emerging public health threats, even when a condition is identified from its symptoms and epidemiology and the causative organism is not yet identified. This is particularly relevant in the modern world of global travel and trade. For example, urgent public health action was required in the early stages of the SARS (Severe Acute Respiratory Syndrome) outbreak in 2003 and the Influenza AH1N1 outbreak in 2009, even before the causative agent was known.

Other examples from the past of conditions that would fulfil the criteria of a health risk state include the initial five cases of *Pneumocystis* carinii pneumonia heralding the AIDS epidemic, avian flu, Polonium exposure and poisoning in the Litvinenko case.

What should be notified?

This is for practitioners to determine, based on reasonable suspicion. However, the following advice should assist.

[1] Section 14 (7) of the Public Health etc. (Scotland) Act 2008 defines a 'health risk state' as (a) a highly pathogenic infection; or (b) any contamination, poison or other hazard which is a significant risk to public health.
References to a patient having been 'exposed to a health risk state' is defined in section 14 (8) as (a) having been in physical contact with a health risk state; (b) having been contaminated by a health risk state; or (c) having been in physical contact with or contaminated by a person who, or an object which, has been in physical contact with or contaminated by a health risk state.

(a) If a novel serious condition occurs at home or abroad, it may be designated an HRS by the Scottish Government's Chief Medical Officer (CMO), who will provide a case definition for exactly what should be notified.

(b) In the absence of a definition from the CMO, medical practitioners should notify as an HRS any condition which is:

1. Serious:
A case must be very ill or have died, or be likely to become very ill or die.

AND

2. Be potentially serious to others.
The three principal ways in which an HRS might be serious for others are if it is:
(i) infectious;
(ii) the result of contamination with, for example, a radioactive material;
(iii) the result of a toxin or poison to which others may be exposed.

An HRS is likely to be new, rare, unexplained, or difficult to diagnose. Obviously, the more serious the condition, and the greater the likelihood of spread, the more important it is for the medical practitioner to notify it. The more cases the medical practitioner sees within a given period of time, the more likely is the potential for spread, but an HRS presenting in a single case may still have the potential to affect others.

Notifications of an HRS will be an exceptional occurrence and should only be made on the basis that the registered medical practitioner considers there is a risk of significant public health implications of the condition. If in doubt whether to notify a condition, on grounds of either its seriousness or potential to affect others, the medical practitioner should discuss the condition with the local Health Protection Team.

How to notify

Immediate oral notification by telephone is strongly recommended in these circumstances, followed up in writing / electronically with the required information within 3 days of forming the suspicion of the health risk state.

APPENDIX 3

NOTIFIABLE ORGANISMS FOR NOTIFICATION BY DIAGNOSTIC LABORATORIES

Bacillus anthracis	*Verocytotoxin-producing E.coli (VTEC)	*Machupo virus	Enterotoxigenic Staphylococcus aureus
Bacillus cereus	*Francisella tularensis	*Marburg virus	Staphylococcus aureus (all blood isolates)
*Bordetella pertussis	Giardia lamblia	*Measles virus	Methicillin-resistant Staphylococcus aureus (MRSA)
Borrelia burgdorferi	*Guanarito virus	Mumps virus	*Streptococcus pyogenes (from blood, cerebrospinal fluid or other normally sterile site)
Brucella genus	*Haemophilus influenzae type b (from blood, cerebrospinal fluid or other normally sterile site)	*Mycobacterium bovis	Streptococcus pneumoniae (from blood, cerebrospinal fluid or other normally sterile site)
*Campylobacter genus	Hantavirus	*Mycobacterium tuberculosis complex	Toxoplasma gondii.
Chlamydia psittaci	*Hepatitis A virus	*Neisseria meningitidis	Trichinella genus
*Clostridium botulinum	*Hepatitis B virus **(see Note 1)**	Norovirus	Varicella-zoster virus
Clostridium difficile	Hepatitis C virus	*Omsk haemorrhagic* Plasmodium falciparum, vivax, ovale and malariae	*Variola virus
Clostridium perfringens	Hepatitis E virus	*Polio virus	*Vibrio cholerae
*Clostridium tetani	Influenza virus (all types, including *those caused by a new sub-type)	*Rabies virus	*West Nile fever virus
*Corynebacterium diphtheriae (toxigenic strains)	*Junín virus	Rickettsia prowazekii	*Yellow Fever virus
*Corynebacterium ulcerans	*Kyasanur Forest disease virus	*Rift Valley fever virus	*Yersinia enterocolitica
*Coxiella burnetii	*Lassa virus	*Rubella virus	*Yersinia pestis
*Crimean-Congo haemorrhagic fever virus	*Legionella genus	*Sabia virus	*Yersinia pseudotuberculosis
*Cryptosporidium	Leptospira genus	*Salmonella (all human types)	
Dengue virus	*Listeria monocytogenes	*SARS-associated coronavirus	
*Ebola virus	fever virus	*Shigella genus	
Echinococcus genus			

*It is recommended that those organisms above marked with an * require urgent notification, i.e. within the same working day. Follow up written / electronic notification within 10 days is still required.

Note 1: For Hepatitis B, only acute infections require urgent notification.

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Responsible Lead Executive Director:	**Director of Public Health**
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