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Public Health England

Protecting and improving the nation's health

Review of Port Health Service in Public Health England

Report for the PHE Management Committee

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1. Introduction

Public Health England (PHE) is responsible for fulfilling the Secretary of State's duty to protect the public's health from infectious diseases and other public health hazards and to secure improvements to the public's health. Border public health services are needed to limit and respond to the international spread of diseases and other public health threats.

1.1 Context for the review

Port health functions in PHE are delivered through a dedicated port health team based at Heathrow airport, PHE local Centres and various specialist teams in the Centre for Radiation Chemicals and the Environment (CRCE) and the National Infection Service (NIS). Local PHE Centres are responsible for the protection of the health of their local population and their staff may also be appointed as Proper Officers for the Local Authority under the Health Protection Regulations 2010. The dedicated Port Health team at Heathrow delivers health protection and immigration-related health assessment functions at Heathrow and Gatwick. The Food Water and Environmental (FW&E) Microbiology Laboratories within NIS act as Official Control Laboratories for the examination of imported foods sampled at Border Inspection Posts and provide sampling, testing and advice regarding food and water hygiene on-board ships.

Over the past few years the increasing focus on Global Health Security has raised the profile for the public health work at the border. There have been some important changes in the port health function including the ceasing of on-entry TB screening, new responsibilities for administering the overseas pre-entry TB screening programme and the need to rapidly respond to Public Health Emergencies of International Concern including, for example, the provision of a port of entry screening service as part of the response to the Ebola outbreak in West Africa, or the response to the Zika outbreak (aircraft disinfection) and Fukushima radiological incident.

In this context, PHE has undertaken a review of its public health functions at ports of entry in the broadest sense, in consultation with key external partners and stakeholders with the aim of strengthening public health at the border.

1.2 Aims and objectives

The review aimed to scope out what is required and then strengthen the delivery of port/border health functions in PHE, wherever these are currently delivered and agree organisational arrangements for the delivery of these functions. The review

describes what is legally required of PHE and PHE's aspirations of the delivery of public health services at the border.

The specific objectives of the review were:

- To define the roles and responsibilities of PHE in relation to public health at the border and ensure that these are aligned and agreed with key partners in DH and across government.

- To undertake an assessment of the current delivery of port health functions in PHE including identification of opportunities and challenges and recommendations for the future delivery of the port health functions of PHE.

- To consider the organisational arrangements for delivery of public health functions at the border in PHE.

- To develop a plan for the implementation of the recommendations from this review and a clear set of guidance in relation to how PHE will engage with intergovernmental departments to deliver the recommendations.

1.3 Project scope and arrangements

The scope of the review included the breadth of PHE's public health work at the border and lessons learnt from abroad where relevant. It covered the description of PHE's port health function including clarification of statutory responsibilities and legislation that applies for the delivery of this function (including the medical inspection function); the work of the dedicated port health team based at Heathrow; the work of the local health protection team, the links with NIS and CRCE functions, and the links with work on global health and UK interface (International Health Regulations (IHR) and travel and migrant health).

The review did not include specific plans for specific diseases and delivery of health care at the border.

A project steering group oversaw the delivery of the project (see Terms of reference in Appendix A). They met monthly to review key deliverables and approve progression to the next stage of the review. A communication plan was developed including arrangements for consultation internally within PHE and externally with key stakeholders on the proposed new arrangements for the delivery of port health functions in PHE. Key external partners and stakeholders such as DH, DfT, Home Office, NHS England and relevant CCGs, Cabinet Office Civil Contingencies, LA representatives, CAA, were engaged in the review.

The review was undertaken in the context of the Operating Model for PHE[1]. It took into account and linked with the related programmes of work, in particular the High Consequences Infectious Diseases Programme (HCID), the review of local health protection future work including the work to improve consistency across centres, and the NIS design work.

1.4 Context in which PHE operates – overview of legislation

Legal responsibilities of PHE with respect to Port Health can be considered under three categories. They are:

- To fulfil the duties of the Secretary of State for Health and Home Secretary with respect to the protection of the public from infectious disease and other public health hazards at the border and overseas.
- To provide staff to carry out the role of the Medical Officer when appointed as such by local authorities.
- To ensure the provision of an appropriate medical inspection function i.e. advice to immigration officers with respect to entry decisions for individuals when there is a health component to the decision.

Wider Health Protection Duties of the Secretary of State for Health

A number of statutory functions are delegated to PHE by the Secretary of Health to carry out on his behalf related to port health[2]:

- Public Health (Control of Disease) Act 1984 gives the Secretary of State powers in relation to port health.
- Section 2A and 2B of the National Health Service Act 2006 ("the 2006 Act") – a duty to take such steps as Secretary of State considers appropriate to protect and improve the health of the public in England.
- Paragraph 12 of Schedule 1 to the 2006 Act – a power to provide a microbiological service in England.
- Section 1E of the 2006 Act – in so far as this duty relates to the statutory functions performed by PHE a duty to promote research on matters relevant to the health service (including public health), and the use of evidence obtained from research.
- As a Category 1 responder under the Civil Contingencies Act 2004 (CCA) in respect of emergency planning, the response and resilience functions for public health.

PHE obligations are set out in the PHE remit letter 2017-18[3]. This states that one PHE's critical function is to *"to fulfil the Secretary of State's duty to protect the*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216716/dh_131892.pdf
[2] http://phenet.phe.gov.uk/Policies-and-Procedures/Policy%20Documents/Public-Health-Englands-statutory-functions.pdf
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/609071/PHE_remit_1718.pdf

public's health from infectious diseases and other public health hazards…." "This means providing the national infrastructure for health protection including… ensuring effective emergency preparedness, resilience and response for health emergencies, including global health security…" In order to deliver this function, PHE has to consider the risks posed by ports of entry and deliver services working within current policy and legislative parameters at the border.

Recent experience has also shown that PHE may be required to undertake other additional actions by the Secretary of State in addition to the duties and obligations outlined above e.g. oversight of disinfection of aircraft in the early stages of the Zika response. In many respects, this means that PHE may be requested to act as if it were the "national competent authority" for health emergencies.

Wider Health Obligations of the Minister for Immigration

PHE (as the successor body to the HPA) has the same responsibilities as HPA had. In relation to pre-entry screening of migrants from high risk countries, the powers to enable this to happen are with the Immigration Act. PHE's role is advisory to Home Office as they set up the contracts / licences with overseas providers and to deliver a quality assurance programme

On 21 May 2012 the Government announced its intention to expand the pilot pre-entry screening programme to allow for comprehensive pre-departure screening overseas[4]. PHE is jointly responsible with Home Office for the delivery of the screening programme at what is effectively the overseas border via the immigration process[5]. PHE is specifically tasked with ensuring quality of overseas screening providers which are named in statute.

Medical Officer Role under the Public Health (Aircraft) Regulations 1979 and the Public Health (Ships) Regulations 1979

The main operational legislation with respect to port health activities are the Aircraft and Ships Regulations. These gives specific powers to local authorities and port health authorities and PHE can provide medical officers for appointment by the local authorities/port health authorities under a long-standing agreement with the Department of Health.

Where PHE employees are appointed as medical officers under the Regulations by local authorities/port health authorities, these employees acquire responsibilities and discretionary powers as *de facto* officers of the local/port health authorities.

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[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/289215/HC1130EM.pdf
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117947/policy-statement-statement.pdf

PHE also provides the examination of food and water samples taken by the authorised officer as required under Regulation 7.

There are also the Public Health (International Trains) Regulations 1994, but they differ from the Ships and Aircraft Regulations as they do not confer specific powers and responsibilities on a medical officer and, as such, do not give ability to appoint PHE employees to them.

Requirements under these acts are listed in Appendix B. It is important to note that a PHE employee, who is an appointed medical officer and is responding to an incident in a port or airport is aware of the point of transition from being a PHE health professional conducting a risk assessment / providing advice to that of local authority/port health authority medical officer, i.e. when the legal obligations contained in the Regulations become super-ordinate. PHE has a responsibility to ensure this distinction is understood and appropriately acted upon.

Medical Inspector function

The Immigration Act 1971 places a duty on the Secretary of State for Health to provide medical inspectors. Medical Inspectors for the purposes of the Act are registered medical practitioners appointed by the Secretary of State to act at his direction[6]. The Secretary of State has delegated that duty to PHE, which is the competent authority for appointing medical inspectors. A Medical Inspector acts as an advisor to an immigration officer where there is an immigration decision that has a health component. Extracts from the Home Office Immigration medical rules and Department of Health Instructions are given in Appendix B.

In **summary**, PHE's legal responsibilities in relation to border health are wide ranging and result largely from the delegated responsibilities from the Secretary of State for Health. Most of them are advisory in just the same way that PHE's routine health protection functions are. In addition, PHE can support local authorities by providing medical officers to Local Authorities/Port Health Authorities to allow them to discharge their obligations under the Ships and Aircraft Regulations and Proper Officers under the Health Protection Regulations and by agreement with Department of Health, PHE ensures the provision of an appropriate Medical Inspector function at all UK ports. The Secretary of State's for Health wider remit encompasses the response to novel and unexpected threats that require a public health response at the border to be instigated rapidly and consistently across the country.

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[6] Department of Health. Medical Inspection under the Immigration Act 197. Instructions to Medical Inspectors. London: HMSO, 1992.

1.5 Brief description of current services

1) Port Health Team

PHE has a dedicated **Port Health Team** based at Heathrow which covers both Heathrow and Gatwick airports and also delivers wider port health functions. Their responsibilities fall into two broad areas; health protection and immigration (Appendix C1).

Health protection related activities include:

Delivery functions

- Delivery of first-line response to health protection issues at Heathrow including providing the Medical Officer function under the Public Health Aircraft Regulations (1979).
- Provision of operational support within PHE on issues with a port health component.
- Contribution strategically to the development of national policies and procedures for large scale public health activities in port.

Advisory and liaison functions

- Provision of expert advice within PHE on port health-related issues.
- Provision of expert advice to DH on the operational implications of changes to national policy or legislation with respect to ports/airports.
- Provision of specialist port health-related health protection advice to external bodies drawing on PHE's subject matter experts as appropriate.
- Provision of operational support and guidance to Health Protection Teams on health protection issues relating to ports/airports.
- Liaison with national agencies on port health issues.
- Liaison with international agencies to maintain awareness of current international best practice on port health issues.

Immigration related activities include:

- Provision of the Medical Inspector function at Heathrow and Gatwick under the Immigration Act 1971.
- Major contribution to the PHE Quality Assurance programme supporting the Home Office pre-departure TB screening programme.
- Wider work with HO and DH and internal stakeholders on migration and health.

The Port Health team 2107/18 Allocated budget is £1,467,468, which includes expected income of £30,000 therefore resulting in a GIA (Grant in Aid) budget of £1,437,468 (Table 1.5.1a). The outline of the current organisational structure of the Port Health team is shown in Figure 1.5.1b.

Table 1.5.1a: Port Health team Budget allocation and breakdown by key elements

Allocated Budget	Amount £
Pay (16.0wte)	1,130,754
Non-Pay*	336,714
Total Budget	**1,467,468**
External Income**	-30,000
Total GIA Budget for 17/18	**1,437,468**

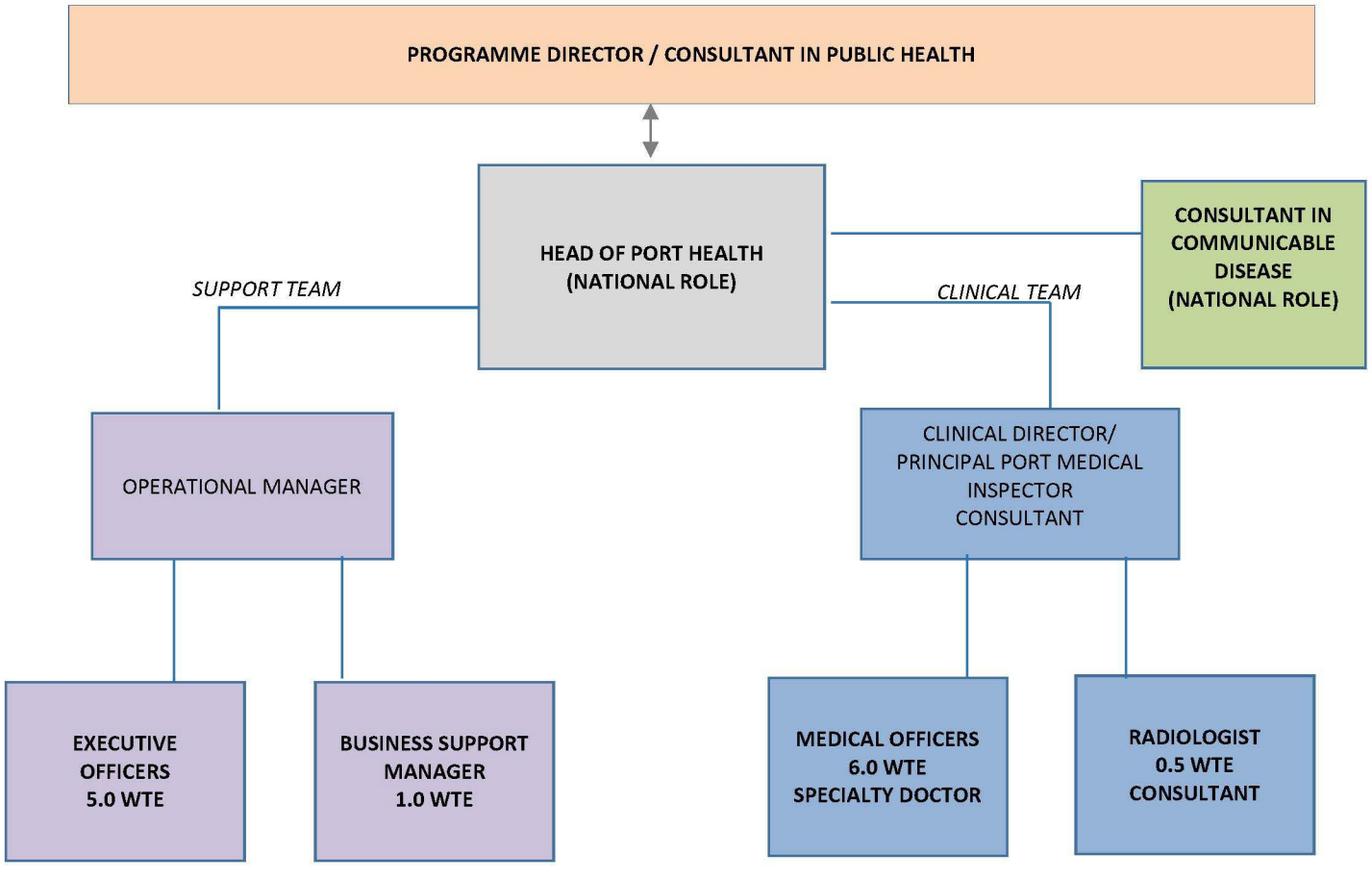
Pay budget	WTE	Amount £
Doctors (8x)	8.0	695,931
Managers (1xG6, 1xG7)	2.0	171,764
Admin (1xHEO, 5xEO)	6.0	263,060
Total Pay Budget	**16.0**	**1,130,754**

*Non-Pay includes the following key budgets:
- £85,000 Travel and Subsistence budget to support the Pre-Entry screening at partner ports.
- £81,000 Sub-contracted Healthcare Radiologist Advice.
- £86,000 budget as a result of savings released by ceasing the AGFA contract.

The remaining non-pay budgets cover day to day operational costs.

**Income expected is £30,000 from Manchester Council for Port Health services at Manchester Airport.

Figure 1.5.1b: Current organisational structure of the Port Health team (including vacancies)



2) Other teams and departments supporting delivery of port health functions

Several other teams deliver port health functions as part of their wider responsibilities. These teams are accountable through the relevant directorate.

PHE Centres and Health Protection Teams (HPTs)
The functions listed below are currently delivered by the Centres through their HPTs in relation to port health. However the extent of those functions may differ depending on the presence of airports, seaports or land borders in the areas they cover.

- Health protection response to cases of infectious disease(s) at airports/ seaports/ rail borders, including risk assessment, advice on control measures and contact tracing and other PH actions if needed.
- Management of and advice on incidents and outbreaks on board an aircraft or sea vessel.
- Response to public health emergencies of international concern as required by the International Health Regulations.
- Provision of health protection and infection control advice and support relating to port health issues, including local training and education if required.
- Development and review of local port health response plans and Standard Operating Procedures (SOPs) jointly with stakeholders.
- Attendance at Local Resilience Forum/ Emergency Planning meetings. Participation in Health Protection/Emergency Planning exercises held at ports.
- Chairing/ Attendance at Multi-Agency Port Health Liaison meetings and/or local Port Health Team Meetings. Linking between local partners and the national focal point in Colindale/ Attendance at national PHE Port Health meetings.

Some functions are provided on behalf of local authorities such as the Proper Officer and Medical Officer functions. Some staff in PHE feel that the indemnity arrangements for these are not clear.

National Infection Service (NIS)
There are several services and teams within NIS that deliver port health related functions. The following activities have been identified as part of NIS delivery in relation to port health:

- Contact tracing activities related to international travel through air or seaports.
- Provision of the IHR National Focal Point (NFP) function including:
    - EU communication through the EWRS.
    - Oversight of issue and activities related to Ports of Entry.

    - Contribution to international guidance for infections transmitted on aircraft.
- Pre-entry TB screening programme data management and monitoring including:
    - Data collection, analysis and reporting; support with quality assurance; panel physician training; public health advice; development of tele-radiology.
- Provision of specialist information and advice, e.g. airport posters on reducing risk of MERS-CoV; infection control advice for transfer of patients with respiratory diseases; risk assessments of novel respiratory diseases and specialist advice on follow-up.
- Outbreak and incident investigation and control.

The **Food, Water and Environment (FW&E)** microbiology services within NIS have some unique port health functions. They liaise closely with Port Health Authorities throughout England, and perform microbiological examination of imported foods as part of official controls, ships waters and other relevant samples in support of ship sanitation certification, many of which are covered by PHE central funding although some are charged on a per test basis.
The service provided includes:

- Courier collection of samples and same-day transport to the laboratory. Provision of cold boxes and suitable contents to ensure maintenance of samples at an appropriate temperature until they reach the laboratory.
- Assistance to Port Health Authorities in ensuring that food and feed imported into the EU for placing on the market within the Community complies with the relevant requirements of official control food law (Regulation (EC) No 178/2002), including compliance with microbiological criteria (Regulation (EC) no 2073/2005). This is done through the provision of official food control laboratories as designated by the competent authority (the FSA) according to the National Control Plan as required by Regulation (EC) 882/2004. Testing can be in response to the Rapid Alert System for Food and Feed (RASFF) notifications (Regulation (EC) No 178/2002) or based on sampling priority lists from the Food Standards Agency (FSA).
- Advice on appropriate sampling procedures, testing strategies and interpretation of results.
- Provision of formal certificates and witness statements to assist with legal proceedings where imported food is found to be of an unsatisfactory microbiological quality.
- Liaison meetings between the local lab and the regional Port Health Authorities on a regular basis. Liaison meetings between the FW&E microbiology network and Port Health Authority representatives, held twice per year to address issues of national relevance.

- Assistance with sampling on-board ships during investigations and outbreaks. Assistance with outbreak investigation on board ships.
- Provision of training to Port Health Officers in local authorities on sampling techniques and interpretation of microbiology results.
- Production of microbiological test results (usually in relation to water samples) to support issue of Ship Sanitation Certificates.
- Provision of public health and health protection data to inform the actions of others, e.g. survey of Legionella contamination of merchant ships and survey of galley hygiene in merchant ships.

Centre for Radiation, Chemical and Environmental Hazards (CRCE)

CRCE currently delivers the following functions relating port/border health:

- Support function to the implementation of PHE civil contingency responsibilities at ports and designated Points of Entry (24/7 on call).
- Surveillance of chemical events (via NPIS, GP notifications, event-based surveillance).
- Public health incident response including provision of scientific knowledge and expertise, risk assessment, access to specialist services (e.g. toxicology), specialist advice, identification of sensitive PH receptors, GIS capability.

Health Protection & Medical Directorate (HPMD): Medical Director and Response Officer function

The Medical Director Division of HPMD in PHE provides support to port health related functions as listed below:

- Medical revalidation to doctors employed by PHE in port health / medical immigration roles. Delivered through the Office of the Responsible Officer
- Caldicott function. Delivered through the Caldicott Oversight Group, chaired by the Caldicott Guardian.
- Quality & Clinical governance function with an identified quality lead within port health and overseen by the Quality and Clinical Governance Delivery Board (QCGDB), co-chaired by the Chief Nurse and Medical Director..
- Medicines management function. Overseen by the Medicines Management Group, a subgroup of QCGDB.

Table 1.5.2a summarises the resources that the PHE teams and departments estimated to devote to the functions related to port health, by professional background, grade and time commitment.

See Appendix C2 and C3 for further detail on current services and functions and resources in relation to port health.

Table 1.5.2a: Estimate of resources devoted to functions related to port health

Division/ Department	Team stating resource	Professional background	Grade	WTE
PHE Centres – HPTs	2 HPTs	Deputy Director for Health Protection	Consultant	0.1-0.2
	1 HPTs	Consultant (CCDC/CHP) Lead for Gatwick	Consultant	1.25
	8* HPTs	1-2x Consultant (CCDC/CHP) per Centre	Consultant	0.05-0.2
	9 HPTs	1-2x Health Protection Nurse/Health Protection Practitioner	Band 6/7/8a or SEO/Grade7	0.1 (~2days/ month)
	3 HPTs	Emergency Planning Officer	Band 7 or SEO	0.05-0.1
	2 HPTs	Administrator	AO	0.05
	3 HPTs	Other staff (e.g. TB specialist, Chartered Environ. Health Practitioner, Surveillance Officer)	Ranging from Band 4/5 to Band7/SEO	variable
NIS – FW&E microbiol. service**		Unit Head / Lab Manager	Band 8c / Grade 7	0.1
		Food Examiners	HEO/SEO	1.0
		Healthcare Scientist Practitioners and Support Workers	AO/ EO	3.0
NIS – CIDSC	Travel & Migrant Health	Four scientists and one medical/epidemiology consultant	CS AO/ EO	3.0
	TB screen. unit	Team of a consultant, SEO, EO and AO (each 1wte) (pre-entry screening)		<0.5 each
	Respiratory team	Medical/Epidemiology consultant and SEO scientist		0.1 each
	Other teams	Scientists (additional support as and when needed)		
		Deputy Directors (HR and EWRS support out of hours)		OOH
Other teams/depts.		Variable		***

CCDC Consultant in Communicable Disease Control; CHP Consultant in Health Protection

*The HPTs in London and SE estimated 2 consultants per Centre involved in functions related to port health. The remaining HPTs estimated involvement of one consultant per Centre and the SW stated the DDHP as an interim consultant port health lead.

**Data included for whole FW&E network, based on Port Health sample numbers constituting 4% of all FW&E workload, as well as attendance at meetings etc.

***Time too difficult to estimate, but likely only a very small proportion of the departmental resources.

2. Findings: Public health at the border

PHE directorates and local PHE Centres were invited to comment on opportunities to strengthen public health at the border (Appendix C2). The information collected informed discussions of the Steering Group to consider what a great public health service at the border would look like and what services and functions should be provided by PHE at the border.

A number of principles and aims were taken into consideration throughout these discussions. Any future arrangements should:

- Ensure strong leadership and national coordination.
- Improve internal and external communication.
- Foster the development of strategic partnerships and national policy engagement.
- Ensure services of consistent high quality across the country.
- Follow a risk-based approach (common minimum standards with enhanced service provision as needed based on risk) and ensure that arrangements are proportionate to the potential public health risk.
- Have clear accountability and governance arrangements and ensure greater integration of the dedicated port health team based at Heathrow within PHE structures.
- Make most effective use of resources.

Some areas where greater clarity is needed were identified. This include the medical inspector function. It is not clear of this function could be delivered by nursing staff or if there are other organisations who could be responsible for the function. Some people felt that the arrangements for indemnity for some of the functions delivered on behalf of other organisations are not clear.

2.1 A 'great public health service at the border'

There are risks to public health associated with borders and PHE has an important role to protect the health of the population from those risks, but there are also opportunities to improve public health through the port health service, for example through the provision of information and advice.

Many of the functions that PHE needs to deliver at ports are similar to those that PHE needs to deliver in other settings, for example the response to cases and outbreaks of infectious diseases.

However, some elements of Port Health are special and different to business as usual, either because of the setting, the legislative framework, or the relationship with other organisations. Furthermore certain public health services may be delivered indirectly through partner organisations (e.g. Border Force officer trained in risk assessment).

The review identified a set of basic principles to ensure a great public health service at the border (Table 2.1a).

Table 2.1a: Principles of a great public health service (at the border)

1. Visibility and awareness *(external & internal)*	• PHE services known and well recognised by partners and the public. • Good knowledge and understanding of port health function within PHE. • Good understanding (within PHE and externally) of legal principles and partnerships in relation to port health.
2. Integration *(external & internal)*	• Good national integration and coordination of the dedicated port health functions with the rest of PHE • Good communication and relationship building with key external partners. • Clear lines of communication and governance internally within PHE. • Clarity about functions, roles and responsibilities, and how they relate to those of other partners internally and externally (e.g. linking with other government depts.). • Alignment of arrangements with key PHE policies and protocols (e.g. CONOPS and IERP).
3. Strong strategic leadership	• Strong visible leadership and accountability. • Clear sense of purpose and staff that is aware of their responsibilities and is highly motivated to deliver the best service. • Strategic leadership during Public Health Emergencies of International Concern. • Confidence within stakeholders, wider public and government in the public health system. • Public and political reassurance.
4. Comprehensive	• Effective global surveillance and alert function. • Robust surveillance and information management with links to NIS, CRCE and other departments. • Timely, appropriate and proportionate response functions with a clear system for escalation. • Planning and preparedness. • Proactive services including a preventive PH function with general PH messages alongside HP advice.

	• Commercial function (e.g. issuing certificates about microbiological quality). • Trans-border activities, e.g. pre-entry TB screening and refugee programme. • Smooth operation of ports and mitigation of adverse health related impacts on travel and trade.
5. Consistency and common standards	• Proportionate services underpinned by protocols and guidance. • National standards and guidance. • Clear escalation procedures. • Systematic in response. • Robust quality and governance arrangements.
6. Effective legislative framework	• Meeting and using the legislative framework effectively and efficiently to protect and improve health. • Effective delivery of statutory functions and using powers appropriately.
7. International engagement and obligation	• International commitments as a signatory of the IHRs. • IHR obligation – development of appropriate UK standards (e.g. ship sanitation certificates, DPEs, Exit/boarding controls). • Trans-border collaboration (WHO PAGNET, CAPSCA, SHIPSAN, AIRSAN) • Positive international partnerships and interaction, and best international practice.
8. Quality-focused and evidence-based research active	• Active participation in quality and clinical governance through the 'One-PHE' Quality Model. • Continual quality monitoring and improvement, raising standards. • PHE services evidence based and research active. • Efficient, maximising available resources. • Training programmes. • Learning from others.

2.2 Description of PHE functions and services going forward

The review has identified a set of Public Health services and functions to be delivered by PHE at the border (Table 2.2a). These have been categorised by proposed model of service delivery:

- Services / functions that should be provided once for the whole country in a centralised manner.
- Services / functions that should be provided locally in a consistent manner and to common standards in all areas.

- Services / functions that may vary across areas because they can be delivered at local discretion or based on risk assessment or because they are commercial functions.

Services will be proportionate to need and public health risk making most effective use of available resources. A risk stratification tool has been developed (Appendix D) to ensure this.

Table 2.2a: Public Health services and functions provided by PHE (at the border)

Model of service delivery	List of services/functions provided	Arrangements to support delivery
National port health role		
Services / functions provided once for the whole country (national functions of leadership and coordination)	Strategic coordination of PHE port health work including: - Implementation of policies; e.g. health register for major incidents, disinfection / infection control - Participation in PHE Quality Model, quality improvement plan and engagement with adverse incident reporting and management - Coordination of sharing best practice and lessons learnt - Coordination of Port Health activity in incident response and PHEICs (e.g. large contact tracing exercises)	National border health network group with clear leadership (Port Health Core management group) and accountability/governance arrangements. Through national Port Health Team E.g. Post incident debriefs; National away day or newsletter Through Strategic and Incident Director. Through FES
	Establishment of standards and provision of training including: - Development of PHE guidance and templates in relation to port health - HCID related work on standards and protocols - Development of preventive materials, PH messages and health guides - Hazards guidance for Port Health, incl. non-infectious disease threats	E.g. SharePoint site
	National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH)	
	Advisory function: - Advice to DH - Advice on SSCs and DPEs	
Centralised dedicated port health role		
Services / functions provided once for the whole country (operational functions	Delivery of front-line activities at Heathrow and Gatwick including:	Medical Inspector function with clear JD and clear lines of sight for clinical governance and quality. Engagement with medical and nursing/midwifery

delivered by the dedicated port health team or NIS on behalf of all local areas)		- First-line HP response at Heathrow/Gatwick - Advisory and liaison functions at Heathrow/Gatwick - PMI delivery (in person at Heathrow/Gatwick and by phone to rest of country)	revalidation.
		Trans-border activities: - Pre-entry TB screening - Immigration and refugee programme	
		National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH)	
		Negotiation of local arrangements with ports re. airside passes and airside room	National agreements with external organisations to facilitate this (e.g. HO, DfT and CAA)
		International collaboration and port related IHR obligations	IHR National Focal Point (NFP) Involvement of Port Health Team, DH, etc. Links with Global Health
		Global surveillance and alerting systems	NIS-TMH Emerging diseases and Zoonosis Links with WHO/ ECDC; Ref Micro/ virology
Dispersed port health roles			
Services / functions provided in a consistent manner and to common standards in all areas		Acute PH response including: - Response to notifications of cases or outbreaks of infectious diseases, chemical and other incidents and hazards - Contribution to UK response to Public Health Emergencies of International Concern	Part of local liaison groups? Familiarisation sessions for staff providing acute response and for on-call staff
		Planning and preparedness including: - Development of local Port Health Response Plans proportionate to risk - Emergency planning and preparedness working with key stakeholders	Consistent with national standards and plans/templates. One per centre with specific appendices. LRF, Emergency Planning exercises
		Delivery of statutory functions and duties of medical officer (joint PHE/LA responsibility)	Arrangements with LAs Nominated Port Health Lead, PMO(s)
Services / functions that may vary across areas, i.e.	**Delivered flexibly at local discretion**	Provision of training and education of external professionals	Supported by national training materials.
		(Co-)organisation of Emergency Planning exercises at ports	Supported nationally through IHR responsibilities and integrated with national multi-port coordination exercises. Local Resilience Forums.
		(Co-)organisation of local multi-agency Port Health Liaison meetings	
	Delivered	Specialist advice to chemical and radiation	Through CRCE.

	according to risk	events	Following PHE's risk register process. Nominated risk lead.
		Microbiological examination of food and animal feed samples	Done on behalf of others
		Assistance with / training or advice on microbiological sampling on-board	
		Other locally agreed HP functions and responsibilities (e.g. Animal Reception Centre, Advice on health of Immigrants)	
	Delivered commercially	Courier collection of food and animal feed samples and transport to the FW&E laboratories	
		Provision of formal certificates and witness statements to inform about food microbiological quality	
		Production of microbiological test results to support issue of Ship Sanitation Certificates	

2.3 Relationship with other organisations/stakeholders

Strong and positive partnerships and interactions are crucial to the delivery of the great public health service at the border. A review of stakeholder engagement (Appendix E) identified how PHE currently engages with stakeholders. This work was conducted at the outset of the review and key partners in the delivery of port health functions were identified by the respondents (Table 2.3a).

Table 2.3a: Key partners in the delivery of port health functions (as identified in the internal consultation)

	Responding PHE departments					
Stakeholders identified	**Port Health team**	**Centres & HPTs**	**NIS**	**FW&E Micro Services**	**CRCE**	**HPMD (MDD)**
HPTs	X		X	X	X	
CRCE		X				
PHE other depts.	X[1]	X[4]	X[6]			X[11]
Port Health Authorities		X	X	X	X	
Local authorities	X	X		X	X	
DoH	X		X			
DoT	X		X			
DFiD			X			
Home Office	X		X			
Border Force	X	X				
Ambulance service(s)	X	X				
Hospital(s)		X				
CCGs / NHSE		X				
Police		X				
Fire Service(s)		X				
Airport(s) / Seaport(s)	X[2]	X				
Airlines	X	X				
Civil Aviation Authority	X					
Environment Agency					X	

FSA				X		
DEFRA			X	X		
Other organisations	X[3]	X[5]	X[7]	X[9]	X[10]	X[12]
Other countries/ governments	X		X			
WHO EURO / ECDC			X			
Other intl. organisations			X[8]			

[1]PHE respiratory disease section
[2]Heathrow Airports Limited
[3]Devolved Health Administrations
[4]EPPR
[5]City of London Corporation
[6]Travel and Migrant Health team, Communication dpt., Emergency response dpt., PHE International office
[7]NaTHNaC
[8]International Organization for Migration, International Panel Physicians Association, Overseas panel physicians
[9]Ship owners/Food importers, Association of Port Health Authorities, EU Shipsan
[10]Maritime and Coastguard Agency
[11]HR, Associate CGs in PHE, Office for Data Release; Confidentiality Advisory Group, Head of Quality & Clinical Governance; other quality leads and quality component leads in PHE; in L3+ strategic incident response: incident director(s), incident manager(s) and other cell leads
[12]GMC, NMC, external software support provider

Consultation with external stakeholders

Key external partners and stakeholders such as DH, DfT, Home Office, NHS England and relevant CCGs, Cabinet Office Civil Contingencies, LA representatives, CAA, were kept informed and engaged with the review. Feedback and/or contributions were received from the following partners:

- Siôn Lingard – Health Protection Team, Wales
- Dr Gerry Waldron – Public Health Agency, Mary Carey PHA Emergency Planning Lead and Nigel McMahon, Northern Ireland's Chief Environmental Health Officer
- Dr Nigel Dowdall - Head of Aviation Health Unit - CAA Safety and Airspace Regulation Group
- Alan Massey – Chief Executive – Maritime & Coastguard Agency
- Gary Gould - The Association of Port Health Authorities

The following key themes were identified:

- Desire for the development of stronger more proactive strategic relationship between PHE and key national stakeholders
- Need for greater clarity of public health functions at the border and to increase awareness of the role of PHE.
- Need to improve communications and flows of information
- Some stakeholders were keen for PHE to have a more proactive approach for example in the provision of information and advice

3. Recommendations: Strengthening public health at the border

The following section describes key themes identified in the review and recommendations for strengthening public health at the border. It also outlines the recommended operating model and future organisational and governance arrangements.

3.1 Key themes identified and recommendations

1) Establishment of clear line management and governance arrangements[7] for the border health function and all the constituent parts within PHE

a) Communicate that "border health" at PHE has two main elements – local services that are led through PHE Centres/PHE London and national services that are led by National Infection Service.
b) Ensure that PHE Centres know about all ports within their geography and have an appropriate relationship with those ports and have an appropriate relationship with relevant local partners with a designed local lead responsible for border health accountable through the Deputy Director of Health Protection.
c) Ensure that each PHE team working on any issues that may relate to public health at the border has a designated "border health" lead. For example this will include Food, Water and Environment Laboratories in NIS, Emergency Response Division, Health Improvement Directorate etc.
d) Establish a nationwide specialist "border health" function within current resources managerially accountable through NIS (Field Services).
e) Create a Border Health Network with a prime role in improving communication and co-ordination between all parts of PHE engaged in border health (for all designated local leads, the national teams "border health" leads and the nation-wide "border health specialist function).

Overall action: Led by Deputy Chief Executive.

[7] See Section 3.2 for description of the proposed accountability arrangements.

2) Clarification of specific issues identified by the review about PHE's role in Border Health in relation to other agencies

a) Produce a simple description (or graphic) for external partners to describe PHE's role.
b) Identify a named individual to be the key national contact point with the key national partners (Border Force, Department of Health and others). This would be the Lead for Border Health or a nominated deputy.
c) Consult the Department of Health on the extent of the responsibilities of PHE in relation to the Medical Officer role under the Public Health (Aircraft) Regulations 1979 and the Public Health (Ships) Regulations 1979 and confirm that PHE's current model for providing the Port Medical Inspector service is appropriate.

d) Confirm with the Department of Health whether PHE should have Trader Provider status at airports.
e) Present to the new "UK wide" public health group chaired by Professor Richard Parish to agree a consistent approach across the UK and mechanisms for future collaboration.

Overall action: Led by Deputy Chief Executive.

3) Creation and communication of a "border health" Operating Model to describe the detail of the internal and external arrangements set out above

a) Ensure governance arrangements are clearly described that deliver 'clear line of sight' for clinical and corporate accountability.
b) Ensure indemnity arrangements are clearly described.

Overall action: Led by Border Health specialist function but involving all parties within the Board Health Network.

4) Development of the operational aspects of PHE's work with ports on public health

c) PHE to explore options for promoting public health education messages and campaigns (e.g. travel vaccine, staying safe abroad advice, air/noise pollution) in the (air)port environment with a task and finish group involving

NIS (Travel and Migrant health, NaTHNaC), the Health Improvement and Marketing directorates developing a specification of the PHE offer in this area.

d) PHE to work with DfT to facilitate access to air side (air side passes) for PHE staff as and when required. This would most likely require a national agreement and guidance for airport operators to avoid delays in public health emergencies.
e) PHE to strengthen arrangements for information sharing key partners, for example through information sharing agreements (e.g. between PHE and airlines) to facilitate emergency response.

Overall action: Led by Border Health Lead.

5) Ensuring that Border Health is fully integrated into PHE's EPRR work

a) Commission a review of the evidence of the effectiveness of a range of large scale "border" responses from the HPRUs on Evaluation of Interventions and / or Emergency Response
b) Once this review and the work on High Consequence Infections are completed, to include the needs of ports of entry into a revision of the National Incident and Emergency Plan with a specific element of how PHE will respond to the need to develop different levels of a nation-wide "public health response" at the border.
c) All PHE Centres to engage with the Local Health Resilience Partnerships (LHRPs) to ensure response to a threat to the public's health at their local ports have been appropriately included in local plans. A local plan with action cards for the multi-agency response may be developed.
d) Future EPRR exercises to include port health responses and frequency of testing should be a standard within the new standards framework.

Overall action: Led by EPRR Director with the Border Health Lead and support from all parts of PHE that provide services at the border.

6) Putting in place actions in line with one-PHE Quality Model to improve the quality of PHE's border health functions

a) Establish standards for the delivery of public health local border health work which is based on a proportionate and risk-based approach and is consistent with the Local Health Protection Development Programme.
b) Develop a core training plan for any staff in PHE working at the border.

c) Once the new arrangements have be operational for 6 months, undertake an audit of public health at the border on PHE's work and how we engage with other agency responsibilities.
d) Engage fully with the delivery of PHE's Quality Model through a defined Quality Lead and engagement in quality planning. Engage with PHE's risk management processes through the development of appropriate and integrated risk registers at operational and tactical levels

Overall action: Led by Chair of the Border Health Network.

3.2 Operating model and organisational arrangements

The review identified a need to strengthen public health at the border (rather than just consider port health functions), to strengthen leadership and coordination including strategic relationships with partners, and to ensure a more consistent delivery of high quality services at local level. The review also identified the need to ensure better integration of the Port Health team based at Heathrow with the rest of PHE.

A SWOT analysis (Appendix F) identified a form of "hub and spoke" model as the most appropriate for the delivery of public health functions at the border. This model recognises the need for strong national leadership and coordination but that the plans and arrangements for each port would be based on a risk assessment but all ports need a consistent first line response. Recognising that not all ports are the same, a risk-based approach with common minimum standards that apply in all areas supplemented with enhanced services where needed based on risk is recommended.

At present, the current port health team at Heathrow delivers some national functions (but not all the leadership and coordination functions identified as essential in the review), some centralised operational functions on behalf of the rest of the country and local border health functions for Heathrow and Gatwick. Greater distinction of these separate functions with clarity about governance arrangements would help achieve the aims of strengthening leadership and coordination across all PHE teams contributing to the delivery of public health services at the border and achieve greater standardisation of local service provision while allowing a risk-based approach.

National leadership and coordination functions (hub):

The 'hub' will ensure strong leadership and coordination of the delivery of public health services at the border. The following arrangements are recommended:

- Establishment of a National Lead for Border Health consultant in public health post to provide leadership, coordination of the work of PHE in this area and lead the development of strategic relationships with partners. This post would be hosted by a PHE national Directorate (see below) to ensure clear arrangements for quality, governance and risk management and provide the necessary assurance to PHE's Advisory Board.
- An operational manager will support the National Lead in the delivery of national functions (approximately 0.25wte to be confirmed when further assessment is undertaken) and report to the National Lead for these national responsibilities and manage the Heathrow Port Health Team (approximately 0.75wte to be confirmed when further assessment is undertaken) delivering the local functions for Heathrow and Gatwick Airports and reporting on these to the Deputy Director for Health Protection for London.
- A number of options below were considered for accountability of the national leadership and coordination function. These included:

  - PHE London integrated Centre and Region Director or Deputy Director for Health Protection
  - NIS Deputy Director Field Service
  - NIS Deputy Director ERGIT
  - NIS Operating Officer
  - Medical Director and Director of Health Protection
  - A Lead Regional Director or Centre Director

  Following the review, the options appraisal, the preferred recommended option for hosting the the national leadership and coordination function to be hosted by the National Infection Service (Field Service).

Distributed functions and services (spokes):

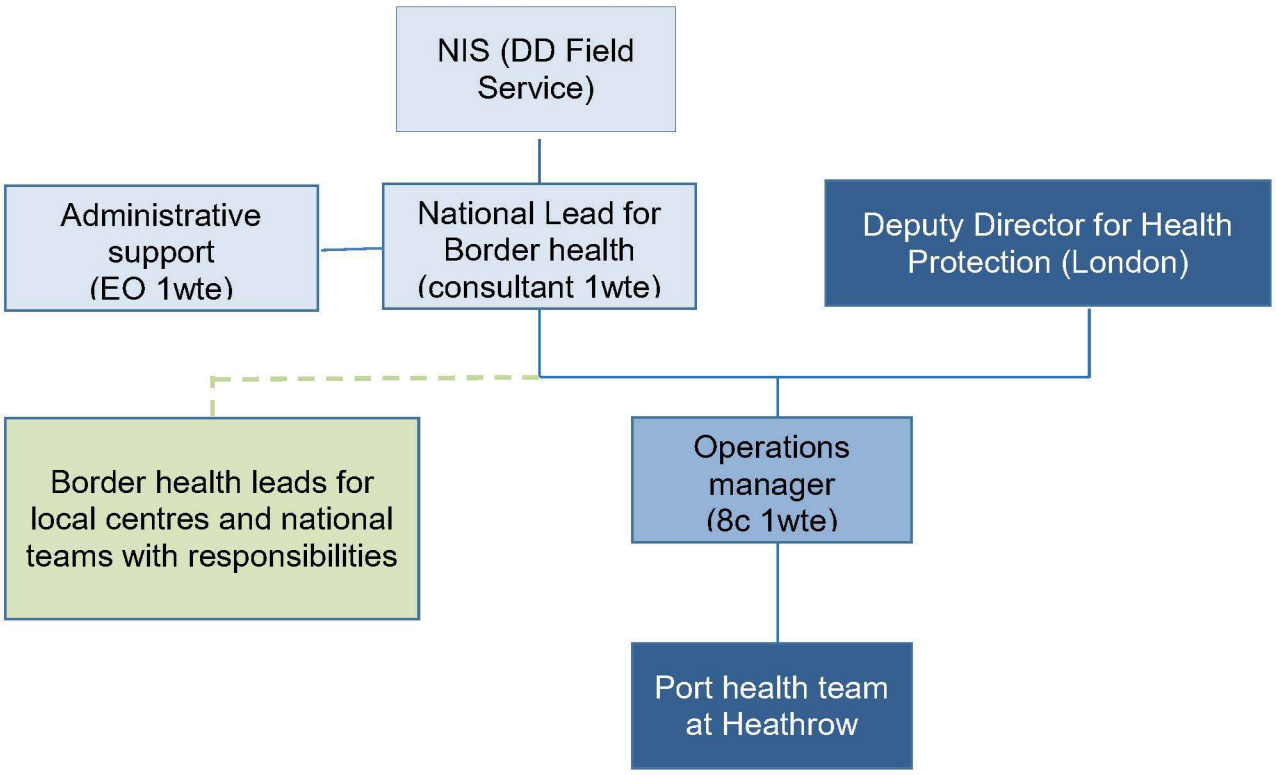
Teams across PHE will continue to contribute to the delivery of public health services at the border.

The establishment of the following arrangements is recommended:

- Each team with border health responsibilities (for example PHE local centres, NIS ERGIT, NIS Field Service, CRCE, Health Improvement Directorate, NIS Laboratories) will have a designated lead for border health identified from within their current establishment.
- PHE centres should operate to common arrangements and minimum standards with a designated border health local lead in each centre (identified from within their current establishment) with a common and agreed description of the role.

- Accountability for these border health leads will be through line management routes but with close working relationship with the National Lead for Border Health.
- Establishment of a Border Health Network chaired by the National Lead for Border Health that brings together the hub and spokes. Guidance and an annual programme of work will be developed through the network and signed off through managerial routes.

Figure 3.2a: Proposed future border public health organisational structure



Financial implications:

The proposed new model requires a new appointment for medical consultant, including on costs (£114,556) and administrative support at EO level (R&D ceiling at national rate including on costs - £30,568 (£35,450 if within London)).

It is proposed that the resources will be identified from the current Port Health Team budget but transitional funding for 6-12 months will be required.

4. Plan for implementation of recommendations

This report will be submitted for consideration by the PHE Management Committee on Tuesday 5th December 2017.

Following this a plan will be developed to implement the recommendations. for the clear priority is the appointment of the new National Lead for Border Health, since some of the recommendations cannot be taken forward until this post and the work of the new Border Health network have been established

The implementation plan will include the following components:

1. Implementation of the new national leadership functions. Lead to be confirmed.
    - Establishment of the National lead for Border Health post.
    - Clarification of other capacity and resources required to support this work including the role of the operational manager and administrative support.
    - Establishment of clear governance and risk management arrangements.
    - Establishment of the Border Health network.

2. Strengthening the role of PHE centres in Border Health and ensure arrangements of consistent high quality. Programme of work to be led by Centres and regions working with the National Lead once in post.

3. Strengthening of EPRR arrangements. To be led by the national lead working with the PHE EPRR director and the Border health network.

4. Implementation of other recommendations including strengthening internal and external communications. To be led by the National Lead once in post working with the network.

5. Appendices

5.1 Appendix A – Terms of reference for Port Health Review Steering Group

1. PURPOSE

This document describes the terms of reference for the steering group of the PHE review of Port Health functions 2016/2017. This group is the forum that provides direction and supports the delivery of the project by informing the various tasks outlined in the PID.

2. MEMBERSHIP

Richard Gleave, SRO
Isabel Oliver, Project Lead
Name Redacted Project Manager
Representatives from the Port Health Team: Name Redacted and Nicol Black
Lead for the HCID programme port health group, Graham Bickler
Lead for the NIS Programme, Mark Driver
Representative from centre Directors, Meng Khaw
Lead for Overseas territories, Jenny Harries
Representative of Deputy Directors of HP, Deborah Turbitt, plus a deputy Name Redacted
Representative from the Travel and Migrant Health team, TBC
Director of Health Protection and Medical Director or a deputy, Paul Cosford and Paul Sutton
NIS representative, Katherine Russell
FW&E representative, Caroline Willis
FES representative, James Sedgwick
CRCE representative Name Redacted
EPRR representative, Ruth Milton
Public Health Strategy/Clinical governance, Imogen Stephens
HR Representative, NR deputy Name Redacted and Name Redacted
Finance representative, Name Redacted
Project Support, Name Redacted and Name Redacted

3. SCOPE

The group will oversee the review of Port Health functions of PHE and support and enable the delivery of the following tasks:

- Review of port health services including a description of services currently provided and a description of the legislative framework

- Outline PHE's aspirations for public health at the border
- Consider options for the delivery of public health services at the border
- Consultation with internal and external stakeholders including meetings with key stakeholders
- Development of a plan for implementation of the recommendations

4. PROPOSED PROCESS

- The group will be a task and finish one and will meet monthly from December 2016 through to June 2017
- The secretariat will be provided by **Name Redacted**
- The secretariat will produce a summary note of each meeting, including a record of attendance, decisions and actions. These will be circulated to all members and attendees within two working days following the meeting.
- The group will draw on expertise from across PHE as needed.

5. ACCOUNTABILITY

- This group reports to the Deputy Chief Executive/Chief Operating Officer of PHE, SRO for the project. He will ensure that the PHE Senior Leadership Group is appropriately briefed and engaged in the way forward. If necessary this will include formal proposals to the Chief Executive or one of the key corporate committees within PHE.

6. OTHER

Business of the group– proposed timetable

1st meeting (January / February 2017)

- Agree ToR and PID
- Discuss current service provision and agree templates for reports on current service provision
- Discuss summary of legal context

2nd meeting (February / March 2017)

- Discuss the reports on current service provision
- Discuss vision / ambitions for future service delivery

3rd meeting (March / April 2017)

- Finalise discussions on review
- Agree an agenda for the workshop

Workshop (May 2017)

4th meeting (June 2017)

- Discuss outcomes of the workshop
- Discuss recommendations

5th meeting (July 2017)

- Discuss action plan

Public Health England

Port Health Review Steering Group
Agenda

Meeting title: **Port Health Review Steering Group Meeting**

Date & time: **January 2017**

Location:

Members:

- **Richard Gleave, SRO**
- **Isabel Oliver, Project Lead**
- **Name Redacted, Project Manager**
- **Representatives from the Port Health Team: Name Redacted and**
- **Lead for the HCID programme post health group, Graham Bickler**
- **Lead for the NIS Programme, Mark Driver**
- **Representative from centre Directors, Meng Khaw**
- **Representative of Deputy Directors of HP, TBC**
- **Representative from the Travel and Mirant health team, TBC**
- **Director of Health protection and Medical Director or a deputy**
- **NIS representative, TBC**
- **CRCE representative, TBC**
- **Name Redacted** (notes)

In attendance:

-

Apologies:

-

		Item	Lead	Paper
	1.	Welcome and Introduction	Name Redacted	
	2.	Background and Terms of reference		1.1
	3.	PID		1.2
	4.	Description of current functions		
	5.			
		a)		
		b)		
		c)		
	6.	Summary of action and close		

DIAL IN DETAILS: Telephone: Participant Code:

5.2 Appendix B – Summary of legislation

Health Protection Powers and Duties

Legislation	Powers
Public Health (Control of Disease) Act 1984	**1) Local Authority Powers and duties**
s. 45G, Part 2A Power to order health measures in relation to persons.	A local authority[8] may apply to the court for an order imposing health measures in relation to a person (P). A justice of the peace may make an order in relation to a person (P) if the justice is satisfied that – a) P is or may be infected or contaminated, b) the infection or contamination is one which presents or could present significant harm to human health, c) there is a risk that P might infect or contaminate others, and d) it is necessary to make the order in order to remove or reduce that risk. An order may impose on or in relation to a person one or more of the following restrictions or requirements – a) that P submit to medical examination[9]; b) that P be removed to a hospital or other suitable establishment; c) that P be detained in a hospital or other suitable establishment; d) that P be kept in isolation or quarantine; e) that P be disinfected or decontaminated; f) that P wear protective clothing; g) that P provide information or answer questions about P's health or other circumstances; h) that P's health be monitored and the results reported; i) that P attend training or advice sessions on how to reduce the risk of infecting or contaminating others; j) that P be subject to restrictions on where P goes or with whom P has contact; k) that P abstain from working or trading. A court may also make an order imposing on or in relation to P a requirement that P provide information or answer questions about P's health or other circumstances (including the identity of related parties: a person who may have infected P, or, a person whom P may have infected). (6) An order may also require a person with parental responsibility for P, to secure that P submits to or complies with the restrictions or requirements imposed by the order.
s. 45H Power to order health measures in relation to things	(1) A justice of the peace may make an order in relation to a thing[10] if the justice is satisfied that – a) the thing is or may be infected or contaminated, b) the infection or contamination is one which presents or could present significant harm to human health, c) there is a risk that the thing might infect or contaminate humans, and d) it is necessary to make the order in order to remove or reduce that risk. (2) The order may impose in relation to the thing one or more of the following restrictions or requirements – a) that the thing be seized or retained; b) that the thing be kept in isolation or quarantine; c) that the thing be disinfected or decontaminated; d) in the case of a dead body, that the body be buried or cremated; e) in any other case, that the thing be destroyed or disposed of.

[8] A "local authority" means – a district council; in England, a county council for an area for which there is no district council; in Wales, a county council or county borough council; a London borough council; the Common Council of the City of London; the Sub-Treasurer of the Inner Temple and the Under Treasurer of the Middle Temple; the Council of the Isles of Scilly (s.1(1)).
[9] "Medical examination" includes microbiological, radiological and toxicological tests (s.45T(3)).
[10] This includes human tissue, a dead body or human remains, animals, and plant material (s.45T(5)).

	(4) The order may require the owner of the thing, or, any person who has or has had custody or control of the thing, to provide information or answer questions about the thing (including where the thing has been or about the identity of any related persons or the whereabouts of any related thing.) (5) Related person means a person who has or may have infected by the thing or a person whom the thing has or may have infected. (6) Related thing means a thing which has or may have infected the thing, or, a thing which the thing has or may have infected.
s. 45I Power to order health measures in relation to premises	(1) A justice of the peace may make an order in relation to premises if the justice is satisfied that – a) the premises are or may be infected or contaminated, b) the infection or contamination is one which presents or could present significant harm to human health, c) there is a risk that the premises might infect or contaminate humans, and d) it is necessary to make the order in order to remove or reduce that risk. (2) The order may impose in relation to the premises one or more of the following restrictions or requirements – a) that the premises be closed; b) that, in the case of a conveyance or a movable structure, they be detained; c) that the premises be disinfected; d) that, in the case of a building, conveyance or structure, the premises be destroyed. (3) A justice of the peace may make an order in relation to premises if the justice is satisfied that – a) the premises are or may be infected or contaminated, or are or may be a place where infection or contamination was spread between persons or things, b) the infection or contamination is one which presents or could present significant harm to human health, c) there is a risk that the premises might infect or contaminate humans, and d) it is necessary to make the order in order to remove or reduce that risk. (4) The order may require the owner or any occupier of the premises to provide information or answer questions about the premises (including, information about the identity of any related person or the whereabouts of any related thing.) (5) Related person means a person who has or may have infected the premises, a person who has or may have infected a person who or thing which is or has been on the premises, a person whom the premises have or may have infected, or, a person who has or may have been infected by a person who or thing which is or has been on the premises. (6) Related thing means a thing which has or may have infected or contaminated the premises, a thing which has or may have contaminated a person or thing which is or has been on the premises, a thing which the premises have or may have infected, or a thing which has or may have been infected by a person who or thing which is or has been on the premises.
s. 45J Orders in respect of groups	(1) The powers in sections 45G, 45H and 45I include power to make an order in relation to a group of persons, things, or premises.
ss.45K-45M & 45O	These sections contain additional provision about Part 2A Orders, in particular about procedural matters and offences.
s.46 Burial and cremation	A local authority is under a duty to cause to be buried or cremated the body of any person who has died or been found dead in their area, in any case where it appears to the authority that no suitable arrangements for the disposal of the body have been made or are being made.

s.48 Removal of body to a mortuary for immediate burial	A proper officer[11] of a local authority for the district in which a dead body lies, may certify to a justice of the peace that the retention of the body in any place would endanger the health of any person. If satisfied with this, the JP may order the body be removed by (and at the cost of) the LA to a mortuary, and that the necessary steps be taken to secure that it is buried either immediately or within a specified period of time.
s.61[12] Power to enter premises	Subject to section 61, any proper officer of a local authority[13] must, on producing an authenticated document showing the officer's authority, has the right to enter premises at all reasonable hours- (a) for the purposes of ascertaining whether there is, or has been, any contravention of a relevant provision of this Act, or of an order made by a justice of the peace under Part 2A of this Act, which it is the function of the local authority to enforce, (b) for the purpose of ascertaining whether or not circumstances exist which would authorise or require the local authority to take any action, or execute any work, under such a provision or in relation to such an order, (c) for the purpose of taking any action, or executing any work, authorised or required by such a provision or in relation to such an order, or by any order made under such a provision, to be taken, or executed, by the local authority, or (d) generally, for the purpose of the performance by the local authority of their functions under such a provision or in relation to such an order.
	2) Secretary of State powers
s.13 Regulations for control of certain diseases	The SoS may make regulations (as respects the whole or any part of England and Wales) (a) with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases, (b) for preventing danger to public health from vessels or aircraft arriving at any place, and (c) for preventing the spread of infection by means of any vessel or aircraft leaving any place, so far as may be necessary or expedient for the purpose of carrying out any treaty, convention, arrangement or engagement with any other country. Etc.
s.14 Application of s.13 to aerodromes	The SoS has s.13 powers in relation to aerodromes under his control.
s.45B[14] Health protection regulations: international travel etc.	The appropriate Minister[15] may make regulations: (a) for preventing danger to public health from vessels, aircraft, trains or other conveyances arriving at any place, (b) for preventing the spread of infection or contamination by means of any vessel, aircraft, train or other conveyance leaving any place, and (c) for giving effect to any international agreement or arrangement relating to the spread of infection or contamination. Such regulations may include provision: (a) for the detention of conveyances, (b) for the medical examination, detention, isolation or quarantine of persons, (c) for the inspection, analysis, retention, isolation, quarantine or destruction of things, (d) for the disinfection or decontamination of conveyances, persons or things or the application of other sanitary measures, (e) for prohibiting or regulating the arrival or departure of conveyances and the entry or exit of persons or things,

[11] "proper officer" means, in relation to a purpose and to an authority, an officer appointed for that purpose by the authority (s.74).
[12] See also s.62: supplementary provisions as to entry, and ss.63-69 concerning offences, prosecutions and protection from liability.
[13] Note that the legislation refers to the "relevant health protection authority" but s.74 clarifies that this means a local authority with functions under a relevant provision of the Act.
[14] Regulations under s.45B may not include provision requiring a person to undergo medical treatment (including vaccination and other prophylactic treatment) (s.45E)). They may create offences, appeal processes etc and may amend enactments in order to give effect to an international agreement or arrangement (s.45F).
[15] The "appropriate Minister" means, the SoS as respects England and the Welsh Ministers, as respects Wales.

	(f) imposing duties on masters, pilots, train managers and other persons on board conveyances and on owners and managers of ports, airports and other points of entry, and (g) requiring persons to provide information or answer questions (including information or questions relating to their health). Health protection regulations may confer functions on local authorities and other persons (s.45F).
s.45C[16] Health protection regulations: domestic	The appropriate Minister may make regulations for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales (whether from risks originating there or elsewhere). Such regulations may, in particular, make provision: (a) imposing duties on registered medical practitioners or other persons to record and notify cases or suspected cases of infection or contamination, (b) conferring on local authorities or other persons functions in relation to the monitoring of public health risks, and (c) imposing or enabling the imposition of restrictions or requirements on or in relation to persons, things or premises in the event of, or in response to, a threat to public health. The restrictions or requirements mentioned in subsection (3)(c) include in particular– (a) a requirement that a child is to be kept away from school, (b) a prohibition or restriction relating to the holding of an event or gathering, (c) a restriction or requirement relating to the handling, transport, burial or cremation of dead bodies or the handling, transport or disposal of human remains, and (d) a special restriction or requirement[17]. Health protection regulations may confer functions on local authorities and other persons (s.45F).
s.45N Power to make further provision by regulations about the taking of measures pursuant to Part 2A orders	The appropriate Minister may make regulations about the taking of measures pursuant to Part 2A orders, in particular – (a) the type of investigation which may be carried out as part of a medical examination; (b) the manner in which measures are to be taken; (c) who is to be responsible for executing and enforcing measures; (d) who is to be liable for the costs of measures; (e) the payment of compensation or expenses in connection with the taking of measures.
s.47 Regulations about dead bodies	The SoS may make regulations imposing certain conditions and restrictions about dead bodies which may appear to be desirable in the interests of public health or public safety.
The Health Protection (Local Authority Powers) Regulations 2010	
Reg. 2 Requirement to keep a child away from school	(2) The local authority may by serving notice on C's parent (PT) require that PT keep C away from school. (1) This regulation applies where a local authority is satisfied in relation to a child that – a) C is or may be infected or contaminated; b) the infection or contamination is one which presents or could present significant harm to human health; c) there is a risk that C might infect or contaminate others; d) it is necessary to keep C away from school in order to remove or reduce that risk; and e) keeping C away from school is a proportionate response to the risk to others presented by C. (3) The notice must include the following information – a) the date from which the requirement commences; b) the duration of the requirement (max. 28 days); c) why the requirements is believed to be a necessary and proportionate measure;

[16] There are tight restrictions on the power to make regulations under s.45C. These restrictions are specified in s.45D. Regulations under s.45C may also not include provision requiring a person to undergo medical treatment (including vaccination and other prophylactic treatment) (s.45E). They may create offences, appeal processes etc and may amend enactments in order to give effect to an international agreement or arrangement (s.45F).
[17] This means a restriction or requirement which can be imposed by a justice of the peace by virtue of s.45G(2), s.45H(2) or 45I(2) (subject to the exceptions in s.45C(6)(b))

	d) the penalty for failing to comply with the notice; and e) contact details for an officer of the local authority who is able to discuss the notice. (4) The local authority must as soon as reasonably practicable after serving notice inform the headteacher of C's school that it has served such a notice in relation to C and of the contents of that notice. (5) PT may request that the local authority review the notice at any time before the requirement lapses. (6) The local authority must review the notice within 5 working days where PT is requesting a review in respect of that notice for the first time or may review the notice in the case of all other requests. (9) The local authority must as soon as reasonably practicable after varying or revoking the notice inform PT and the headteacher that the notice has been varied or revoked, and if varied, the nature of the variation. (10) A local authority may serve consecutive notices. (11) A local authority must inform PT and the headteacher as soon as reasonably practicable where a notice has expired and no further notice is to be served.
Reg. 3 Requirement to provide details of children attending school	(1) A local authority may by serving notice on a headteacher of a school require that headteacher to provide it with a list of the names, addresses and contact telephones numbers for all the pupils of that school, or such group attending that school as it may specify. (2) The condition is that the local authority is satisfied that – a) a person (P) who is or has recently been on the school's premises is or may be infected or contaminated; b) the infection or contamination is one which presents or could present significant harm to human health; c) there is a risk that P may have infected or contaminated pupils at the school; d) it is necessary for the local authority to have the list in order to contact those pupils with a view to ascertaining whether they are or may be infected or contaminated; and e) requiring the list is a proportionate response to the risk presented by P. (3) The notice must – a) specify a time limit for meeting the requirement; b) specify an address where the list is to be sent; provide contact details for an officer of the local authority who is able to discuss the notice.
Reg. 8 Requests for co-operation for health protection purposes	(1) The local authority may by serving notice on any person or group of persons request that the person or group of persons do, or refrain from doing, anything for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents or could present significant harm to human health. (2) The local authority must provide contact details for an officer of the local authority who is able to discuss the notice. (3) The local authority may offer compensation or expenses in connection with its request.
The Health Protection (Notification) Regulations 2010	
Reg. 2 Duty to notify suspected disease, infection or contamination in patients	(1) A registered medical practitioner (R) must notify the proper officer of the relevant local authority where R has reasonable grounds for suspecting that P whom R is attending - a) has a notifiable disease; b) has an infection which, in the view of R, presents or could present significant harm to human health; or c) is contaminated in a manner which, in the view of R, presents or could present significant harm to human health. (2) The notification must include the following information insofar as it is known to R –

	a) P's name, date of birth and sex; b) P's home address including postcode; c) P's current residence; d) P's telephone number; e) P's NHS numbers; f) P's occupation (if relevant); g) The name, address and postcode of P's place of work or education; h) P's relevant overseas travel history; i) P's ethnicity; j) Contact details for a parent of P (where P is a C); k) The disease or infection which P has or is suspected of having or the nature of P's contamination or suspected contamination; l) The date of onset of P's symptoms; m) The date of P's diagnosis; n) R's name, address and telephone number. (3) The notification must be provided in writing within 3 days beginning with the day on which R forms a suspicion. (4) If R considers that the case is urgent, notification must be provided orally as soon as reasonably practicable. (5) In determining whether the case is urgent, R must have regard to – a) the nature of the suspected disease, infection or contamination; b) the ease of spread of that disease; c) the ways in which the spread of that disease can be prevented or controlled; d) P's circumstances (including age, sex and occupation).
Reg. 4 Duty to notify causative agents found in human samples	(1) The operator of a diagnostic laboratory must notify Public Health England where the diagnostic laboratory identifies a causative agent in a human sample. (2) The notification must include the following information insofar as it is known to the operator of the diagnostic laboratory – a) name and address of the laboratory; b) details of the causative agent identified; c) date of the sample; d) name of person (P) from whom the sample was taken; e) P's date of birth and sex; f) P's current address including postcode; g) P's current residence; h) P's ethnicity; i) P's NHS number; and j) The name, address and organisation of the person who solicited the test which identified the causative agent. (3) The notification must be provided in writing within 7 days beginning with the day on which the causative agent is identified. (4) If the operator of the laboratory considers that the case is urgent, notification must be provided orally as soon as reasonably practicable. (5) In determining whether the case is urgent, the operator must have regard to – a) the nature of the causative agent; b) the nature of the disease the causative agent causes; c) the ease of spread of the causative agent; d) the ways in which the spread of the causative agent can be prevented or controlled; and where known, P's circumstances (including age, sex and occupation).
Reg. 5 Duty to provide information to Public Health England.	(1) This regulation applies where a notification has been made by the operator of a diagnostic laboratory to Public Health England under regulation 4. (2) PHE may request that the person who solicited the laboratory test which identified the causative agent, to which the notification relates, provide to it the information listed at regulation

	4(2) insofar as that information was not included in the notification. (3) R must provide the information requested under paragraph (2) insofar as it is known to R. (4) The information must be provided in writing within 3 days beginning with the day on which the request is made. (5) If the PHE considers the case to be urgent and informs R of this fact when making the request, the information must be provided orally as soon as reasonably practicable. (6) In determining whether the case is urgent, PHE must have regard to – a) the nature of the causative agent; b) the nature of the disease which the causative agent causes; c) the ease of spread of the causative agent; d) the ways in which the spread of the causative agent can be prevented or controlled; and e) where known, the circumstances of the person from whom the sample was taken (including age, sex and occupation).
The Health (Aircraft) Regulations 1979	
Reg 7 Inspection of Aircraft	(1) An authorised officer may, for the purposes of these regulations, inspect any aircraft at a customs airport. (2) The medical officer or other authorised officer acting on the medical officer's instructions shall— (a) inspect on arrival any aircraft in respect of which the commander has sent a message under regulation 12; and (b) inspect any aircraft at the airport when he has reasonable grounds for believing that there is on board a case or suspected case of infectious disease. (3) The medical officer or other authorised officer acting on the medical officer's instructions may require any aircraft which he intends to inspect under this regulation to be taken to some safe and convenient part of the airport for such inspection if it cannot otherwise be carried out effectively. (4) The inspection of an aircraft under paragraph (1) or (2) may include taking from the aircraft samples of food or water for analysis or examination. (5) The analysis or examination under paragraph (4) must be— (a) with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases; or (b) for preventing other danger to public health.
Reg 8 Inspection etc of persons on aircraft	(1) The medical officer may, and if so requested by the commander or required by the Secretary of State shall examine any person on board or leaving an aircraft at a customs airport, when there are reasonable grounds for suspecting that— (a) the person is suffering from an infectious disease; (b) the person has been exposed to infection from an infectious disease; (c) the person is verminous. (2) The authorised officer may— (a) detain any such person for such examination at a place appointed for the purpose; (b) require the clothing and other articles belonging to any person so examined to be disinfected and, where necessary, disinsected and any person found to be verminous to be disinsected; (c) except as provided in regulation 21 , prohibit any person so examined from leaving the aircraft or airport, or permit him to leave it on such conditions and subject to the taking of such measures, under these regulations, as the medical officer considers reasonably necessary for preventing the spread of infection [or other danger to public health] [1] ; and (d) require the commander to take or assist in taking such steps as in the opinion of the medical officer are reasonably necessary for preventing the spread of infection [or other danger to public health] [1] , for disinfection and the destruction of vermin, and for the removal of conditions on the aircraft likely to convey infection [or other danger to public health] [1] , including conditions the existence of which might facilitate the harbouring of insects or vermin. [...] [1] (6) The medical officer, customs officer or other authorised officer shall immediately notify the responsible authority of any directions given to him by the Secretary of State under this regulation.

Reg 9 Powers in respect of persons leaving aircraft	(1) Where a person intending to leave an aircraft at a customs airport is suffering, or the medical officer suspects that he is suffering, from an infectious disease or tuberculosis, the medical officer may— (a) in the case of an infectious disease, cause such person on leaving the aircraft to be isolated, or to be sent to a hospital or to some other suitable place approved for that purpose by the responsible authority, as may be appropriate; or, except as provided in regulation 21, the medical officer may, by notice in writing to the commander, prohibit the person from leaving the aircraft without the consent in writing of the medical officer; (b) in the case of tuberculosis, if the person leaves the aircraft, send information to that effect to the medical officer for the area in which the intended destination and address of the person is situated. (2) Where the Secretary of State is satisfied that a grave danger to public health exists by reason of infectious disease and notifies medical officers accordingly, the medical officer may, and if the Secretary of State so directs shall, require a person leaving an aircraft at a customs airport to state in writing his name and intended destination and address.
Reg 11 Supply of information by commanders	(1) The commander of an aircraft at a customs airport shall— (a) answer all questions as to the health conditions on board which may be put to him by an authorised officer or a customs officer visiting the aircraft, and furnish any such officer with all such information and assistance as he may reasonably require for the purposes of these regulations; [(b) in addition to any message sent under regulation 12— (i) notify immediately on arrival to an authorised officer any death on the aircraft during its voyage caused by— (aa) any case of infectious disease or tuberculosis on the aircraft; or (bb) any circumstances on board which are likely to cause the spread of infectious disease or tuberculosis, or other danger to public health; (ii) include in that officer's notification under sub-paragraph (i) particulars as to the presence or suspected presence on board of any animals or captive birds of any species;] [1] (c) comply with these regulations, and with any directions or requirements of an authorised officer given or made for the purposes of these regulations. (2) For the avoidance of doubt, the expression *"captive birds"* includes poultry.
Reg 12 Notification of infectious disease on board	(1) Where a member of the crew of an aircraft becomes aware of an event described in paragraph (1A), that person shall report it to the commander of the aircraft. (1A) The event referred to in paragraph (1) is that there is on board the aircraft during a flight a person who— (a) is suffering from an infectious disease or tuberculosis; or (b) has symptoms which may indicate the presence of an infectious disease, tuberculosis or other danger to public health. (1B) Immediately following a report under paragraph (1) the commander of the aircraft shall send a radio message or other communication about the event to one of the persons identified in paragraph (1C) at the first customs airport at which the aircraft is due to land. (1C) The persons referred to at paragraph (1B) are— (a) the authorised officer; (b) the manager of the airport; or (c) the owner of the airport.] [1] (2) If such radio message [or other communication] [1] is sent to the authorised officer, he shall immediately notify the customs officer of its contents. (3) If such radio message [or other communication] [1] is sent to the person in charge of the customs airport he shall immediately notify the authorised officer and the customs officer of its contents. (4) The owner or manager of an aerodrome or any person deputed to act on his behalf, shall inform the authorised officer of any aircraft arriving at that aerodrome which during its flight last landed at [...] [1] (b) such aerodrome as may be notified by the medical officer. (5) The information required under paragraph (4) shall be given to the authorised officer before or immediately after the arrival of the aircraft mentioned therein. [

	(6) The medical officer may require the commander of an aircraft to complete the Health Part of the Aircraft General Declaration in the form set out in Schedule 1.] [1] (7) The [Health Part of the Aircraft General Declaration] [1] completed in accordance with dparagraph (6) shall be delivered to the authorised officer by the commander of the aircraft, or by a member of the crew deputed to act on his behalf.
Reg 14 Detention of Aircraft	(1) When on the arrival of an aircraft at a customs airport the medical officer has reasonable grounds for believing that the aircraft may be an infected aircraft or a suspected aircraft, or an aircraft which, although not falling within either of such categories, has had on board during the voyage a case of [plague, cholera, yellow fever or smallpox] [1] in respect of which the aircraft has not outside the United Kingdom been subjected to appropriate measures equivalent to those provided for in these regulations, he may cause the aircraft to be detained for medical inspection. (2) If the medical officer has caused an aircraft to be so detained, he shall inform the person in charge of the customs airport of such detention and send a notice in writing of such detention to the customs officer.
Reg 16 Detention of Aircraft	Where on the arrival of an aircraft at a customs airport it appears to the customs officer that during the voyage of the aircraft— (a) there has been on the aircraft a death caused otherwise than by accident, or a case of illness which is or is suspected to be of an infectious nature; or [(b) the aircraft has been in an area infected with plague, cholera, yellow fever or smallpox; or] [1] (c) death not attributable to poison or other measures for destruction has occurred amongst rodents on the aircraft, he shall, unless the authorised officer otherwise directs, give such directions as seem necessary to him to secure the detention of the aircraft, the persons carried thereon, and its stores, equipment and cargo.
Reg 18 Detention of Aircraft	(1) The medical officer shall inspect any aircraft and the persons carried thereon as soon as possible and in any case within 3 hours after it has been detained under these regulations. (2) If the aircraft is one to which the authorised officer is required by these regulations to apply any further or additional measure, or if after such inspection the medical officer considers it necessary to apply any further or additional measure under these regulations, the medical officer may continue the detention of the aircraft, if such continued detention is necessary for the application of that further or additional measure.
Reg 20 Persons from infected areas	On the arrival of an aircraft at a customs airport, the medical officer may place under surveillance for the appropriate period specified in regulation 30(1)— [(a) any person disembarking from the aircraft who has come from an area infected with cholera, smallpox or viral haemorrhagic fever; and] [1] (b) any suspect disembarking from the aircraft who has come from an area infected with yellow fever, plague, lassa fever, viral haemorrhagic fever or marburg disease.
Reg 21 Removal of infected persons from aircraft	(1) A commander of an aircraft on arrival at a customs airport may require the medical officer to cause to be removed from the aircraft— (a) any infected person, or (b) any person suffering from tuberculosis. (2) The medical officer shall carry out any requirement of a commander under paragraph (1).
Reg 22 Removal to airport to apply measures	(1) Where— (a) an authorised officer considers that there should be applied to an aircraft which alights at an airport or to any person carried on such an aircraft measures under these Regulations; and (b) that airport is not able to apply the measures, he may direct that the aircraft or the person proceed to a customs airport that is able to apply the measures. (2) Where an authorised officer gives a direction under paragraph (1), he shall give the commander of the aircraft concerned notice in writing of the direction which shall include the reasons for the direction.
Reg 23 Additional Measures	Without prejudice to any other provision in these regulations, the additional measures in Schedule 2 shall be applicable on the arrival at a customs airport of— (a) any infected aircraft or suspected aircraft; (b) any aircraft which has during its voyage been in an area infected with plague, cholera, yellow

	fever, lassa fever, rabies, viral haemorrhagic fever or marburg disease; (c) any suspect for smallpox on an aircraft other than an infected aircraft; (d) any other aircraft or person, when the authorised officer is satisfied that, notwithstanding that measures equivalent to such additional measures have been applied to the aircraft or person previously during its voyage, there is on board or has been on board since such previous application an infected person or suspect and that it is necessary again to apply any such measure, or the authorised officer has reasonable grounds for believing that such previous application was not substantially effective.
The Health (Ships) Regulations 1979	
Reg 7 Inspection of Ships	(1) The authorised officer may, for the purposes of these regulations, inspect any ship on arrival or already in the district. (2) An authorised officer shall— (a) inspect on arrival any ship in respect of which the master has sent to the **[** local authority **]** **1** a message or notification under regulation 13(1)(a)(ii) and (iii), (b) or (c), and (b) inspect any ship already in the district when he has reasonable grounds for believing that there is on board a case or suspected case of infectious disease. **[** (3) The inspection of a ship under paragraph (1) or (2) may include taking from the ship samples of food or water for analysis or examination. (4) The analysis or examination under paragraph (3) must be— (a) with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases; or (b) for preventing other danger to public health.
Reg 9 Examination etc of persons on ships	(1) The medical officer may, and if so requested by the master or required by the Secretary of State shall, examine any person on board a ship on arrival or already in the district, when there are reasonable grounds for suspecting that— (a) the person is suffering from an infectious disease; (b) the person has been exposed to infection from an infectious disease; (c) the person is verminous. (2) An authorised officer may— (a) detain any such person for such examination either upon the ship or at some place on shore appointed for the purpose; (b) require the clothing and other articles belonging to any person so examined to be disinfected and, where necessary, disinsected, and any person found to be verminous to be disinsected; (c) except as provided in regulation 31, prohibit any person so examined from leaving the ship, or permit him to leave it on such conditions and subject to the taking of such measures, under these regulations, as the authorised officer considers reasonably necessary for preventing the spread of infection; and (d) require the master to take or assist in taking such steps as in the opinion of the authorised officer are reasonably necessary for preventing the spread of infection, for disinsection and the destruction of vermin, and for the removal of conditions on the ship likely to convey infection, including conditions the existence of which might facilitate the harbouring of insects or vermin. (3)-(6) **[...]1** (7) The medical officer **[...]1** shall immediately notify the **[** local authority **]** **1** of any directions given to him by the Secretary of State under this regulation. (8) Nothing in this regulation shall be deemed to authorise the use of a ship for the isolation of a person who is suffering from, or had been exposed to infection from, an infectious disease unless such isolation can be effected without delaying or unduly interfering with the movements of the ship.
Reg 10 Powers in respect of certain persons on ships	(1) Where there is, or the medical officer suspects that there is, on board a ship on arrival or already in the district a person suffering from an infectious disease or tuberculosis, the medical officer may— **[** (a) in the case of an infectious disease— (i) cause the person to be removed from the ship and isolated or sent to hospital or to some other suitable place approved for that purpose by the local authority; (ii) in the case of cholera, smallpox or viral haemorrhagic fever, place such person under surveillance for the appropriate period specified in regulation 36(1); or (iii) except as provided in regulation 31, the medical officer may, by notice in writing to the master, prohibit the removal of the person or the disembarkation from

	the ship without the consent in writing of the medical officer; **] 1** (b) in the case of tuberculosis, if the person disembarks, send information to that effect to the medical officer for the area in which the intended destination and address of the person is situated. (2) Where the Secretary of State is satisfied that a grave danger to public health exists by reason of infectious disease and notifies medical officers accordingly, the medical officer, if the Secretary of State so directs, shall require a person disembarking from a ship to state in writing his name and intended destination and address.
Reg 11 Supply of information by masters	(1) The master of a ship on arrival or already in a district shall— (a) answer all questions as to the health conditions on board which may be put to him by a customs officer or an authorised officer and furnish any such officer with all such information and assistance as he may reasonably require for the purposes of these regulations; (b) notify the authorised officer immediately of any circumstances on board which are likely to cause the spread of infectious disease **[** or tuberculosis **] 1** , including in his notification particulars as to the sanitary condition of the ship and the presence of animals or captive birds of any species, or mortality or sickness among such animals or birds, on the ship; (c) comply with these regulations, and with any directions or requirements of an authorised officer or customs officer given or made for the purposes of these regulations.
Reg 13 Notifications of infectious diseases etc on board	(1) The master of a ship shall, in accordance with paragraph (2) below, report (a) the occurrence on board ship before arrival of (i) the death of a person otherwise than as a result of an accident, or (ii) illness where the person who is ill has or had a temperature of 38°C or greater which was accompanied by a rash, glandular swelling or jaundice, or where such temperature persisted for more than 48 hours, or (iii) illness where the person has or had diarrhoea severe enough to interfere with work or normal activities; (b) the presence on board of a person who is suffering from an infectious disease **[** or tuberculosis **] 1** or who has symptoms which may indicate the presence of an infectious disease **[** or tuberculosis **] 1** ; (c) any other circumstances on board which are likely to cause the spread of infectious disease **[** or other danger to public health **] 1** ; and (d) the presence of animals or captive birds, and the occurrence of mortality or sickness amongst such animals or birds. **[** (2) For the purposes of paragraph (1) the master shall— (a) send by appropriate means before arrival, either directly to the local authority or through an agent approved by the local authority, a radio message, fax, email or other communication complying with paragraph (3) of this regulation; or (b) where it is not possible to comply with sub-paragraph (a) before arrival, notify the local authority immediately on arrival of the presence on board of such infectious disease or tuberculosis, symptoms or other similar circumstances. **] 1** **[** (3) Any radio message, fax, email or other communication sent for the purpose of this regulation shall be sent so as to reach the local authority not more than twelve hours, and whenever practicable not less than four hours, before the expected arrival of the ship. **] 1**
Reg 17 Restriction on boarding or leaving ships	(1) Where the authorised officer so directs, or where the master is required to make a report in accordance with regulation 13(1)(a), (b) or (c), no person, other than the pilot, a customs officer or an immigration officer, shall, without the permission of the authorised officer, board or leave a ship until free pratique has been granted, and the master shall take all reasonable steps to secure compliance with this provision. (2) Before granting permission to a person to leave the ship, the authorised officer may require him to state his name and his intended destination and address, and to give any other information which the authorised officer may think necessary for transmission to the medical officer for the area in which the intended destination of the person is situated. (3) If such a person cannot state his intended destination and address or arrives, within a period, not exceeding fourteen days after landing, to be specified to him by the authorised officer, at an address other than that which he has so stated, he shall immediately after his arrival at that address send particulars thereof to the authorised officer of the port where he left the ship.

Reg 18B Production of a Ship Sanitation Certificate	(1) If the master of a ship which during its voyage has been in a foreign port cannot produce to an authorised officer of the local authority for the district in which the ship arrives or for any district at which the ship calls a valid ship sanitation certificate in respect of the ship— (a) if the ship is within the area of an authorised port, an authorised officer may inspect the ship for evidence of danger to public health or infection with a view to issuing a ship sanitation certificate; (b) if the ship is not within such an area, an authorised officer must— (i) consult with a customs officer; and (ii) direct the ship to proceed at the risk of the master of the ship to an area of an authorised port convenient to the ship and the customs officer. (2) An authorised officer must issue or cause to be issued a Ship Sanitation Control Exemption Certificate if, after he has inspected a ship under paragraph (1)(a), the authorised officer is satisfied that the ship is exempt from control measures (provided he has complied with regulation 18A(3)). (3) If, after a ship has been inspected by an authorised officer, the authorised officer is not satisfied that the ship is exempt from control measures he must— (a) if the ship is within the area of an authorised port— *SI 1979/1435 Page 25* (i) carry out or require to be carried out under the supervision of an authorised officer control measures necessary for the control of danger to public health or the spread of infection; or (ii) otherwise take or cause to be taken any steps which he considers necessary to satisfy himself that the ship does not present a danger to public health and is free of infection; (b) if the ship is not within the area of an authorised port— (i) consult with a customs officer; (ii) direct the ship to proceed at the risk of the master of the ship to an area of an authorised port convenient to the ship and the customs officer; (iii) at the time of the ship's departure for the authorised port referred to in sub-paragraph (ii), inform an authorised officer of the authorised port of— (aa) the evidence found; and (bb) the control measures required; and (iv) note or cause to be noted in any ship sanitation certificate the matters described at sub-paragraph (iii). (4) If the master produces a ship sanitation certificate but the authorised officer has evidence of danger to public health or infection, notwithstanding such certificate the authorised officer must— (a) either— (i) carry out or require to be carried out under the supervision of an authorised officer control measures necessary for the control of danger to public health or the spread of infection; or (ii) otherwise take or cause to be taken any steps which he considers necessary to satisfy himself that the ship does not present a danger to public health and is free of infection; (b) if the ship is not within the area of an authorised port— (i) consult with a customs officer; (ii) direct the ship to proceed at the risk of the master of the ship to an area of an authorised port convenient to the ship and the customs officer; (iii) at the time of the ship's departure for the authorised port referred to in sub-paragraph (ii), inform an authorised officer of the authorised port of— (aa) the evidence found; and (bb) the control measures required; and (iv) note or cause to be noted in the ship sanitation certificate the matters described at sub-paragraph (iii). (5) An authorised officer may extend the period of validity of a ship sanitation certificate by one month if— (a) any inspection or control measures required cannot be carried out at the port; (b) there is no evidence of danger to public health or infection; and (c) the port is authorised to extend the validity of a ship sanitation certificate. (6) The master of a ship must immediately make arrangements to carry out any control measures required by an authorised officer under paragraph (3)(a) or (4)(a). (7) When control measures referred to in paragraph (3)(a) or (4)(a) have been completed to the satisfaction of an authorised officer the authorised officer must— (a) issue or cause to be issued a Ship Sanitation Control Certificate; and *SI 1979/1435 Page 26* (b) note or cause to be noted on the certificate the evidence found and the control measures taken.

Regs 21, 22, 24, 26, 28, and 29 Detention of ships	**21.—** (1) On the arrival of an infected ship or a suspected ship, or any other ship on which there has been, during its current voyage and within the last four weeks before arrival, a case of **[** plague, cholera, yellow fever or smallpox **]** **1** in respect of which the ship has not, outside the United Kingdom, been subjected to appropriate measures equivalent to those provided for in these regulations, the master shall take it to a mooring station unless an authorised officer otherwise allows or directs. (2) When the authorised officer has reason to believe that a ship on arrival may be one to which paragraph (1) of this regulation applies, he may direct the master to take it to a mooring station or to such other place as he considers desirable. **22.** The authorised officer may for the purposes of these regulations direct that any ship from a foreign port shall on arrival be taken to a mooring station for medical inspection, and he may, if a customs officer is to be the first officer to board the ship, give a notice in writing of such direction to the customs officer, who shall deliver the notice to the master. **[24.** If after the arrival of a ship a case of plague, cholera, yellow fever, smallpox, rabies or viral haemorrhagic fever occurs on board, or an animal infected with any such disease is discovered or suspected of being on board, the authorised officer may direct the master to take the ship to a mooring station. **]** **26.** An authorised officer may detain, or give notice in writing to a customs officer to detain, any ship for medical inspection at its place of mooring (not being a mooring station) or at its place of discharge or loading. **28.—** (1) The medical officer shall inspect any ship and the persons on board as soon as possible after it has been taken or directed to a mooring station or after it has been detained under these regulations. (2) If the ship is one to which the authorised officer is required to apply any further measure under these regulations or additional measures in schedule 4, or if after such inspection he considers it necessary to apply any such further or additional measures he may detain the ship at the mooring station or at such other place as he considers desirable, or continue the detention, as the case may be, if such detention or continued detention is necessary for the application of such further or additional measures. **29.** The authorised officer may require the master of a ship which under these regulations has been taken or directed to a mooring station or detained because rodents have been discovered or there are reasonable grounds for suspecting that rodents are on board to take all practicable measures to prevent the escape of rodents from the ship.
Reg 30 Persons from infected areas	On the arrival of a ship the medical officer may place under surveillance for the appropriate period specified in regulation 36(1)— *SI 1979/1435 Page 34* **[** (a) any person disembarking from the ship who has come from an area infected with cholera, smallpox or viral haemorrhagic fever; and **]** **1** (b) any suspect disembarking from the ship who has come from an area infected with yellow fever, plague, lassa fever, viral haemorrhagic fever or marburg disease.
Reg 31 Removal of infected person from ship when required by Master	The medical officer shall, if so required by the master of a ship on arrival, cause any infected person to be removed from the ship.
Reg 32 Additional Measures	Without prejudice to any other provision in these regulations the additional measures in schedule 4 shall be applicable on the arrival of— (a) any infected ship or suspected ship; (b) any ship which has during its voyage been in an area infected with plague, cholera,

	yellow fever, lassa fever, rabies, viral haemorrhagic fever or marburg disease; (c) any suspect for smallpox on a ship other than an infected ship; *SI 1979/1435 Page 35* (d) any other ship when the medical officer is satisfied that, notwithstanding that measures equivalent to such additional measures have been applied to the ship or any person on board at a previous port during its voyage, there is on board or has been on board since such previous application an infected person or suspect and that it is necessary again to apply any such measure, or the medical officer has evidence that such previous application was not effective.
Reg 36 Surveillance	(1) Where these regulations permit a medical officer to place a person under surveillance, the period of such surveillance shall not exceed such of the following periods as may be appropriate:— (a) in respect of plague, six days; (b) in respect of cholera, five days; (c) in respect of yellow fever, six days; (d) in respect of smallpox, fourteen days; (e) in respect of lassa fever, viral haemorrhagic fever, or marburg disease, twenty-one days. (2) Where a person has been placed under surveillance for plague, cholera, smallpox or viral haemorraghic fever under regulation 30 by reason of his having come from an area infected with such a disease, the period shall be reckoned from the date of his leaving the infected area. (3) When a person has been so placed under surveillance under the additional measures in schedule 4, the period shall be reckoned in the manner therein specified.
The Public Health (International Trains) Regulations 1994	
Reg 8 Sick Travellers on Incoming Trains	(1) Where the train manager of an international train whose journey terminates in the United Kingdom (or if he is not on board, the most senior member of the crew) becomes aware during the journey that there is on board a sick traveller, on or before arrival at the next stopping place he shall arrange for the enforcement authority for that stopping place to be provided– (a) if the sick traveller is still on board the train, with details of the sick traveller's presence and whereabouts; (b) if the sick traveller is no longer on board the train, with details of the circumstances in which– (i) the sick traveller was identified as a sick traveller, and (ii) the sick traveller alighted from or was removed from the train, unless he has already reported those details to the enforcement authority at another stopping place. *SI 1994/311 Page 7* (2) The enforcement authority at the stopping place notified in accordance with paragraph (1) may require the disinfestation or decontamination in such a manner and with in such a time as they may reasonably determine, of– (a) any article on board the train; or (b) any rolling stock, which the enforcement authority considers may be infested or contaminated. (3) An enforcement authority may require any or all of the measures which may be required under paragraph (2) to be undertaken elsewhere at– (a) a designated customs approved area; or (b) a designated shuttle control area, if the enforcement authority for that area (if different) agrees. (4) The enforcement authority for an area referred to in paragraph (3)(a) or (b) may require such additional measures to be undertaken to disinfest or decontaminate the train or its contents as in their opinion are necessary. (5) For the avoidance of doubt, arrangements made in accordance with paragraph (1) may include arrangements whereby a train operator employee who is not on board the train contacts the relevant enforcement authority.
Reg 9 Questioning of persons on board or alighting from trains	Where there are reasonable grounds for suspecting that there is a significant danger to public health because a person either is believed to be a sick traveller or may have been exposed to infection with a serious epidemic, endemic or infectious disease, an enforcement authority may require him while he is on or when he alights from an international train– (a) to answer in a control area questions pertaining to his current state of health or his contact with the possible source of infection; (b) to answer in writing in a control are questions about his name, address and intended

	destination.
Offences Against the Person Act 1861	
Section 18 Shooting or attempting to shoot, or wounding with intent to do grievous bodily harm	Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person, [...] [1] with intent, [...] [1] to do some [...] [1] grievous bodily harm to any person, or with intent to resist or prevent the lawful apprehension or detainer of any person, shall be guilty of felony, and being convicted thereof shall be liable [...] [2] to be kept in penal servitude for life [...] [3]

Medical Inspector role under the Immigration Act 1971	
	Home Office website – medical rules 36. A person who intends to remain in the United Kingdom for more than 6 months should normally be referred to the Medical Inspector for examination. If he produces a medical certificate he should be advised to hand it to the Medical Inspector. Any person seeking entry who mentions health or medical treatment as a reason for his visit, or who appears not to be in good mental or physical health, should also be referred to the Medical Inspector; and the Immigration Officer has discretion, which should be exercised sparingly, to refer for examination in any other case. 37. Where the Medical Inspector advises that a person seeking entry is suffering from a specified disease or condition which may interfere with his ability to support himself or his dependants, the Immigration Officer should take account of this, in conjunction with other factors, in deciding whether to admit that person. The Immigration Officer should also take account of the Medical Inspector's assessment of the likely course of treatment in deciding whether a person seeking entry for private medical treatment has sufficient means at his disposal.
***Medical Inspection under the Immigration Act 1971, Instructions to Medical Inspectors,* Department of Health 1992**	
	1.8 In order to provide medical advice to the Immigration Service, the Medical Inspector may conduct a medical examination and other investigations that he considers necessary. These may, with the knowledge and agreement of the Immigration Service, include attendance at or admission to hospital plus urgent and necessary treatment required on humanitarian grounds and to protect the public health. 1.11 If the entrant is judged to present an immediate and significant risk to the public health, the Medical Inspector should in addition report the matter to the Port Medical Officer who will take appropriate action under current public health legislation. If the entrant is seriously mentally ill, arrangements should if necessary be made for care as permitted by mental health legislation 1.14 Medical Inspectors are not responsible for ongoing medical care or supervision of passengers, whether or not detained by the Immigration Service or by Customs & Excise Officers 3.1 The purpose of referral for medical examination is to bring to notice any person who, if admitted, might: a. endanger the health of others; b. be unable for medical reasons to support himself or his dependants; c. require major medical treatment; d. In the case of a European Community national seeking to exercise Treaty rights, be subject to exclusion under the terms of EC Directive 64/221/EEC).

5.3 Appendix C1 – Supplementary information on Port Health Team

EU exit programme *OFFICIAL-SENSITIVE* *January 2017*

Background note on PHE's Port Health function

1. Aim

To outline the major functions of PHE's port health team to inform Department of Health (DH) work on EU customs union and border controls.

2. High level summary of current functions

PHE's port health team's functions fall into two broad areas; health protection and immigration related:

2.1. Health protection related activities

2.1.1. Delivery

- To provide a first-line response to health protection issues at Heathrow - including providing the Medical Officer function under the Public Health Aircraft Regulations (1979)
- To provide operational support within PHE on issues with a port health component
- To contribute strategically to the development of national policies and procedures for large scale public health activities in ports

2.1.2. Advisory

- To provide advice within PHE on issues with a port health component as PHE's experts on port related health issues
- To provide advice to DH on the operational implications of changes to national policy or legislation with respect to ports/airports
- To provide specialist port health-related health protection advice to external bodies drawing on PHE's subject matter experts as appropriate
- To provide operational support and guidance to Health Protection Teams (HPTs) around the country on health protection issues that relate to ports/airports

2.1.3. Liaison

- With national agencies [Civil Aviation Authority (CAA), Animal & Plant Health Agency (APHA)] on port health issues
- With international agencies to maintain awareness of current international best practice on port health issues

2.2. Immigration related activities

- To provide the Medical Inspector function at Heathrow and Gatwick under the Immigration Act 1971
- To provide a major contribution to the PHE Quality Assurance programme supporting the Home Office (HO) pre-departure TB screening programme
- Wider work with HO and DH and internal stakeholders on migration and health

3. Detail of Health Protection Activities

3.1. Delivery

3.1.1. To provide a first-line response to health protection issues at Heathrow - including providing the Medical Officer function under the Public Health Aircraft Regulations (1979)

- The agreed way of working within PHE is that local Health Protection Teams (HPTs) are responsible for health protection arrangements at their local ports. However, at Heathrow there is an arrangement agreed with the North West (NW) London HPT whereby health protection response at Heathrow Airport is provided by the staff maintained for Medical Inspector duties on behalf of NW London HPT. Staff based at Heathrow are the first line responders and take specialist advice as appropriate. Examples include:
  - Responding to a concern on an inbound aircraft of a health protection nature. The Air Traffic Control system notifies the Executive Officer at the Health Control Unit (HCU) and a Medical Officer may attend the flight.
  - Health protection concerns raised by UK Border Force (UKBF) staff are dealt with by the HCU
- There are agreed plans between NW London HPT, Hillingdon local authority, London Ambulance Service and the HCU to respond to different sorts of health protection issues. Complex issues are escalated to the HPT and the first line response capacity at the HCU runs from 07.00 – 22.00 on a 24/7 basis.
- The medical staff are appointed by the local authority with jurisdiction at Heathrow (London Borough of Hillingdon) as Medical Officers under the Public Health (Aircraft) Regulations 1977 should their presence be requested (or as required by the legislation) to deal with any public health issues.
- In addition to this routine work, port health staff also provide support to any sustained public health response at the airport and considerable input into national co-ordination of the ports response, with the most recent example of this being Ebola screening, though resources were also deployed in response to pandemic influenza and the Fukushima nuclear catastrophe.

3.1.2. To provide operational support within PHE on issues with a port health component

- In relation to the Zika virus response, the port health team provided a significant amount of monitoring, internal updates and regular communication with stakeholders. For example, working with DfT, airlines, port operators and local authorities to oversee the implementation of disinsection of direct flights from Zika affected areas as per Cabinet Office instructions. In relation to Ebola, there was direct operational control of the screening at Heathrow and at a later stage Gatwick, and advice and support to screening sites elsewhere.

3.1.3. To contribute strategically to the development of national policies and procedures for large scale public health activities in ports

- Port health is developing a national port health standardised operational procedure and guidance on how to set up large scale, widespread and ongoing

public health activities at major ports, with a focus on securing agreements within PHE and with partners. To support this, port health will develop a hub at Heathrow Airport to facilitate any such implementation. This will build on the above and the experience of designing and operating complex multi-agency and generic agreements for responding at Heathrow.

3.2. Advisory

3.2.1. To provide advice within PHE on issues with a port health component as PHE's experts on port related health issues

- During the Zika global outbreak, advice was given on the efficacy of means of communication with airport operators, local authorities and airlines and on the limitations of current legislation for potential operational outcomes.

3.2.2. To provide advice to DH on the operational implications of changes to national policy or legislation with respect to ports/airports

- As the source of expert advice and support within PHE on port related issues, guidance has been given to DH on the review of the Public Health (Aircraft) Regulations 1977 and the Public Health (Ships) Regulations 1977, including on-site discussions with DH staff at Heathrow and the Port of Southampton to illustrate the operational implications of potential changes to the legislation. Also, on behalf of DH, a national review of International Health Regulations (IHR) Designated Points of Entry was recently undertaken, which also coordinated the responses from the Devolved Administrations.

3.2.3. To provide specialist port health-related health protection advice to external bodies drawing on PHE's subject matter experts as appropriate

- External agencies, including Port Health Authorities, the Maritime and Coastguard Agency (MCA), the Association of Port Health Authorities, individual port and airport operators, airlines and shipping companies ask for assistance, e.g. interpreting the Guidance for the Management of Norovirus infection on Cruise Ships published jointly by the Health Protection Agency (HPA), MCA and APHA in 2007, or airlines asking for advance warning of when Florida might become a Zika-affected area.

3.2.4. To provide operational support and guidance to HPTs around the country on health protection issues that relate to ports/airports

- All PHE Centres have ports in their geographies (there are over 800 ports in England) but only infrequently have a health protection issue at them and so do not build up expertise and experiences about the issues that arise in these environments. So, the port health team provides advice about the relevant legislation, adequacy of plans, contact-tracing and appropriate responses to incidents from norovirus on cruise ships to infectious diseases on aircraft

3.3. Liaison

3.3.1. With national agencies [CAA, APHA] on port health issues

- Port health has collaborated with national agencies on the range of port health issues. For example with APHA on a series of policy issues (norovirus guidance

for ships) and with CAA about the need for meeting CAPCSA standards (response standards) at UK ports.

3.3.2. With international agencies to maintain awareness of current international best practice on port health issues

- This includes organisations with similar functions,such as the US Centres for Disease Control, the US Vessel Sanitation Programme and the US Quarantine Service, but also includes agencies which publish advice and guidance to nation states or to the shipping or airline industries, including the World Health Organisation International Health Regulations Office, Lyon (as a technical expert), SHIPSAN (European Joint Action on ship sanitation) (as a collaborative partner), ECDC, CAPSCA (Collaborative arrangements for the prevention and management of public health events in civil aviation), ICAO (International Civil Aviation Organisation) and IATA (International Air Transport Association).
- The underlying purpose is to identify new guidance in relation to port health activities as it is published and consider its implications for UK practice. Examples include the updated WHO Handbook for the Management of Public Health Events in Air Transport, published in March 2016 and is updated to include Zika virus, and the SHIPSAN second edition of the European Manual for Hygiene Standards and Communicable Disease Surveillance on Passenger Ships, published in April 2016.

4. Detail of Immigration activities

4.1. To provide the Medical Inspector function under the Immigration Act 1971

- There is an agreement between the Home Office and DH as part of the 1971 Immigration Act for the Secretary of State for Health to provide medical officers at ports and airports to support the Border Force in reviewing travellers entering the UK to ensure that they meet the medical rules for entry, as set out in the immigration rules. This responsibility is discharged by PHE by long standing agreement between HPA, DH and HO.
- At Heathrow Airport Medical Inspectors and administrative Executive Officers provide this service from 07.00 – 22.00. The Heathrow staff now also cover Gatwick airport. The Medical Inspectors, appointed by PHE, see travellers referred to them in the Health Control Unit situated in Terminal 3, Heathrow Airport. They interview the traveller and advise the Border Force Officer as to whether there is any health or public health issue that should influence their immigration decision. There are approximately 150 referrals a year across Heathrow and Gatwick. In addition to this, there is a plan to provide a national telephone service for other ports nationally, which will allow local the current out-sourced contracts for this service at Manchester and Birmingham Airports to be stopped.

4.2. To provide a major contribution to the PHE Quality Assurance programme supporting the HO pre-departure TB screening programme

- PHE and the HO collaborate on the UK's pre-departure immigration TB screening programme, with PHE being responsible for the quality assurance

aspects of the provider network abroad. This has been in place globally since 2012. The programme requires that all entrants into the UK who will stay for longer than six months and who arrive from a high risk country for TB are screened for pulmonary TB as part of their visa application process.

- Port Health is responsible for managerial oversight and coordination (programme management) of the QA programme and also several specific projects and related work streams for the medical component of the operational delivery of the UK's pre-entry TB screening program. This is in partnership with National Infection Service (NIS) TB section, which has distinct responsibilities within the programme for epidemiological evaluation and the delivery of technical TB advice. Details of the port health specific contributions include:
  - SRO oversight and organisation wide sponsoring of the programme
  - Co-ordination of all operational aspects along with direct delivery of two of the three components of the quality assurance/performance assessment of overseas clinics. These are tele-radiology to provide second readings for quality assurance purposes of around 10% or 40,000 of the screening CXRs taken overseas per year taken and outreach - on-site clinic inspection visits, education and training and support and guidance for overseas panel physicians. As the programme is not yet mature there remains significant development work to do, for example there is a significant project to procure a future IT system to support our screening activities.
  - Responsibility for leading on the initial specification, procurement, ongoing first line systems support (through Port Health Executive Officers) and rollout of an overarching IT system to collect data directly from screening clinics that will enable more effective monitoring of panel activities across the 101 countries in which screening takes place and the provision of data to the NHS to enable in-country follow-up.

4.3. Wider work with HO and DH and internal stakeholders on migration and health

- Port Health, with TB section, represents the UK on the Five Country Conference (FCC) Immigration and Refugee Health Working Group (a high level intergovernmental collaboration between the USA, Canada, Australia, UK and New Zealand) and actively participates in its collective activities, which primarily seeks ways to align activities between the five countries to achieve synergies and secure continual quality improvement in the screening arrangements for migrants and refugees.
- There is considerable and continuing work to improve the design of the assessment tools and protocols being used for quality assurance purposes. Port Health has actively participated in all the sub-working groups, including chairing one in 2014 and organising the annual Inter-governmental Training Summit for overseas providers. UK is chairing the Immigration and Refugee Health Working Group this year.

5.4 Appendix C2 – Summary of written submissions from internal stakeholders

REVIEW OF PORT HEALTH SERVICE IN PHE

Summary of submissions from internal stakeholders

1. Background

1.1. As part of the Review of port health a data collection form was circulated to PHE centres and divisions to describe their current port health function and engagement with local stakeholders in this regard.

1.2. The purpose of this paper is to provide an initial summary of the written submissions from internal stakeholders, outline challenges and identify emerging themes for discussion by the Port Health Review Steering Group.

1.3. As of 30th April 2017, we have received a total of 14 responses from the following centres/divisions:

- Port Health Team
- 9 PHE Centres
- CIDSC/NIS
- CRCE
- FW&E Microbiology Laboratories
- PH Strategy Department

1.4. It should be noted that a separate 'Summary of the submissions from local PHE Centres' on behalf of their HPTs have been compiled to supplement this document.

2. Summary of current functions in relation to port health

2.1. Port Health Team at Heathrow

2.1.1. Health protection related activities including:

- Delivery of first-line response to health protection issues at Heathrow and operational support on port health issues;
- Advisory on issues with a port health component;
- Liaison with national and international agencies on port health issues.

2.1.2. Immigration related activities including the provision of the Medical Inspector function at Heathrow and Gatwick and contribution to the pre-departure TB screening programme.

2.2. HPTs

2.2.1. Health protection response to notifications of infectious disease(s) at airports/ seaports/ rail borders, including risk assessment, advice on control measures and contact tracing and other PH actions if needed.

2.2.2. Management of and advice on incidents and outbreaks on board an aircraft or sea vessel.

2.2.3. Response to public health emergencies of international concern as required by the International Health Regulations.
2.2.4. Health protection advice and support relating to port health issues, including local training and education.
2.2.5. Development and review of local port health response plans and SOPs (jointly with stakeholders).
2.2.6. Attendance at Resilience Forum/ Emergency Planning meetings. Participation in Health Protection/Emergency Planning exercises held at ports.
2.2.7. Chairing/ Attendance at Multi-Agency Port Health Liaison meetings and/or local Port Health Team Meetings. Linking between local partners and the national focal point in Colindale/ Attendance at national PHE Port Health meetings.

There is mostly adequate knowledge of the teams regarding port health responsibilities. Challenges outlined in 4.1.

2.3. NIS

2.3.1. Contact tracing activities related to international travel through air or seaports.
2.3.2. Provision of the IHR National Focal Point (NFP) function including:
- EU communication through the EWRS;
- Oversight of issue and activities related to Ports of Entry;
- Contribution to international guidance for infections transmitted on aircraft.

2.3.3. Pre-entry TB screening programme data management and monitoring including:
- Data collection, analysis and reporting; support with quality assurance; panel physician training; public health advice; development of tele-radiology.

2.3.4. Provision of specialist information and advice (e.g. airport posters on reducing risk of MERS-CoV; infection control advice for transfer of patients with respiratory diseases; risk assessments of novel respiratory diseases and specialist advice on follow-up).
2.3.5. Outbreak and incident investigation.

There is good knowledge and understanding of the responsibilities of teams that are regularly involved in specific port health functions.

2.4. CRCE

2.4.1. Support function to the implementation of PHE civil contingency responsibilities at ports and designated Points of Entry (24/7 on call)
2.4.2. Surveillance of chemical events (via NPIS, GP notifications, Event based surveillance).
2.4.3. Public health incident response including provision of scientific knowledge and expertise, risk assessment, access to specialist services (e.g. toxicology), specialist advice, identification of sensitive PH receptors, GIS capability.

There is good specialist knowledge about chemical and radiation issues at ports and associated legislative requirements, including chemical emergency preparedness and response.

2.5. FW&E Microbiology Laboratories

2.5.1. It should be noted that FW&E Laboratories have some unique port health functions. They liaise closely with Port Health Authorities throughout England, and perform microbiological examination of imported foods, ships waters and other relevant samples, many of which are covered by PHE central funding although some are charged on a per test basis.

2.5.2. The service provided includes:

- Courier collection of samples and same-day transport to the laboratory.
- Provision of cold boxes and suitable contents to ensure maintenance of samples at an appropriate temperature until they reach the laboratory.
- Microbiological examination of food and animal feed samples collected at Border Inspection Posts (located both at sea ports and airports). Testing is often in response to RASFF notifications or based on sampling priority lists from the FSA.
- Advice on appropriate sampling procedures, testing strategies and interpretation of results.
- Provision of formal certificates and witness statements to assist with legal proceedings where imported food is found to be of an unsatisfactory microbiological quality.
- Liaison meetings between the local lab and the regional PHAs on a regular basis.
- Liaison meetings between the FW&E network and Port Health Authority representatives, held twice per year to address issues of national relevance.
- Assistance with sampling on-board ships during investigations and outbreaks. Assistance with outbreak investigation on board ships.
- Provision of training to Port Health Officers on sampling techniques and interpretation of microbiology results.
- Production of microbiological test results (usually in relation to water samples) to support issue of Ship Sanitation Certificates. .
- Provision of public health and health protection data to inform the actions of others, e.g. survey of Legionella contamination of merchant ships and survey of galley hygiene in merchant ships.

The testing requirements of Port Health Authorities are well understood within the FW&E microbiology laboratories, as are the unique pressures of Port Health Authorities in comparison to Local Authorities (e.g. 7 day working; rapid turnaround required for detained samples; unsatisfactory results often lead to the rejection of entire consignments of food and therefore have significant financial and legal implications; ships are only in port for a few hours and therefore sampling has to happen within a limited timeframe). Food samples are all tested as formal samples (in compliance with evidential rules and Police and Criminal Evidence Bill) since, for Official Food Control purposes, testing results are the sole supporting evidence for the importation certificates since observation of the point of production is not available to the Environmental Health Practitioner in the BiP.

2.6. PH Strategy Department

2.6.1. Medical revalidation to doctors employed by PHE in port health / medical immigration roles. Delivered through the Office of the Responsible Officer.

2.6.2. Caldicott function. Delivered through the Caldicott Oversight Group.

2.6.3. Quality & Clinical governance function with an identified quality lead within port health.

3. Port Health Team at Heathrow

3.1. Perceived roles and responsibilities

3.1.1. Well understood in relation to medical inspection, liaison with international partners, administration of pre-departure TB screening programme and first line response at Heathrow.

3.1.2. Continued difficulty between PHE and HO in relation to the pre-entry TB screening programme and unclear accountability for the programme QA.

3.1.3. Less clarity about the purpose of the team within PHE and about the boundaries of their responsibility

3.2. Challenges and concerns raised

3.2.1. Accountability and management arrangements.

3.2.2. Lack of data/information support within PHE.

3.2.3. Resources and premises.

3.2.4. Issues around the current organisation of the refugee aspects of the border health arrangements and links with Home Office.

3.2.5. Concerns regarding awareness of actual policy, changes in policy due to the small size of the Port Health team often working in isolation.

3.2.6. Challenges around clinical governance outcomes which are hard to measure in the medical immigration function.

3.2.7. Concerns regarding incidents reporting and safeguarding.

3.2.8. Lack of information about changes to medical personnel (starters and leavers) complicating revalidation.

3.3. Suggestions for improvement

3.3.1. Ensure clearer and more transparent management structure in place, including clear medical management.

3.3.2. Develop clearer roles and responsibilities.

3.3.3. Ensure consistency and high standard of practice, e.g.

- Provision of training by the Port Health team to staff at Border Entry Points to encourage dependable professional standards;
- Development of public health standards for BAU.

3.3.4. Ensure preparedness, e.g.

- Integration and enhancement of data intelligence, e.g. pro-active use of data to monitor border threats; establishment of intelligence capability within the Port Health team; integration of information from internal and external inputs;
- Development of flexible response arrangements at Border Entry Points;
- Development of public health plans for response escalation.

3.3.5. Ensure adequate recording of adverse incidents and up to date safeguarding training.

3.3.6. Ensure staff engagement in job planning, appraisal, CPD and personal development planning, revalidation, education and development, mandatory training etc., and opportunities to progress and develop.

3.3.7. Better and more strategic arrangements for the refugee aspects of the port health role.

4. Challenges to roles and responsibilities in relation to port health

4.1. Knowledge

4.1.1. Less knowledge regarding port health responsibilities amongst junior members of the team as incidents are not frequent and often complex thus go to senior team members (HPTs).

4.1.2. Less knowledge regarding usual procedures/specific difficulties of managing port health incidents as they occur so infrequently (HPTs). Lack of clarity around the functions of the PMI and PMO (HPTs).

4.2. Pre-entry screening

4.2.1. Disagreements between PHE and the Home Office about leadership responsibilities of the Pre-entry TB screening programme (NIS).

4.2.2. Challenges around communication and roles and responsibilities with the Port Health team around the pre-entry screening (NIS).

4.3. Communication, collaboration and governance

4.3.1. Less understanding of internal communication pathways (e.g. to clarify which PHE department to pass queries on to if the FW&E team unable to answer) (FWE).

4.3.2. Unclear management structures.

4.3.3. Challenges to collaboration with HCU. Challenges to liaison and communication with UKBA nationally and regionally (HPTs).

4.3.4. Challenges to defining organizational boundaries prior to and during an incident response. Lack of clarity among stakeholders about who does the medical assessment of travellers at point of entry (HPTs).

5. Emergency preparedness and response in relation to port health

5.1. Planning

5.1.1. Lack of clear PHE procedures and guidelines or HPT action cards for consistent management of case/ incidents of communicable diseases at ports (HPTs).

5.1.2. Lack of clarity about legislation that can be used/cited

- To request passenger manifests from airlines for contact tracing purposes.
- In different port health situations and to achieve the desired relevant outcomes (HPTs).

5.1.3. Challenges around consistency of planning, preparedness and response arrangements for chemical events at ports due to a large number of ports of varying scale, size and complexity (CRCE).

5.1.4. Challenges around engagement with ports due to commercial sensitivity of information (e.g. securing anchorage point information, chemicals transported from ports) (CRCE).

5.2. Resilience

5.2.1. Low resilience due to low staff numbers /lack of resources or significant staff changes (HPTs).

5.3. Response

5.3.1. Challenges around active contact tracing due to limited cooperation from airlines and time lag between the incident and case identification (NIS).

5.3.2. Challenges with displaying public health messages due to limited cooperation from airlines (NIS).

5.3.3. Challenges around the pre-entry screening data collection (laborious partly manual collection; issues with completeness and quality) (NIS).

5.3.4. Access and timeliness of response:

- On site airside passes required and must be regularly renewed/activated, security clearance required (HPTs).
- Long distance to airports and seaports. Physical presence may be guaranteed if required (HPTs).

5.3.5. Communication challenges during incidents. Some stakeholders further up the chain may be less reliant to notify cases and incidents (e.g. ships masters) (HPTs).

5.3.6. Specific challenges identified by the FW&E laboratories:

- Challenges around timely sample transport (long distances from ports to laboratories, rapid turnaround times required 24/7).
- Challenges to liaison with port health colleagues and the ability to assist with sampling on-board ships when required due to greater distances.
- Border Inspection Posts (where much of the imported food sampling takes place) are often within secure areas of the ports, making collections by courier companies more complicated to organise.

6. Stakeholder relationships

6.1. Formal arrangements

6.1.1. Response plans

- Majority of centres reported having Port Health Response Plans usually based on the HPA template.
- East Midlands have a Port Health Partnership Agreement which is in the process of being renewed and a draft MOU. The NENCL HPT as an MOU with the Port Health Authority and an agreement with local authorities for risk assessment / action matrix for potential communicable disease aboard aircraft and protocol for notification with Heathrow Airport. Health Protection Plan /MoU in place since 2012 between Airport, Local Authority, Police, Fire, Ambulance services in West Midlands.
- See the separate '*Summary of the submissions from local PHE Centres*' for further details.

6.1.2. MOUs

- Memorandum of Understanding in place between Port Health Authority and NENCL HPT.
- There is an agreement between the PHE port health team and Colindale about functions in the screening programme.

- Border Force – draft MoU for Medical Inspection, currently with Border Force for renewal/review.
- The relationship between PHE and the Home Office is defined through an MOU although this remains unsigned this includes TB screening partnership – HO is currently disputing agreed responsibilities.

6.1.3. Proper officer / medical officer roles

- From the Centre responses it seems that Proper Officer / Port Medical Officer roles vary across the HPTs.
- See the separate '*Summary of the submissions from local PHE Centres*' for further details.

6.1.4. Service Level Agreements

- FWE has SLA with each Port Health Authority, to clarify what is included in the service provided by the laboratory, including a specification of the allocation of funding that each PHA is able to use for microbiological examination.

6.2. Local stakeholder matrix

6.2.1. A large number of stakeholders have been identified:

	Port Health	HPTs	CIDSC	CRCE	FW&E Labs	PHE Strat. Dpt.
Port Health Authorities		X	X	X	X	
HPTs	X		X		X	
CRCE		X				
PHE other dpts.	X[1]	X[4]	X[6]			X[11]
Local authorities	X	X		X		
DoH	X		X			
DoT	X		X			
DFiD			X			
Home Office	X		X			
Border Force	X	X				
Ambulance service(s)	X	X				
Hospital(s)		X				
CCGs / NHSE		X				
Police		X				
Fire Service(s)		X				
Airport(s) / Seaport(s)	X[2]	X				
Airlines	X	X				
Civil Aviation Authority	X					
Environment Agency				X		
FSA					X	
DEFRA			X		X	
Other organisations	X[3]	X[5]	X[7]	X[9]	X[10]	X[12]
Other countries/ governments	X		X			
WHO EURO / ECDC			X			
Other intl. organisations			X[8]			

[1]PHE respiratory disease section
[2]Heathrow Airports Limited
[3]Devolved Health Administrations
[4]EPPR
[5]City of London Corporation

[6]Travel and Migrant Health team, Communication dpt., Emergency response dpt., PHE International office
[7]NaTHNaC
[8]International Organization for Migration, International Panel Physicians Association, Overseas panel physicians
[9]Maritime and Coastguard Agency
[10]Ship owners/Food importers
[11]HR, Associate CGs in PHE, Office for Data release; Confidentiality Advisory Group, Head of Quality & Clinical Governance; other quality leads and quality component leads in PHE; in L3+ strategic incident response: incident director(s), incident manager(s) and other cell leads
[12]GMC, external software support provider

7. Suggestions for improvements/recommendations

7.1. Clarify roles and responsibilities and develop plans

7.1.1. Clearly define and set out agreed PHE role and responsibilities in relation to port health (different teams and tiers of input within PHE, DH and other governmental departments), and clarify expectations on what PHE is to deliver and how (HPTs, NIS).

7.1.2. Clarification from PHE nationally about who fulfils the role of the Proper Officer (HPTs).

7.1.3. Better understand the role that is carried out by the various agencies that work at the border to protect public health (HPTs).

7.2. Internal nation-wide coordination and communication

7.2.1. Proactive role from PHE nationally in developing knowledge and relationship (e.g. regular meetings of key partners, sharing of intelligence, capacity building and investing in staff to provide the expertise when needed (HPTs).

7.2.2. Improve national co-ordination of the PHE Port Health function, and (re)establish national port health network meetings to:

- improve communication with the HPTs/port health leads;
- ensure consistent port health work plans and staff trainings;
- ensure sharing of best practice and lessons learnt;
- harmonise the offer to stakeholders (HPTs).

7.2.3. Consider an away day nationally and/or regular newsletter to share news and issues regarding Port/Border Health (HPTs).

7.2.4. Develop some operational capabilities nationally to undertake wider public health activities at the border, especially in situations where it is difficult to identify a single organisation (HPTs).

7.2.5. Clearly define organizational boundaries prior to and during an incident response; e.g. who does the medical assessment of travellers at point of entry, logistics of laboratory samples or paying for accommodation for stranded foreign passengers etc.(HPTs).

7.3. Emergency preparedness and response

7.3.1. Have clear national PHE guidance/action cards to allow HPTs to respond to port health incidents on a consistent basis (HPTs).

7.3.2. Ensure appropriate emergency planning, preparedness and response arrangements for chemical events at ports.

- Increase awareness of emergency preparedness and response arrangements;
- Develop contingency plans for chemicals at ports;
- Test and exercise plans and arrangements (CRCE).

7.3.3. Ensure adequate resources are available to respond to potential large scale incidents at ports (HPTs).

7.3.4. Ensure timely information from national /international level to Centres regarding emerging threats (HPTs).

7.3.5. Organise more frequent exercises that would help staff increase their familiarity with ports and specific HP issues. Provide training on the non-infectious disease threats for Port Health (similar to the CRBN training) (HPTs).

7.4. Airport environment and access

7.4.1. Have national agreement for provision of unescorted airside passes for PHE staff to access relevant airports when needed that do not require regular renewal/activation (HPTs).

7.4.2. Have formal/national agreements with ports for provision of rooms if required for port health purposes (HPTs).

7.4.3. Consider the airport environment for PH education and promotion campaigns (e.g. highlighting travel vaccine, advice on staying safe abroad) (HPTs).

7.5. External communication and collaboration

Nationally

7.5.1. Promote/improve the use of information tools and systems (e.g. IHR tool to assess competencies; Maritime Single Window; SafeSeaNet) (CRCE).

7.5.2. Improve communication and engagement with ports and other relevant stakeholders to improve multi agency risk assessment and incident management (CRCE).

7.5.3. Ensure closer collaboration (e.g. collaboration between Port Health and NIS when undertaking contact tracing and facilitating contact with airlines – consider integrating Port Health team within NIS given that the bulk of issues are related to infectious disease) and improve integration of Port Health with other PHE teams and capacity strengthening (NIS).

7.5.4. Improve communication with Port Health liaison group and other parts of PHE with port health functions to clarify internal communication pathways, preferably a single point of contact within PHE for Port Health Authorities where they can direct their queries and be confident that they will get directed to the right person or unit for action; a directory of contact names for different areas of Port Health responsibility would also be useful (FWE).

7.5.5. Build closer ties with the HCU and key partners within the airports to enable better interaction and effective collaboration (HPTs).

7.5.6. Improve communication nationally with key external partners (UKBA, HO) and establish stronger professional relationships (HPTs).

Locally

7.5.7. (Re)establish regular multi-agency port health meetings to support shared learning and links between partner agencies (HPTs).

7.5.8. Encourage closer working with local Port Health teams, e.g. attendance at meetings and training sessions. Support port health training and engagement events across the Centre (HPTs).

7.6. Other

7.6.1. Consider a full review of the evidence for effectiveness and cost-effectiveness of different interventions at ports to justify specific PH actions (HPTs).

7.6.2. Support other publicly funded agencies to maintain public health protection (particularly around imported foods) as the UK leaves the EU (FWE).

7.6.3. Encourage the use of more rapid, molecular test methods, which allow more timely detection of pathogens (FWE).

7.6.4. Encourage the national/international community to develop regulations for information sharing (e.g. by airlines/ships) (NIS).

7.6.5. Clarify what to do if someone needs 'detaining' for medical assessment at the port due to potential communicable disease (Part 2a order too lengthy in this setting) (HPTs).

7.6.6. Consider additional PHE/PH promotion activities at ports, e.g. air/noise pollution, healthy workplace health promotional work. Raise awareness and education regarding Public Health issues (HPTs).

7.6.7. Develop more services nationally on a centralised model which can be accessed by local teams as required (e.g. recent national developments such as centralised delivery of a Port Medical Inspection service) (some HPTs).

5.5 Appendix C3 – Summary of written submissions from internal stakeholders (PHE Centres)

REVIEW OF PORT HEALTH SERVICE IN PHE

Summary of submissions from local PHE Centres

1. Background

1.1. As part of the Review of Port Health Services in PHE, written submissions were requested from local PHE Centres using a standardised data collection for.

1.2. The purpose of this paper is to provide a summary of the written submissions from local centres to describe current service provision and identify challenges and opportunities for the future delivery of .Public Health Services at the border.

1.3. We have received and summarised responses from all nine PHE Centres (London (North West, and North East & North Central), South East, South West, East of England, East Midlands, West Midlands, Yorkshire & Humber, North East, North West). The original responses are embedded as appendices. In additional the summarised information in the tables in this report has been validated withy PHE centres.

2. Description of current functions in relation to port health

2.1. Functions delivered

- There was consistency in the acute response functions delivered by PHE centres but there was variation in the extent of proactive work with partners to strengthen public health at the border.

Functions / PHE centres	Lon	SE	SW	EoE	EM	WM	Y&H	NE	NW
RESPONSE									
Response to notifications of infectious diseases at ports*, incl. risk assessment, advice on control measures, contact tracing and other PH actions if required	X	X	X	X	X	X	X	X[1]	X
Management of and advice on incidents and outbreaks at ports*, incl. leading of Outbreak Control Teams, debrief and lessons learnt.	X	X	X	X	X	X	X	X	X
Response and support to Public Health Emergencies of International Concern as required by the IHRs	X			X	X	X	X		
PLANNING & PREPAREDNESS									

Development and review of local port health response plans and SOPs (jointly with stakeholders)	X	X	X	X	X	X	X	X	X
Organisation of/participation in Health Protection/Emergency Planning exercises held at ports	X	X	X	X	X	X	X		X
Attendance at Resilience Forum/ Emergency Planning meetings	X	X	X	X	X	X	X	X	
SPECIALIST KNOWLEDGE & ADVICE									
Health protection advice and support relating to port health issues, incl. local training and education	X	X	X	X	X	X	X		X
Advice in partnership with the Port Medical Inspector (PMI) regarding the health of Immigrants					X	X			
Health protection responsibility for Animal Reception Centre	X								
COLLABORATION & PARTNERSHIPS									
Chairing/ Attendance at Multi-Agency Port Health Liaison meetings and/or local Port Health Team Meetings	X		X	X	X	X	X	X	
Linking between local partners and the national focal point in Colindale/ Attendance at national PHE Port Health meetings			X		X		X		
Ensuring a partnership agreement is in place and keeping relevant Port Health Authority up to date with personnel changes		X		X	X	X			X
Proper Officer / Port Medical Officer role (for some local authorities)	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*	*X*

*At airports/ seaports/ rail borders and/or on board an aircraft/ sea vessel/ international train
[1]In reality, North East HPT get very few enquiries from ports.

It should be noted that the table above has been completed using the information provided in the submissions by PHE Centres, thus might not contain a comprehensive list of functions.

2.2. How are those functions delivered?

- Health Protection teams receive notifications to HPTs from EHOs, the public, ports and airlines/ship masters, emergency services and other stakeholders.
- All centres operate 24/7 arrangements via the Acute Response centre/duty room during hours and on-call rota out of hours.

- Local health protection teams undertake risk assessment, provision of advice and take PH actions jointly with or via the EHOs and other stakeholders.
- They undertake of contact tracing if required and communicate with other HPTs as needed.
- Arrangements for Port Health Leads vary between teams with some teams having all CCDCs as designated Port Medical Officers (e.g. West Midlands for Birmingham airport) while others have a designated Port Health Lead for the centre.
- All centres work with local partners but some have more extensive partnerships than others. This includes attendance at relevant meetings in relation to port health (local and national), direct, regular liaison with the port health authorities, ports and other relevant partners (e.g. on matters of policy, development/ review of plans, etc.).
- Most areas exercise their plans with partners and some provide training/exercises to local stakeholders.
- A minority of Centres reported that their staff have airside passes. West Midlands stated that they have access to a designated space (Port Health room) provided to PHE on long-term lease at Birmingham airport (airside). This is the only centre that mentioned this resource (outside the arrangements at Heathrow).

3. Partnership working in the delivery of port health functions

3.1. Formal arrangements with stakeholders

3.1.1. Key points:

- Majority of centres reported having Port Health Response Plans usually based on the HPA template.
- East Midlands have a Port Health Partnership Agreement which is in the process of being renewed and a draft MOU. The NENCL HPT as an MOU with the Port Health Authority and an agreement with local authorities for risk assessment / action matrix for potential communicable disease aboard aircraft and protocol for notification with Heathrow Airport. The SE PHEC have an SOP in Hampshire and IOW.
- From the responses it seems that Proper Officer / Port Medical Officer roles vary across the HPTs.

3.1.2. Table summary by PHE Centre of formal arrangements and standards applied to delivery of port health functions:

	Response plans / Agreements	**MOUs**	**Proper Officer / Port Medical Officer roles**	**Standards/ Guidance**

Lon	Agreement between PHE and BAA/ Heathrow Airport – Protocol for notification of communicable disease or any death on board an aircraft at Heathrow airport (2014). Agreement between HPT, HCU, LAS and LB Hillingdon – Risk assessment/action matrix for potential communicable disease aboard aircraft- June 2014	MOU in place between Port Health Authority and NENCL	PHE doctors in HCU and NWL HPT all appointed as Medical Officer/Authorised Officer (Aircraft Regulations) 1979 by Hillingdon LA; PHE doctors in NENCL HPT appointed as Medical Officers (Ship's Regulations) 1979 by City of London Corporation to the Port Health Authority, London.	• PHE Guidance- Medical Transfer from Overseas; Guidance for receiving hospitals and clinicians in both the NHS and the private sector- June 2013. • Other standards are as according to each disease/ incident protocol e.g outbreak plan
SE	Gatwick Port Health Plan under development. Gatwick Airport Notice explaining process for notification of a sick passenger with a suspected communicable disease is being updated. Agreed SOP for port health in HIOW, none in Kent.	No formal MOU signed; there is an informal agreement that GAL would assist PHE as best possible if required.		• IATA standards for airlines to notify a suspected communicable disease. • RAGIDA guidance for HPT public health management of certain cases of infection in terms of contact tracing. • Ships regulations in seaports. • ACDP guidance. • Guidance management of Measles or TB on a plane, and Norovirus infection in cruise ships.
SW	LA Port Health Plans drafted with the SW Centre input. These plans indicate the responsibilities of the LA port health team and SW PHE Centre when responding to a health protection issue at the port of entry.	No specific MOU for port health.	Port Medical Officer and Proper Officer documentation maintained by the Local Authority.	• None mentioned.

EoE	LA Port Health Plans written in agreement with the interested parties, currently being reviewed within the planning cycle.	No specific MOU for port health. MOU for health protection incidents and outbreaks being developed through LHRPs. MOU for major incidents signed through LHRPs.	PHE CCDCs/CHP appointed Medical Officer/Authorised Officer (Aircraft Regulations) 1979 and Medical Officers (Ship's Regulations) 1979 by relevant local authorities in the EoE.	• Category 1 response to major incidents under the CCA 2004. This outlines minimum standards for responding to major incidents in any setting within the EoE, incl. ports. • PHE Quality Standards. Compliance with National Standards for Management of specific notifiable diseases • Rolling programme of audit and clinical reviews to ensure that local SOPs remain up to date.
EM	Port Health Partnership Agreement - currently being renewed.	MOU to be adopted soon.	CCDC's appointed as Medical Doctors. Proper Officer documentation in place.	• Operational guidance for health protection responders and port medical officers.
WM	Health Protection Plan for Birmingham Airport, being updated annually (last update Nov 2016).	Health Protection Plan /MoU in place since 2012 between Airport, Local Authority, Police, Fire, Ambulance services.	Port Medical Officer and Proper Officer documentation maintained by the Local Authority. All CCDC's in WM are officially designated PMO's for Birmingham airport by the Solihull Council.	• Public Health (Aircraft) regulations 1979. • PHE Outbreak Control Plan • ACDP guidance. • Category 1 response to major incidents under the CCA 2004 • RAGIDA guidance for HPT public health management of certain cases of infection in terms of contact tracing.
Y&H	Port health plans in place.	No MOUs.		• Roles and responsibilities of individual agencies are listed in the port health plans.
NE	Port health plans based on previous HPA template.	No specific MOUs.		• There are no specific standards that apply to Port Health, these are expected to be delivered as per usual health protection response.
NW	Seaport Health plan and individual plans for each airport ratified by SLT and the Local resilience For a.			• None mentioned.

3.2. Local stakeholder matrix

3.2.1. Similar key partners in delivery of port health functions have been identified across the HPTs:

	Lon	SE	SW	EoE	EM	WM	Y&H	NE	NW
PHE	X[1]				X[2]			X[2]	X[6]
Local authorities – Port Health Authorities, EHOs, PH teams, Emergency Planning	X	X	X		X	X	X	X	X
UK Border Force	X	X	X	X	X		X	X	
Ambulance service(s)	X	X	X	X	X	X	X		X
Police	X	X	X		X	X	X		X
Fire Service(s)	X	X				X			X
Hospital(s)/GPs	X		X		X	X	X		X
CCGs / NHSE	X	X		X		X	X		X
Ports (operators, management)	X	X	X	X	X	X	X	X	X
Airlines, Vessel/rail companies	X	X						X	X
Local Resilience Forum		X		X					
Other organisations					X[3]	X[4]	X[5]		X[5,7]

[1]PHE Health Control Unit and Port Health Team, CRCE, EPPR; [2]No specific PHE departments mentioned; [3]RAF; [4]Communication and Media; [5]Maritime and Coastguard Agency; [6]PHE NIS, Communication dpt., neighbouring HPTs, Emergency response dpt., CRCE; [7]Animal and Plant Health Agency, Pilotage, Immigration

4. Resources devoted to port health functions

4.1. Staff resources

- Resources for port health vary across the HPTs. Areas with major international airports seem to devote more resources to port health work than others.
- Port health leads are consultants in some areas and practitioners in others.
- It was often difficult to quantify the time commitment of staff to port health work as it varies with frequency/complexity of health protection response.

4.2. Training

- Most centres mentioned that incidents at ports are infrequent but despite this most said that knowledge among staff was adequate / satisfactory (except one centre stating that in was poor in the area responsible for one major airport) and that awareness among staff had increased after the Ebola response. A couple of centres mentioned familiarisation sessions at airports.

4.3. Table summary by PHE Centre of resources devoted to port health functions:

	Professional background	Grade	Wte	Comments

Lon	CCDC Lead for Port Health	Consultant	0.1-0.2	Mainly strategic work and review e.g. HCID work streams and Port Health review
	CCDC Lead for Hillingdon	Consultant	0.1	Strategic emergency planning and on-going investigations of incidents
	CCDC/CHP, HPN/HPP, Admin, TB specialist, Specialist Trainees/ FY2s			Unable to quantify. Acute response to incidents (in and out of hours) when many members of the multidisciplinary team may be involved
	Deputy Director for HP	Consultant	0.2	
SE	CCDC/CHP for Gatwick	Consultant	1.25	Time commitment is highly variable.
	CCDC/CHP and HPN/HPP in the S&S HPT	Consultant, band 6-8A		Difficult to quantify as depends on the frequency of cases being reported to the HPT. Average of 5-10/year reported to SSHPT. Each incident can take couple of hours to couple of days to sort out.
	HIOW and Kent duty team			Not possible to determine grades as requests made to duty team and responded to according to staff member available.
SW	DDPH – interim lead	Consultant	0.1	Although varies on average 2 days per month between those colleagues involved.
	SWS HPP Lead	Band 7		
	SWN Advanced HPP Lead	Band 8A		
EoE	HPP	CC SEO	0.1	
	Emergency Planning Officer	CC SEO	0.1	
	CCDC/CHP	Consultant	0.05	
	EP Administrator	CC AO	0.05	
EM	HPP, Chartered Environ. Health Practitioner	SEO/Band 7	~ 2 days a month	Strategic review work, emergency planning and on-going investigations of incidents. Time spent would vary considerably depending on situation.
WM	CCDC PMO	Consultant	0.05	One CCDC is the designated Port Health Lead as part of his wider health protection portfolio. Time devoted is highly variable depending on what the issue are reported from Birmingham airport.
	Emergency Planning Manager	AfC Band 7	0.05	
	HPN	Grade 6-7		As and when required
Y&H	CCDC/CHP	Consultant		Time commitment is variable
	HPN/HPP	Grade 6/7/8		
	Surveillance officers	Grade 4/5		
NE	Consultant/nursing staff	Consultant, band 7		Difficult to estimate time commitment as tends to be mostly on an ad hoc basis but is limited to a few enquires/incidents a year. In addition quarterly meetings for some consultants on local port health groups.
NW	CCDC	Consultant		Time commitment limited but variable
	HPP	Band 7		
	Emergency Planning Officer	SEO		

5. Challenges in the delivery of port health functions

5.1. Preparedness and response

5.1.1. Access and timeliness of response:

- On site airside passes required and must be regularly renewed/activated, security clearance required (Lon, SE, WM).
- Long distance to airports and seaports (Lon, SE, EoE). Physical presence may be guaranteed if required (EoE).

5.1.2. Communication challenges during incidents (SW, Y&H). Some stakeholders further up the chain may be less reliant to notify cases and incidents (e.g. ships masters) (SW).

5.1.3. Low resilience due to low staff numbers/lack of resources (Lon/WM) or significant staff changes (EM).

5.1.4. Lack of clear PHE procedures and guidelines or HPT action cards for consistent management of communicable diseases cases/ incidents at ports (SE).

5.1.5. Lack of clarity about legislation that can be used/cited

- To request passenger manifests from airlines for contact tracing purposes (SE).
- In different port health situations and to achieve the desired relevant outcomes (SE).

5.2. Roles & responsibilities

5.2.1. Little knowledge regarding port health responsibilities mainly amongst junior team members as incidents are not frequent and often complex thus go to senior team members (Lon).

5.2.2. Less knowledge regarding usual procedures/specific difficulties of managing port health incidents as they occur so infrequently (SE, Y&H).

5.2.3. Lack of clarity around the functions of the PMI and PMO (WM). Some areas also highlighted the need for greater clarity about response arrangements and the need for guidance and protocols.

5.2.4. No designated HP Nurse for Port Health (WM).

5.2.5. Challenges to defining organizational boundaries prior to and during an incident response; e.g. logistics around obtaining and transporting laboratory samples or paying for accommodation for stranded foreign passengers following an infectious disease outbreak on a ship (Y&H).

5.3. Collaboration & partnerships

5.3.1. Challenges to collaboration with HCU. It is important to enable PHE to operate effectively as HCU have the majority of the relationships and contact details of key partners within Heathrow environment (Lon).

5.3.2. Challenges to the designation of the Proper Officer being a medical doctor who then need to authorise other members of the team to act on their behalf out of hours (SE).

5.3.3. Lack of clarity among stakeholders about who does the medical assessment of travellers at point of entry. There is sometimes an expectation that the

nominated Port Medical Officer (PHE) should carry out urgent medical assessment at ports (SW).

5.3.4. Challenges to liaison and communication with UKBA nationally and regionally (WM).

6. Opportunities to strengthen public health at ports / Suggestions for improvements

6.1. Scope

- When asked to consider what the role of PHE in relation to 'Public Health at the border' should be in future, most Centres expressed that this should continue to be focused on health protection. Three Centres mentioned that there are opportunities for health education and provision of information including on wider health and wellbeing. There were suggestions for the establishment of a PHE rapid response team. There was a suggestion to collate and share lessons to be learned.

6.2. Strengthening Public Health at the border

- There were few suggestions on opportunities to strengthen public health at the border. Most responses focused on strengthening collaboration internally in PHE and partnerships externally.

Suggestions from Centres by topic area:

6.2.1. Roles & responsibilities

- Clearly define and set out agreed PHE role and responsibilities in relation to port health (different teams and tiers of input within PHE, DH and other governmental departments), and clarify expectations on what PHE is to deliver and how (Lon).
- Clarification from PHE nationally about who fulfils the role of the Proper Officer (SE).
- Develop some operational capabilities nationally to undertake wider public health activities at the border, especially in situations where it is difficult to identify a single organisation (Y&H).
- Better understand the role that is carried out by the various agencies that work at the border to protect public health (EM).
- Clearly define organizational boundaries prior to and during an incident response; e.g. logistics of laboratory samples or paying for accommodation for stranded foreign passengers etc. (Y&H).

6.2.2. Collaboration & partnerships

Nationally

- Proactive role from PHE nationally in developing knowledge and relationship (e.g. regular meetings of key partners, sharing of intelligence, capacity building and investing in staff to provide the expertise when needed) (EM).
- Improve national co-ordination of the PHE Port Health function and (re)establish national port health network meetings to:
    - To improve communication with the HPTs/port health leads (SW, WM);
    - To ensure consistent port health work plans and staff trainings (EoE);

  - To ensure sharing of best practice and lessons learnt (EoE, NW);
  - To harmonise the offer to stakeholders (SW).
- Consider an away day nationally and/or regular newsletter to share news and issues regarding Port/Border Health (WM).
- Improve communication nationally with key external partners (UKBA, HO) and establish stronger professional relationships (EM, WM).

Locally

- Build closer ties with the HCU and key partners within the airports to enable better interaction and communication, and more effective collaboration (Lon, Y&H).
- (Re)establish regular multi-agency port health meetings to support shared learning and links between partner agencies (EoE, EM, WM).

6.2.3. Preparedness and response

- Ensure adequate resources are available to respond to potential large scale incidents at ports (SE).
- Have clear national PHE guidance/ national template for Port Health plans with action cards to allow HPTs to respond to port health incidents on a consistent basis (SE, NW).
- Ensure timely information from national /international level to Centres regarding emerging threats (NW).
- Organise more frequent exercises that would help staff increase their familiarity with ports and specific HP issues (Y&H).
- Provide training on the non-infectious disease threats for Port Health (similar to the CRBN training) (NW).
- Ensure regular team updates for HPPS and Consultants on any significant issues and developments regarding port health remit, guidance or legislation (SW).

6.2.4. Airport environment and access

- Have national agreement for provision of unescorted airside passes for PHE staff to access relevant airports when needed that do not require regular renewal/activation (SE).
- Have formal/national agreements with ports for provision of rooms if required for port health purposes (SE).
- Consider the (air)port environment for public health education and promotion campaigns (e.g. highlighting travel vaccine, advice on staying safe abroad (safe sex, Hep A), healthy eating, flu season (hand washing and using tissues)) (Lon).
- Encourage closer working with local Port Health teams, e.g. attendance at meetings and training sessions (SW). Support port health training and engagement events across the Centre (EoE).

6.2.5. Other

- Consider a full review of the evidence for effectiveness and cost-effectiveness of different interventions at ports to justify specific PH actions (SE).
- Clarify what to do if someone needs 'detaining' for medical assessment at the port due to potential communicable disease (Part 2a order too lengthy in this setting) (SE).

- Consider additional PHE/PH promotion activities at ports, e.g. air/noise pollution, healthy workplace health promotional work (Lon, SW). Raise awareness and education regarding Public Health issues (WM).
- Consider Channel Tunnel as a point of entry. It is less likely to necessitate advice regarding infectious diseases, however, does have the potential for experiencing CBRNe incidents, which would be likely to require PHE advice and support for stakeholders (SE).
- Develop more services nationally on a centralised model which can be accessed by local teams as required (e.g. recent national developments such as centralised delivery of a Port Medical Inspection service) (NE).
- *It should be noted that some Centres prefer to remain the local delivery of the Port Health function for PHE without further centralisation (NW).*

5.6 Appendix D – Risk stratification tool

			Risk Factor		
Variable	Very Low The risks are so low as to be unnoticeable.	Low Risks are recognised but easily managed.	Moderate Risks recognised but acceptable in view of the costs involved in mitigating them.	High Risks are high, managing them will be costly.	Very High The risks are so high that they cannot be accepted.
Severity Does the range of diseases expected at this port cause human morbidity and if so do they cause measurable human mortality?	*No known morbidity or mortality known to be associated with diseases associated with this port. There are few travellers and goods arriving at this port from outside the UK.*	*Some mild morbidity has been associated with the port in the past.*	*Incidents are reported from time to time of infections imported through this port causing modest morbidity.*	*The port is associated with regular importations of infectious conditions causing morbidity, rarely there is serious illness.*	*Repeated importations of diseases with high morbidity and mortality. Many travellers and goods arriving from tropical locations in developing countries.*
Spread Is the range of diseases expected at this port associated with a high incidence of spread?	*No anecdotal or documented evidence of any incidents or outbreaks associated with this port.*	*Single incident, of a minor nature, associated with the port 5 years ago.*	*Some infections have been traced back to the port, but this is unusual and there is no clear pattern*	*Some infections have been traced back to the port, but this is uncommon although there is a clear pattern.*	*Repeated incidents and outbreaks documented as associated with importations through this port.*
Confidence Is the disease profile associated with this port known and understood? Is the profile one that includes diseases associated with significant	*No information available. This is probably because it has never been an issue.*	*Limited data available on diseases that might be imported at this port.*	*Profile of diseases that might be imported at this port is known and containment measures are in place.*	*Good understanding of the diseases likely to be imported at this port*	*Significant data on profile of serious disease problems associated with this port.*

morbidity or mortality?					
Variable	Very Low The risks are so low as to be unnoticeable.	Low Risks are recognised but easily managed	Moderate Risks are recognised but easily managed	High Risks are high, managing them will be costly	Very High The risks are so high that they cannot be accepted
Intervention Are there effective and practical interventions available for diseases associated with this port?	*For all diseases associated with this port there are effective and practical interventions available. The cost of these interventions is minimal.*	*Low cost, practical interventions exist for the few diseases associated with the port.*	*Interventions are practical for all diseases thought to be associated with importations at this port.*	*Interventions are limited in effectiveness against the diseases associated with this port and they are high in cost.*	*No interventions known for the majority of diseases known to be imported at this port.*
Context Does the port have a profile in the regional or national context in which a serious failure of port health would cause particular difficulties for any of the organisations responsible for the provision of port health or The port itself?	*The port has a very low regional and national profile, few passengers and minimal cargo. No scheduled arrivals or departures. Closure of the port would cause minimal disruption for adjacent facilities.*	*The port is small with only a few scheduled arrivals and departures. Closure would be managed by diversions to nearby alternative ports.*	*Port of modest size and regional profile. Delays to arrivals or departures could be managed without serious disruption elsewhere and are unlikely to attract media attention unless they become very extended.*	*Busy regional port with a steady flow of arrivals and departures. Some capacity to cope with delayed arrivals and departures with only minor interest from the media*	*Large port with a high regional and national profile. Any delay to arrivals or departures would have immediate consequences for other ports and the media would feature the event and the way it was handled.*

5.7 Appendix E – Stakeholder engagement strategy

Stakeholder Engagement Strategy

1. **Summary**
   This strategy identifies how Public Health England (PHE) will engage with key stakeholders during the Port Health Review. It identifies the key players in terms of impact and influence, key methods of communication and communications activity from the period March – July 2017. The overall objective of this strategy is to ensure the key stakeholders are engaged at an appropriate level in order to produce a framework with a clear set of Port Health recommendations for implementation post July 2017.

2. **Aims of the Engagement Strategy**
   - To keep stakeholders informed and engaged with the Port Health Review
   - Increase awareness of the role and activity of 'Public Health' at the border
   - To ensure engagement is held at an appropriate level (strategic and operational)

3. **Key Messages**
   - To define the roles and responsibilities of PHE in relation to public health at the border and to ensure that these are agreed and aligned with key stakeholders
   - A clear set of guidance in relation to how PHE will engage with inter-governmental departments to deliver the recommendations from the Port Health review

4. Key Milestones

- January 2017 – Port Health steering committee members identified and initial meeting held with members to outline scope and purpose of the Port Health Review
- February 2017
  - 07/02 Communication to internal stakeholders – Data collection form (deadline date 5 March)
  - Communication to Border Force (Sir Charles Montgomery, Director General)
- March 2017
  - Initial communication to key external stakeholders alerting them of the review (deadline date 31 March)
  - Data analysis of internal stakeholders – written submissions and data collection form
- April - May 2017
  - Face to face meetings to be held with key external stakeholders
  - Internal stakeholder workshop
- May - June 2017
  - Communication to external stakeholders seeking comments on our proposals

5. Stakeholders

External

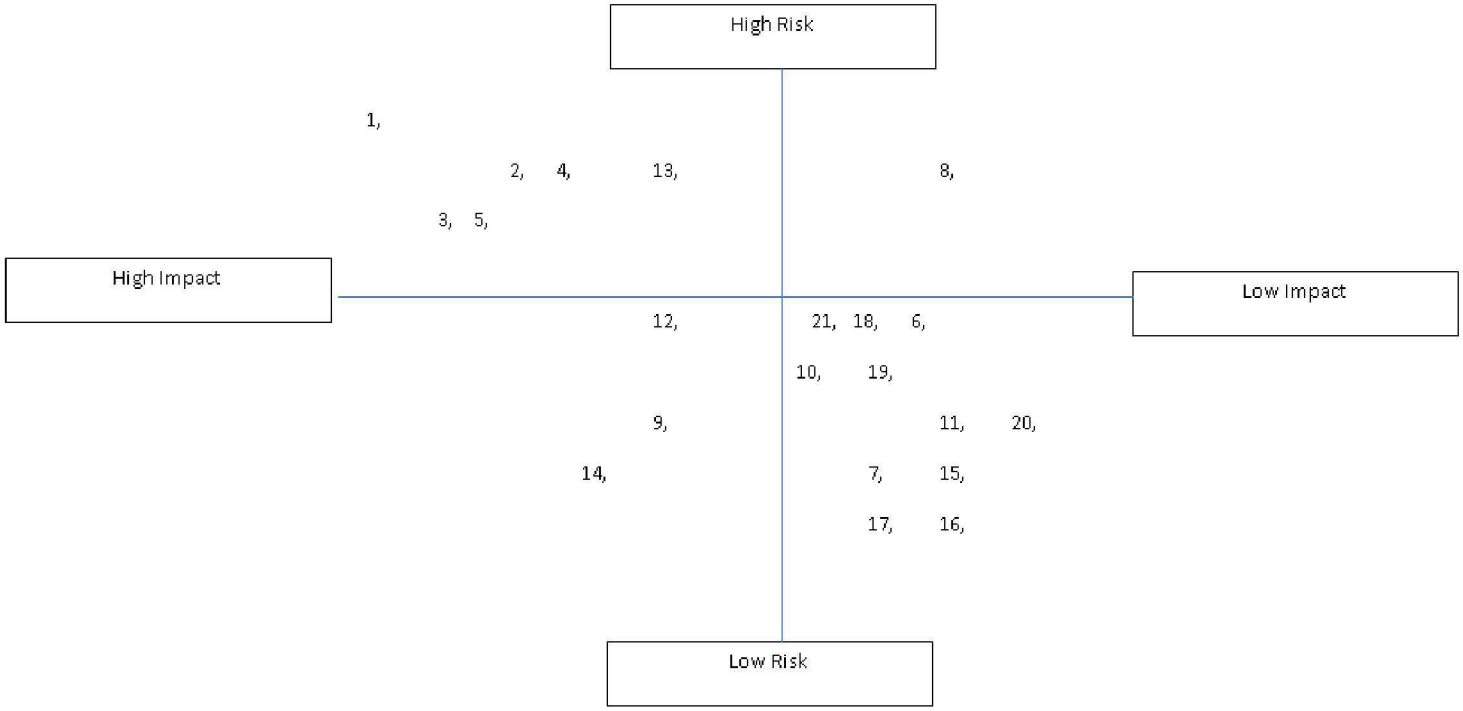
1. Home Office – Border Force Section
2. Home Office – UK Visas & Immigration
3. Department of Health
4. DfT (Department for Transport)
5. CAA (Civil Aviation Authorities)
6. APHA (Association of Port Health Authorities)
7. CIEH (Chartered Institute of Environmental Health)
8. FCO (Foreign Commonwealth Office)
9. Devolved Health Administrations (Scotland, Northern Ireland, Wales)
10. Department for International Development (DFID)

11. Department for Environment, Food and Rural Affairs (DEFRA)
12. Specialist microbiology services
13. Field epidemiology service
14. Reference microbiology service
15. Other PHE teams

Internal

16. HPTs
17. Port Health team (LHR)
18. Travel & Migrant Health team
19. CRCE
20. CIDSC
21. Specialist microbiology services
22. Field epidemiology service
23. Reference microbiology service
24. Other PHE teams

6. Port Health Review – Stakeholder Map



The stakeholder map shows the key stakeholders required for support and engagement are:

- Home Office
  - Border Force
  - UK Visas and Immigration
- DH
- DfT
- CAA

7. Stakeholder Analysis Matrix – External Stakeholders

Stakeholder	Contact Details	Impact	Influence	How could the stakeholder contribute to the project	How could the stakeholder block the project?	Strategy for engaging the stakeholder
Home Office - Border Force	**Name Redacted** **Name Redacted** @homeoffice.gsi.gov.uk Deborah Child Deborah.child@homeoffice.gsi.gov.uk Border Force National Operations, 2nd floor SWQ, Seacole Building 2 Marsham Street London , SW1P 4DF	High	High	1. Health security needs to be recognised as a threat/risk to be appropriately managed at the border as other threats are. To strengthen public health at the border, PHE need agreed principles and standards and a clear understanding of what BF would do both routinely and in special circumstances. This will help frame PHE's BAU and escalation plans. 2. Immigration – health entry requirements to agree the remit for the Medical Inspection service (Immigration Act 1971) and to agree whether there are additional things that could be done. 3. To identify what intelligence could be provided in an HCID incident i.e. intelligence work stream of HCID work.	1. If BF does not agree the framework or development of a set of guidance for BAU/outbreak incident for front line officers, PHE's capacity to deal with public health issues will be significantly diminished. 2. If BF refuses to recognise the health security agenda, no effort will be given to changing the 'status quo'.	1. Face to face meetings with key senior staff at Border Force. 2. Must engage at the right level of the organisation for change to take place. It is recommended that the CE/CE route continues to be used at both the strategic and operational level 3. PHE should use Heathrow as a "pilot" partnership. If it can be done at the busiest ports, smaller ports will follow.
Home Office – UK Visas and Immigration	Simon Peachey, Head of Visa Operations simon.peachey@homeoffice.gsi.gov.uk Tel: Mob **Irrelevant & Sensitive** **Name Redacted** @homeoffice.gsi.gov.uk Home Office 2 Marsham Street	Medium	High	1. Engagement required clarifying the QA pre-entry TB screening programme accountability framework, governance arrangements and performance strategy for the overseas TB screening clinics. At the moment there is no strategic UK led overview of the programme despite a ministerial instruction to do this. 2.Clarify accountability and governance arrangements in other areas (Hep B)	1. Lack of engagement will mean that there is no agreed account of respective organisation responsibilities. 2. It will be difficult to performance manage clinics if there are no rules for enforcing breeches and poor performance as there are in other national screening programmes. 3. Clinic Inspection visits to some parts of the world will be difficult, if not impossible if there is no collaboration from HO in	1. Face to face meeting with senior staff within the Home Office policy division as there is no effective relationship at the operational level despite trying to engage for several years. It is recommended that engagement is through the CE/CE route.

	London, SW1P 4DF				relation to overseas security intelligence and support.	
Department of Health		High	High	1. Change in legislation. 2. Influence other government departments, apply appropriate pressure 3. Devolved Administrations 4. Policy- be clear on what DH want PHE to do (responsibilities) for England and perhaps the UK and our status as "competent authority" 5. To revisit and make possible revisions to the Department of Health's instructions to Medical Inspectors guidelines	1) keeping status quo by not considering: - legislative changes - lobbying other departments on PHE's behalf - lack of engagement will make it harder to implement the Port Health review recommendations (PHE is an executive agency)	1. Deputy CE as nominated lead, all policy communication to be via this channel,
(DfT) Department for Transport	Dan Micklethwaite, Aviation Director dan.Micklethwaite@dft.gsi.gov.uk Erik Pitkethly, Deputy Director for Aviation Strategy and Consumers eirik.Pitkethly@dft.gsi.gov.uk Department for Transport Aviation Strategy & Passenger Rights, Aviation Strategy & Consumers	High	High	1. Define transport/aviation policy e.g. Changes in legislation in relation to access to airline passenger manifests/airside pass requirements in a PHEIC incident. 2. DfT can ensure public health is recognised by the national airport security committee and incorporated into the GSAT (general security training) for all airside pass holders. 3)To provide flight pattern intelligence which will inform HCID and BAU functions 3. To act as the conduit for engagement/appropriate pressure with airlines.	1) Keeping the, 'status quo' by not considering: - legislative changes - lobbying other organisations on PHE's behalf 2) Not agreeing with PHE's recommendations will delay implementation.	1. Deputy CE as nominated lead, all policy communication to be via this channel.
CAA (Civil Aviation Authorities)	Andrew Haines, Chief Executive Andrew.haines@caa.co.uk	High	High	1. As port regulators, CAA can require port operators to take note of public health requirements. E.g. need to meet CAPSCA (collaborative	1. Lack of engagement could have an impact on implementing the Port Health review recommendations. 2. Refusal to influence/ make	1. Deputy CE as nominated lead, all policy communication to be via this channel.

	Chris Tingle, Chief Operating Officer chris.tingle@caa.co.uk Civil Aviation Authorities CAA House 45-49 Kingsway London, WC2B 6TE			arrangement for the prevention and management of Public health events in civil aviation) standards. 2. Changes in licensing agreements. 3. Possible 'route in' to ensure appropriate Isolation facilities are available at suitably identified high risk ports.	changes to licensing agreements will mean negotiations will need to take place at local level with port operators. The drawback to this is that there will be no consistency in processes agreed.	
*APHA (Association of Port Health Authorities)		High	Low	1. Help canvas opinion amongst some local authorities and smaller ports.	No capacity to block the project.	Keep informed via email, telephone briefings.
Chartered Institute of Environmental Health	Tony Lewis, Head of Policy t.lewis@cieh.org Chadwick Court, 15 Hatfields, London, SE1 8DJ Tel: **Irrelevant & Sensitive**	Low	Low	1) Help with best practice and standard setting 2) Help with influencing environmental health practitioners	No capacity to block the project.	Keep informed via email, telephone briefings.
FCO (Foreign Commonwealth Office)		Low	Low			Keep informed via email, telephone briefings
Devolved Health Administration – Health Protection Scotland	**Name Redacted** Senior Epidemiologist Travel & International Health **Name Redacted** @nhs.net Health Protection Scotland Tel: **Irrelevant & Sensitive**	Low	Low	To agree consistency in UK wide approach and alignment, where possible.	If UK wide approach comprises with Scotland's Port Health strategy.	Keep informed via email, telephone briefings.
Devolved Health Administration – Wales		Low	Low	To agree consistency in UK wide approach and alignment, where possible.	If UK wide approach comprises with Wales' Port Health strategy.	Keep informed via email, telephone briefings.

Devolved Health Administration – Northern Ireland		Low	Low	To agree consistency in UK wide approach and alignment, where possible.	If UK wide approach comprises with Northern Ireland's Port Health strategy.	Keep informed via email, telephone briefings.
DFID				1. Agreement of HCID returning workers framework between PHE and DFID and linkage between efforts overseas and the border e.g. returning worker schemes.	No capacity to block the project	
DEFRA		Low	Low	To provide feedback and to ascertain whether any links required with DEFRA's Port Health work.	No capacity to block the project	Keep informed via email, telephone briefings
LGA (Local Government Association)						

*APHA - It is important to note that the larger ports are no longer APHA members; Heathrow, Gatwick, Southampton, Birmingham.

5.8 Appendix F – SWOT analysis

<table>
<tr><td rowspan="4">Option A:
Fully centralised model where all port health functions and services are delivered by dedicated staff with single accountability arrangement</td><td>Strengths</td><td>Weaknesses</td></tr>
<tr><td>• The service is delivered by experts and allows for an overview and co-ordination of unique and valuable contributions from different departments to ensure they all fit together
• Increases control, consistency/uniformity and accountability, especially if there is a legal dimension
• Increases speed of implementation of high level principles and decisions; particularly useful for crisis management
• Allows for consistency nationally
• Accountability is simple and clear
• Effective surveillance and alert function</td><td>• Slower response to local changes in the environment
• Span of control may be too large making delivery unmanageable and bureaucratic
• Lose local initiative
• Lack of flexibility
• Inconsistent with general PHE working models
• Lack of PHE visibility at local ports; local links will be lost
• Still need local staff to ensure the application of protocols</td></tr>
<tr><td>Opportunities</td><td>Threats</td></tr>
<tr><td>• Improve the formulation of standard strategies and procedures
• Will enable delivery of a consistent “product”; deliver a first class service
• Will enable PHE to deliver within national support agreements from other partner agencies e.g. BF, HO, DfT etc.</td><td>• May not be compatible with professional decision making/ethos
• May not be compatible with centre level organisation if applied to its extremes
• There may be insufficient capacity to deliver all functions from a central point</td></tr>
<tr><td colspan="2">Best for the following functions:

Strategic coordination of PHE port health work including:

- Implementation of policies; e.g. health register for major incidents, disinfection / infection control standards
- Participation in PHE Quality Model, quality improvement plan and engagement with adverse incident reporting and management
- Coordination of sharing best practice and lessons learnt
- Coordination of Port Health activity in incident response and PHEICs (e.g. large contact tracing exercises)
Establishment of standards and provision of training including:
- Development of PHE guidance and templates in relation to port health
- HCID related work on standards and protocols
- Development of preventive materials, PH messages and health guides</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">- Hazards guidance for Port Health, incl. non-infectious disease threats
- Reassurance to Ministers and DoH

Delivery of front-line activities at highest risk ports (Heathrow and Gatwick) including:

- PMI delivery (in person at Heathrow/Gatwick and by phone to rest of country),
- Advisory and liaison functions at Heathrow/Gatwick

Trans-border activities:

- Pre-entry TB screening
- Immigration and refugee programme
National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH)
Advisory function:
- Advice to DH
- Advice on IHR implementation e.g. SSCs and DsP

Others
National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH)
International collaboration and port related IHR obligations
Global surveillance and alerting systems</td></tr>
<tr><td rowspan="4">Option B:
Hub and spoke model</td><td>Strengths</td><td>Weaknesses</td></tr>
<tr><td>In reality all organisations are a mixture of decentralised and centralised functions.
National would keep the overall function whilst allowing Centres to develop the local service with their stakeholders
An overlap between functions, i.e., Local Authority EH, can lead to smart working opportunities whilst delivering efficiency and good value for money
Realistic and sustainable option
Can achieve consistency with flexibility
Centre staff are engaged with local ports, having a greater understanding of local needs through place base role</td><td>Lack of resources at Centre level (skills, knowledge and staff)
Flexibility could confuse and lead to gaps in the service
Risk of local arrangements developing independently leading to inconsistency in response
A good method of internal communication is required to ensure all the ‘spokes’ are informed and aware of activities going on in other parts of the port health system</td></tr>
<tr><td>Opportunities</td><td>Threats</td></tr>
<tr><td>Allows PHE to empower employees</td><td>Potential for inter departmental and</td></tr>
</table>

	to act by delegating responsibility to the lowest possible level within an organisational "standards" framework • Development of effective public health at borders network within PHE	inter personal conflict • Will require sufficient attention to be paid to the development of good relationships and partnership working • Lack of clarity around boundaries of responsibility • Without clear coordination, some of the 'spokes' may continue acting autonomously without the intended degree of coordination
	Functions best in the hub: **Strategic coordination of PHE port health work including:** - Implementation of policies; e.g. health register for major incidents, disinfection / infection control standards - Participation in PHE Quality Model, quality improvement plan and engagement with adverse incident reporting and management - Coordination of sharing best practice and lessons learnt - Coordination of Port Health activity in incident response and PHEICs (e.g. large contact tracing exercises) Establishment of national standards and provision of training including: - Development of PHE guidance and templates in relation to port health - HCID related work on standards and protocols - Development of preventive materials, PH messages and health guides - Hazards guidance for Port Health, incl. non-infectious disease threats Delivery of front-line activities at highest risk ports (Heathrow and Gatwick) including: - PMI delivery (in person at Heathrow/Gatwick and by	**Functions best in spokes:** **Acute PH response including:** - Response to notifications of cases or outbreaks of infectious diseases, chemical and other incidents - Contribution to UK response to Public Health Emergencies of International Concern **Planning and preparedness including:** - Development of local Port Health Response Plans proportionate to risk - Emergency planning and preparedness working with key stakeholders - Delivery of statutory functions and duties of medical officer (joint PHE/LA responsibility) - Negotiation of local arrangements with ports re. airside passes and airside room**(supported by national arrangements)** Provision of training and education of external professionals (Co-)organisation of Emergency Planning exercises at ports (Co-)organisation of local multi-agency Port Health Liaison meetings Surveillance of and response to chemical and radiation events Microbiological examination of food and animal feed samples

	phone to rest of country) - Advisory and liaison functions at Heathrow/Gatwick **Trans-border activities:** - Pre-entry TB screening - Immigration and refugee programme National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH) Advisory function: - Advice to DH - Advice on IHR implementation e.g. SSCs and DsP **Others** National communication and collaboration with key national external partners (UKBA, HO, DfT, CAA, APHA, CIEH) International collaboration e.g. CAPSCA and port related IHR obligations Global surveillance and alerting systems	Assistance with / training or advice on microbiological sampling on-board Other locally agreed HP functions and responsibilities (e.g. Animal Reception Centre, Advice on health of Immigrants) Courier collection of samples and transport to the laboratory Provision of formal certificates and witness statements to inform about food microbiological quality Production of microbiological test results to support issue of Ship Sanitation Certificates
Option C Fully de-centralised model where all port health functions and services are delivered as part of the range of responsibilities of many teams and members of staff in PHE with accountability through various management lines.	**Strengths** • Allows for more flexibility; rapid response to local changes, tailored to specific problems • Enables managers closest to the problem to take the initiative • Appropriately takes the burden away for some decisions from a central decision making structure which may have bigger priorities to manage	**Weaknesses** • Results in duplication of effort • Associated with "functional myopia" in the literature i.e. big picture becomes blurred and focus is lost • Will result in inconsistency and invisibility across ports • Hard to mount nationwide response due to lack of control and lack of national oversight • Greater demand on certain HPTs or PHE services near large ports
	Opportunities • Will encourage innovation if port health is a priority area for attention • Will allow local arrangements and relationships to be leveraged to their fullest potential e.g. in emergency response • Staff development	**Threats** • May not be compatible with an organisational culture/remit that requires consistency • May result in the improper discharge of statutory functions • Does not allow for a central repository of expertise/specialisation

		when an overview is required
	Best for the following functions: **Acute PH response including:** - Response to notifications of cases or outbreaks of infectious diseases, chemical and other incidents - Health protection responsibilities including MO role on behalf of Las as per PHE's extant way of working [but to consistent standards] - Contribution to UK response to Public Health Emergencies of International Concern **Planning and preparedness including:** - Development of local Port Health Response Plans proportionate to risk - Emergency planning and preparedness working with key stakeholders - Delivery of statutory functions and duties of medical officer (joint PHE/LA responsibility) - Negotiation of local arrangements with ports re. airside passes and airside room(supported by national arrangements) Provision of training and education of external professionals (Co-)organisation of Emergency Planning exercises at ports (Co-)organisation of local multi-agency Port Health Liaison meetings Surveillance of and response to chemical and radiation events **Other functions** Microbiological examination of food and animal feed samples Assistance with / training or advice on microbiological sampling on-board Other locally agreed HP functions and responsibilities (e.g. Animal Reception Centre, Advice on health of Immigrants) Courier collection of samples and transport to the laboratory Provision of formal certificates and witness statements to inform about food microbiological quality Production of microbiological test results to support issue of Ship Sanitation Certificates Immigration and refugee programme	