PORT HEALTH AND MEDICAL INSPECTION REVIEW

REPORT FROM THE PROJECT TEAM

MARCH 2006

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EXECUTIVE SUMMARY

Following the creation of the Health Protection Agency (HPA), the Department of Health (DH) and the Home Office (HO) agreed that there should be a review of port health. A joint DH, HO and HPA Steering Group was established to oversee the work, and a joint HPA and HO Project Group was asked to undertake the review.

The Terms of Reference were:

- to review the functions of medical inspection of persons subject to immigration control, and port health, at English ports, airports, and juxtaposed controls
- to make practical recommendations, drawing upon current best practice, for improvements in efficiency and effectiveness within existing overall resources and within the current policy framework, so as to ensure that the policy is delivered through safe and secure services according to consistent national criteria while fitting local needs
- to form a concrete action plan for implementation
- to work with stakeholders including Primary Care Trusts and other local partners
- to report to a Steering Group (SG) chaired by DH, and including senior Home Office and HPA Local & Regional Services (LARS) colleagues
- to complete the remit within about six months, advising the Steering Group on key milestones at which it would need to check progress and direction

The Project Group reviewed the literature, took oral evidence from key organisations and individuals and conducted surveys of a wider group. The main issues to emerge were:

1. The overall purposes of health activities at international terminals are to protect the UK population from the adverse impact of imported disease, to support the Immigration Service in its responsibilities and to comply with the IHRs. The accountabilities for these are derived from a wide range of legislation and involve several organisations. It was clear that there was a great deal of confusion about the accountabilities and responsibilities, and the Group recommended that an accessible description of these should be made widely available.

2. In relation to the Immigration Act, the group recommended that the HPA as an organisation be asked to take on the responsibilities that are currently undertaken by individual Medical Inspectors appointed on behalf of the Secretary of State. This would allow the HPA to take an overview of these arrangements and ensure a standard national system with quality standards.

3. As regards Port Health (that is the responsibilities derived from the Public Health Act) the Group asked that the HPA, Local Authorities and PCTs should work together to manage health protection activities at ports. The HPA should take an overview of the arrangements (at least in relation to human health) at each port.

4. The Group was also concerned about the lack of health care arrangements for passengers detained by the immigration service and recommended that the HO should ensure that appropriate arrangements are in place.

5. There was considerable concern about the arrangements for screening for TB at ports. Of around 270,000 people entering the UK for more than six months from countries at high risk of TB, only about 73,000 were screened by X rays; and as a result of these there were only 90 TB diagnoses. It was not possible to establish how many of these were infectious, and the Group had major doubts about the effectiveness and efficiency of the programme. The Group recommended an urgent review of TB screening at ports and an overhaul of the associated information systems that are supposed to inform CsCDC and the NHS of new entrants who need assessing.

Finally, the Group examined a number of other issues:

- Emergency planning – recommending that emergency plans for public health issues at ports needed to be compatible with the emergency plans of PCTs and LAs

- Surveillance – recommending that the HPA should work with the Board of Airline Representatives to agree how information for and on passengers could be made available if this were necessary

- Skills mix – suggesting that a wider skills mix might be needed

- Facilities and accommodation – recommending that the HO and DH should develop plans for free of charge facilities for medical inspection at ports

- Quality – strongly urging that services are brought into the mainstream of HPA and NHS provision so as to put them into normal clinical governance arrangements

INTRODUCTION

This review was carried out for two main reasons. First, with the creation of the Health Protection Agency (HPA) and the related changes in roles and responsibilities, there were concerns within the Agency, Department of Health (DH) and Home Office (HO) about the effective functioning of health protection services at ports. Second, there has been a massive expansion in international air travel over the last decade and this has altered the demands on port health. It was undertaken by an HPA chaired Project Group with Home Office and HPA membership and had the following terms of reference

Terms of Reference

- To review the functions of medical inspection of persons subject to immigration control, and port health, at English ports, airports, and juxtaposed controls
- To make practical recommendations, drawing upon current best practice, for improvements in efficiency and effectiveness within existing overall resources and within the current policy framework, so as to ensure that the policy is delivered through safe and secure services according to consistent national criteria while fitting local needs
- To form a concrete action plan for implementation
- To work with stakeholders including PCTs and other local partners
- To report to a Steering Group (SG) chaired by DH, and including senior Home Office and HPA Local & Regional Services (LARS) colleagues
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During the course of the review there were two further significant developments. New International Health Regulations were adopted by the World Health Organisation in May 2005 and are due to come into force in June 2007. The requirements they place on port health services are different from those created by the International Health Regulations 1969 (IHR) that are currently in force. Additionally, in February 2005, the Government announced plans to alter aspects of immigration controls – including ensuring TB screening for people from high risk countries takes place in the country of origin rather than the port of entry. Both of these became further important contexts to the review.

PROCESS

A Steering Group was established (Appendix 1) with membership drawn from the HPA, HO and DH, and then a Project Group (Appendix 2) to review the literature, take evidence and produce a draft report. As regards the scope of the review, the main focus was the medical inspection of persons subject to immigration control, but the review also considered the port health function. It became clear that there were also links with issues to do with the care of sick travellers at ports, and while the Terms of Reference did not specifically include this function, the close relationships made it necessary to look at and comment on all three aspects of the service. Clearly issues to do with food, animals and conveyances at ports are equally relevant to human health, and these services were described in evidence. However, the focus of the Project Group was in the main more on hazards directly associated with people. For the purposes of the review, the phrase 'health activities at international travel terminals' was used to cover all the health and health care related activities that occur in international travel terminals/ports. Other definitions used are described in the Glossary.

The Project Group met several times during 2005. The Group identified and reviewed the significant UK reports on medical inspection and port health over the last decade (Appendix 3), clarified the key issues that needed to be resolved, and sought the views of stakeholders by sending a questionnaire (Appendix 4) to Primary Care Trusts (PCTs) with ports in England, the Local Authorities of the major ports, Strategic Health Authorities, Health Protection Units, Manchester, Gatwick and Heathrow Airports and other national bodies involved in health activities at international travel terminals. These included the Association of Port Health Authorities. Information on the resources spent on the different elements of these services was obtained by a questionnaire sent to key providers (Appendix 5). Appendix 6 documents the respondents to these questionnaires. In addition 17 key organisations and individuals (Appendix 7) provided oral evidence structured around the first questionnaire.

The UK Immigration Service had already undertaken a survey of medical inspection at all ports in the UK to describe various organisational and capacity issues, and its findings were considered as part of the process.

The Report describes the purpose of health activities at international travel terminals, and the current service provision. There are detailed sections on accountability and screening for tuberculosis (TB), and an exploration of other issues including quality, emergency planning and finance. The information from the questionnaires and from those giving oral evidence are not presented separately. Rather they are integrated into the relevant sections of the report. The recommendations are presented together at the end of the report.

THE PURPOSE OF HEALTH ACTIVITIES AT INTERNATIONAL TRAVEL TERMINALS

The UK has domestic and international obligations, for managing health risks associated with the movement of people and goods through its air, sea and train ports, and for managing the medical needs of travellers and others employed at, or visiting ports.

- The principal international requirements, due to come into force in June 2007, are set out in the World Health Organisation's International Health Regulations 2005. Their stated purpose is *"to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade"*

- Domestic legislation – the Public Health (Control of Disease) Act 1984, and associated Regulations – gives effect to some aspects of the IHR 1969, making provision for medical examinations of travellers and inspections of conveyances

- The Immigration Act 1971 provides for the medical inspection of persons subject to immigration control entering the UK. These are discussed in more detail later

This section explores what the purpose and function of health activities at international travel terminals (including the medical examination of people subject to immigration control) should be in the light of the public health and legislative environments and the arguments the review heard.

Findings from questionnaires and oral evidence
It was clear that respondents generally agreed on the general scope and purposes of health activities at international travel terminals, in particular that the underlying purpose was to protect the health of the UK's population. However perceptions did vary, particularly in relation to whether the care of ill travellers and others at ports should be part of the scope of such services. Many felt that it should not, although the care of ill travellers is required by the IHRs; albeit not necessarily at ports. One PCT commented, "the difficulty … is that port health is not really a service at all. It is a setting in which a number of functions are fulfilled".

Some respondents indicated that there should be more emphasis on proactive preventive work, including providing health information and advice for travellers and new migrants, and acting on WHO intelligence. Some mention was also made of action to protect the public purse by avoiding expensive NHS treatment for people who are not entitled to it, the benefits of health screening to the individuals concerned; and in the case of students, to the colleges where they would be studying.

Many of the environmental health functions required by legislation and dealt with by Port Health Authorities, were described to the Project Group by representatives of the APHA.

They felt that these functions are part of health activities at international travel terminals, and that they should have had a greater role in this review.

Conclusions

The Group considered that it was important to be clear about the overall purposes of health activities at international travel terminals. Given the importance of the IHRs, the Group believed these to be to:

- comply with the requirements of the IHR
- protect the population of the UK from the adverse consequences of imported diseases (including issues concerned with public health and those to do with the public purse)
- prevent the export of infection from the UK

As regards the specific functions that are the focus of this review, those giving evidence felt that they should be:

1. the medical inspection of arrivals under the 1971 Act
2. support for the Immigration Service at ports, including generally advising immigration staff on medical matters and providing for the medical needs of immigration detainees
3. ensuring the capacity to respond to actual or potential threats to public health locally (in the context of international travel)
4. contingency planning for response to public health emergencies of international concern
5. the assessment and care of ill travellers

There are other health functions in ports such as occupational health or environmental health that lie out with the subject of this review

These five functions broadly correspond with the three areas of work described in the section on accountability later in this review. That is medical inspection (function 1), port health (functions 3 and 4) and the care of sick travellers including detainees (functions 5 and 2).

ACCOUNTABILITY

Accountability and responsibility for public health services at ports emerged as critical issues. To assist with exploring the issues, the current arrangements are outlined with a summary of the evidence received.

Current arrangements
The arrangements are complex, and there is no doubt that the different lines of accountability for the various functions and their diverse legislative and professional origins are hard to follow. This section does not pretend to be a text-book for those wishing to understand every nuance. Rather, it provides a high level overview of the main lines of accountability and of their underlying origins.

The origins of the current accountability arrangements are derived from:

- the Public Health (Control of Disease) Act 1984 and its Regulations
- the Immigration Acts, including the Immigration Act 1971, the Asylum and Immigration Act 1999 and the Nationality, Immigration and Asylum Act (2002), and Immigration Rules (HC 395 as amended) made under the Immigration Act 1971
- the International Health Regulations
- the HPA Act 2004
- relevant DH Executive Letters and Health Service Circulars and Guidance. These include HC(88)64, EL/HSC(91)123, HSG(93)56, HRC(73)34
- the NHS Act(s) and the consequent changes in structures and responsibilities, and
- the Civil Contingencies Act

The rest of this chapter explores the impact of all the above on the three main areas (medical inspection, port health and care of sick travellers) covered by this review.

Medical inspection of persons subject to immigration control
The responsibility for this function falls to the Secretary of State for Health. At the moment this is discharged through the NHS and HPA, and the resources to support the function are also split between these two routes. This dual route has led to some difficulties and confusion. The responsibility for the employment of medical inspectors falls to the employing organisation which may be the PCT or HPA. The HPA formally appoints them on behalf of the Secretary of State for Health so as to support a Home Office

responsibility (the Immigration function). However no single organisation has a responsibility for the provision of the service.

Medical inspectors are appointed under the Immigration Act 1971. The Act provides that anyone subject to immigration control seeking to enter the UK may be referred for a medical examination. DH has issued Instructions to Medical Inspectors to assist them in their role, though these have not been amended for over 10 years. The Immigration Rules say that Immigration Officers should refer all who intend to remain in the UK for more than six months to the Medical Inspector, but the policy has long been that only those arriving for more than six months from countries with a high TB incidence should routinely be referred. In addition, passengers who mention health or medical treatment as a reason for their visit, or who appear not to be in good mental or physical health, should also be referred to the Medical Inspector.

Should a Medical Inspector advise that any passenger is suffering from a condition that may interfere with his or her ability to support themselves or their dependants, the Immigration Officer should take this into consideration in deciding whether to admit them. Where someone is entering for private medical treatment, the Immigration Officer should also take account of the Medical Inspector’s assessment of the likely cost of treatment in deciding whether they have sufficient means at their disposal. While it is clear that the Medical Inspector has a role in protecting both the public health and the public purse, in practice, it is very unusual for such cases to be refused entry by immigration staff, and in reality medical inspectors only have a peripheral role in immigration issues. The Project Group was not able to obtain information on the precise impact of Medical Inspectors’ advice on immigration decisions, and it would have been helpful had this been possible. Any future evaluations of this function would benefit from this information. What was clear however was that at the major ports, large parts of their time are associated with X ray screening for TB.

Where entry to the UK is granted, there is a statutory gateway in the Nationality, Immigration and Asylum Act 2002 for Medical Inspectors to pass information about migrants they have examined to a health service body, to enable the NHS locally to contact the entrants concerned and offer them any further investigations or treatment that might be desirable.

Medical Inspectors are employed by different organisations (PCTs or the HPA) and as individuals often have other responsibilities within ports as well. In smaller ports, HPA staff who have the role of Medical Inspectors are almost always the Port Medical Officer and the Consultant in Communicable Disease Control (CCDC). We learnt that many Medical Inspectors are asked to provide care and advice for sick travellers and staff. Whether or not they are competent to provide these functions, they clearly fall outside the narrow responsibilities defined by the Immigration Act and the relevant Instructions.

Port Health

The port health responsibilities with which this report is concerned arise from the Public Health (Aircraft, Ships, International Trains) Regulations made under the Public Health (Control of Disease) Act. In the same way that local authorities need to appoint proper officers for functions identified in the Public Health (Control of Disease) Act, so those local

authorities with port health responsibilities need to appoint medical officers for functions identified in the port health regulations.

It is very common for CsCDC employed by the HPA to be appointed by the local authority as medical officers although the responsibilities can be and are undertaken by others. For example at Gatwick, these medical officers are mainly PCT employees though one of the local CsCDC is also a port medical officer. In practice, financial support for medical officer roles has largely fallen to the HPA, because they either employ the staff or use their resources to commission the service.

This review has focused on hazards directly associated with people, and not on the activities and responsibilities of environmental health practitioners (EHPs). The Project Group was clear that these staff make a vital contribution to human health protection. Amongst other roles EHPs play an important part in tackling human infectious disease outbreaks, in partnership with Health Protection Agency colleagues and this role in outbreak control is long established. They provide an essential surge capacity and are well placed to do this as result of their wider port health roles.

Care of sick travellers

Although these issues were not explicitly in the Terms of Reference of the review, the practical relationships are so strong that it is essential to explore this area, especially given that several respondents were unclear about the relevant responsibilities. To understand the issues it is necessary to distinguish between a number of issues:

- **Port side and land side.** Many respondents distinguished between port side and land side. All ports have separate areas for Immigration Control and passengers on port side have not formally been admitted to the country, while those on land side have. The understanding of the Group is that in relation to the responsibilities that fall on the NHS, this distinction is not relevant in that (in general), the NHS has a responsibility to provide emergency care for anyone in the UK whether or not they have been formally admitted. There is no requirement on PCTs / the NHS to provide specific services at ports, and the various walk in primary care centres that exist at some ports are either privately operated, or are funded by PCTs because they have chosen to invest in them, not because they have to invest in them. The distinction that respondents identified about port and land side may lead to some confusion about responsibility for emergency care and about how it can be provided

- **Passengers detained by Customs**. For such passengers, the customs authorities have made arrangements via the Forensic Medical Examiners (formerly the police surgeons) to provide assessment and care for detained passengers; and we heard of no specific difficulties with this arrangement

- **Passengers detained by the Immigration Service.** As far as could be ascertained, there is no arrangement between the Immigration Service and any healthcare provider to assess and treat sick passengers who are detained at ports, although presumably the Immigration Service is subject to the same duty of care as Customs.

In general it is rare for passengers to be held at ports for more than 24 hours because beyond this they are transferred to centres, the arrangements for which include contracts with healthcare providers. However – and this point is explored later – it is common for those detained to require some sort of medical/nursing attention, and immigration staff at times ask health professionals in ports (medical inspectors, port medical officers) to provide clinical input. Their wider obligations as professionals often lead them to provide such support and input even though this is beyond their formal organisational responsibilities

Other issues

Some specific issues emerged during the review. Many of these are to do with service provision rather than accountability:

- CsCDC and PHAs are sometimes unclear as to the basis on which the CCDC is acting when they are providing advice in a port context. Was this general professional advice, was it as a proper officer or as a medical officer?
- PHAs are unclear as to how they can get more or better medical support for their port health responsibilities. This appeared to be because of a perceived lack of clarity as to where the responsibility for provision lies
- there was a consistent message about the difficulties for port health staff and for medical inspectors when they are asked to provide clinical input for people detained by the Immigration Service. This arose because they were not resourced to do this and / or because they had no responsibilities in this area and / or because the staff were not properly trained for these responsibilities
- the split funding line (that is some of the finance going via the HPA and some direct to PCTs) for the medical inspection role created difficulties for providers in not knowing who to turn to in relation to funding issues
- the fact that the Instructions had not been updated for over ten years reduced their credibility and impact
- the interpretation of the Instructions varies between ports, and what Immigration staff value is the non specific support that the Medical Inspectors offer in relation to clinical concerns with individuals. This includes explaining what medicines might be and asking whether they should be concerned because of a particular diagnosis
- concerns about the quality of the medical inspection function. The Immigration Service survey showed large variations in the nature and scale of provision between ports. Some of this did reflect real differences between ports; but most appeared to reflect history rather than need or risk
- concerns about variations in the nature and quality of the port health and medical inspection function. There are no clear competencies or training arrangements; and there is no obvious mechanism for raising standards and ensuring appropriate consistency
- At Heathrow, a pedal powered paramedic team provide immediate care to anyone in the port and the PCT reported that the service was well received and had reduced the proportion of cases being taken to hospital
- Some respondents suggested that in the larger ports where the need and demand for medical inspection, port health and health care is considerable, it might be

sensible to have a one stop shop model. In this, a single provider would deliver all the functions with appropriately trained staff. The fact that the accountabilities for the different functions were in different directions should not be seen as an obstacle to a simpler and integrated service

Conclusions and recommendations
The Group identified considerable confusion amongst organisations and professionals in relation to the range of health related functions in ports.

Recommendation:

1. the DH, HPA and HO should publish a clearly written explanation of accountabilities and responsibilities for stakeholder organisations and staff. This should be accessible from the websites of all three organisations, be subject to regular joint review and be drawn to the attention of those with a need to know

Medical inspection. The arrangements for appointing inspectors are clear, though it would seem that there is still a task for the HPA to communicate them to those with a need to know. The big issues concern funding and quality. Split funding has led to providers not knowing where they can discuss resource issues and to an inability of the whole system to think about how best to use the total resource that is currently being applied to the function. Regarding quality, there are serious concerns about the lack of standards and consistency, as the function appears to sit outside mainstream clinical governance arrangements.

Since medical inspection is a national service, there is a strong case for bringing the funding streams together and for making the same organisation responsible for ensuring delivery of a service to consistent and high standards. The Group considered a number of options for this and concluded that the best way ahead would be to route all the funding for medical inspection via the HPA, and for the DH to ask the Agency to ensure a consistent and high quality service.

The difficulties the Group identified in documenting the impact of advice on immigration decisions needs addressing and some form of routine system needs to be established.

Recommendations:

2. the HPA should be given the responsibility and resources for ensuring that medical inspection under the 1971 Immigration Act is delivered appropriately and consistently in England. This could either be delivered directly (via staff employed to do this alone or as part of the job of staff with other responsibilities) or by commissioning a service from PCTs or (given the recent plans for NHS changes) from NHS Trusts or other providers. This would also allow the HPA to mainstream the clinical governance issues including training and standards

3. the HO should ensure that there are systems for monitoring the response made in immigration decisions to the advice of Medical Inspectors

Instructions to Medical Inspectors

It is clear that these are instructions from the DH to the clinicians involved in relation to their role in supporting immigration staff, and the need for instructions can be seen to arise from the statutory basis of immigration. The role has elements to do with the public health and some to do with the public purse; but issuing instructions can sit uncomfortably with the more normal means of getting policy and advice out to clinical NHS staff; and in practice the contribution of the role to immigration matters is very limited. If the HPA were to assume responsibility for medical examinations, then there would be no need for Instructions to Medical Inspectors. If this does not happen, then one way of dealing with the issue would be for the DH to instruct Medical Inspectors to take note of HPA advice on specific health issues / concerns that the HPA might issue from time to time. Similar advice could also be issued to HPA staff responsible for or involved with Port Health, since it is this latter function that is critical to protecting the UK population. Since the HPA has been established to provide advice to government and other organisations on health protection matters this approach would be consistent with its role, and allow clinicians to receive advice from an organisation they perceive as experts in the field. This would not preclude the DH from issuing its own instructions if it felt a need to, but it could create greater flexibility, and be more consistent with how the DH and HPA operate in other areas.

Recommendations:

4. if and when HPA assume responsibility for medical examinations (as recommended above) the *Instructions to Medical Inspectors* as a formal DH document may no longer be needed. Instead HPA, in agreement with its "customer" (the Immigration Service) and its "sponsor" (DH) should guide and direct these activities as appropriate

5. appropriate amendments should also be made to Immigration Directorate Instructions, which specify how the policies set out in immigration legislation including Immigration Rules should be implemented

Port Health

Achieving an appropriate degree of national consistency for Port Health emerged as an important theme, and the arguments are similar to those for medical inspection. Since the skill base for much of the port medical officer role is very similar to that of CsCDC, and since the main purpose of the function is to protect the UK from imported infection, then it makes sense to make the HPA and its senior professional staff central to the function and roles. There is however a difficulty. A common scenario is for medical officers to be asked to board a plane because of illness aboard it. At that point there is in effect a triage function because the clinical staff will not initially be clear if the concerns are to do with ensuring that those who are ill are dealt with appropriately in clinical terms, whether there is an issue that might need liaison with immigration or whether the concern is about protecting the UK (or the other passengers) from imported infection. We believe that there would be value in having the HPA take an overall responsibility for ensuring that appropriate staff are provided for the purposes of the Port Health Regulations, working with Local Authorities and PCTs to achieve this. This would not undermine the formal responsibilities of LAs and PHAs to provide the port health service, but would ensure a

proper alignment of accountability, responsibility and skills. In suggesting this, the Project Group does not assume that CsCDC should always play these roles. This would be inappropriate – in much the same way that within the mainstream of the NHS, the clinical task of assessing sick people so as to clarify whether they need clinical care and/or whether they pose a threat to the public because of an infectious disease is dealt with by routine NHS systems.

LAs and PHAs have previously been encouraged to appoint CsCDC as Proper Officers and while there is a case for reminding LAs and PHAs to use HPA staff for these positions, what is more important is that they are actively involved and retain an oversight of the responsibilities without providing the triage function described above. The details will need to be worked out at each port, but ensuring such a process would facilitate a dialogue between the APHA, LGA, DH and the HPA on standards and expectations for these roles.

Recommendation:

6. the HPA should work together with LAs and PCTs to manage health protection activities at ports in ways which draw on the expertise of all organisations and their staff

Care of sick travellers

The difficulties created by the lack of formal arrangements for health care for passengers detained by the Immigration Service in ports are considerable. Clinical staff with other responsibilities are asked to be involved when it is not appropriate for them in organisational or professional terms, and the Immigration Service runs the risk of failing in its duty of care. The adverse consequence for the NHS may be that people are unnecessarily referred to hospital, for lack of more appropriate care.

Recommendation:

7. the HO should make formal arrangements for the healthcare of sick travellers detained by the Immigration Service. In doing this, the HO may wish to note the arrangements used by customs and the police

As regards responsibilities for care for all people at ports who are not detained, it is clear that there is a responsibility on the NHS to provide emergency care; but not to provide any specific model of care. However, it was clear that there is an argument that there should be some provision at the larger ports beyond that provided by the Ambulance Service. It is not the responsibility of this Project Group to undertake a needs assessment for this sort of service; nonetheless the review noted the difficulties caused by the lack of (or inconsistent) provision of urgent or emergency health care on those responsible for medical inspection and port health. The argument is similar to that in relation to the need for care for those detained by the Immigration service. Other (perhaps untrained) staff are asked to provide care and ambulances may be used inappropriately as a front line response because there is no alternative. As regards the care of sick travellers, the DoH needs to encourage local NHS bodies to ensure that there is a clear understanding at each port of the arrangements for care and advice.

Recommendation:

8. SHAs and PCTs in whose areas the larger ports are, should work with port authorities and stakeholders to review the health services available to sick travellers and to develop any new services which may be needed; and at all ports to ensure that there are well understood arrangements for accessing NHS services when required

Should such services be funded in the larger ports, the possibility of a ‘one stop shop model’ in which health care, port health and medical inspection are undertaken by the same staff, albeit with different accountabilities for the different functions, should be considered.

Overall organisation of health activities at international travel terminals

The recommendations above relate to the three specific areas this review has looked at. However, there is also an issue about how all this is coordinated at a national level and at each port. Since the overall purpose of the services at ports is mainly to do with protecting the health of the UK population, the DH should ask the HPA to ensure that there is a single point of contact as a way into the services for Medical Inspection and Port Health at all ports. This would of itself make no assumptions about who provides the service, but it would allow the HPA to take an appropriate overview of such services and facilitate the development of a nationally consistent service with clear standards.

Recommendation:

9. the HPA should work with partners to ensure that there is a single point of contact for port health and medical inspection services at all ports, and information about this route into these services should be made widely available

SCREENING FOR TUBERCULOSIS AT PORTS IN ENGLAND

Tuberculosis in the world today

Tuberculosis (TB) is a serious but treatable infectious disease. The WHO estimates that one third of the world's population, around 2000m people, are infected with the bacteria causing the disease tuberculosis (M Tuberculosis). A comprehensive WHO study based on data from 1997, showed that out of this pool of infected people, 8m developed active TB. Around 1.5m cases occurred in sub-Saharan Africa, nearly 3m in South East Asia and more than quarter of a million in Eastern Europe. WHO estimated that with the present level of TB infection, one billion people will be infected between 2000 and 2020, 200m will develop active tuberculosis and 25m will die of it.

Tuberculosis in England

TB reached its peak in England early in the 20th century, when 300 new cases per 100,000 people were reported every year. Until the mid 1980s, the incidence of TB fell - in 1987 there were only 10 new cases per 100,000. However, in recent years, there has a small increase in the incidence of TB, so that by 2002, there were about 13 new cases per 100,000 per year.

There are marked differences in the incidence of TB in different parts of England, with most new cases occurring in the large cities. For example, there were 38 new cases per 100,000 in London in 2001, as compared to less than five in the South West of England. There are also substantial variations in incidence of TB within cities, with as much as a thirty-fold difference between London boroughs

The risk of TB is significantly higher in people from minority ethnic groups. The rate of TB in Black Africans in England in 2001 was 211 per 100,000, as compared to 145 in Pakistanis, 104 in Indians and four in the white UK-born community. People born abroad were fifteen times more likely to contract TB as people born in England. The majority of cases in people born abroad occur after they have lived in the UK for several years.

The current position on new entrant assessment for tuberculosis

Long standing policy is that new arrivals coming to the UK for over six months from a country of high incidence of TB (> 40 cases per 100,000 population a year) should be screened for TB. Historically, screening has mostly happened at the port of entry to the UK, but more recently moves have started to increase the numbers screened pre-entry.

The UK Immigration Service survey of medical inspection found that the provision of medical inspection facilities varied considerably from one port to another, and that sometimes the on-call arrangements did not work well. Heathrow and Gatwick airports are the only ports currently undertaking TB screening by x-ray and there are large differences in numbers between the two ports. The Project Group heard that at Gatwick Airport, there are differences in the procedures between the North and the South Terminals. As the x-ray facilities are only in one terminal, new entrants at the other are not screened in a systematic manner and the majority are not screened at all. Figure 1

below summarises the Group's understanding of the position for England as a whole. It is drawn from Heathrow Health Control Unit and HO statistics. Information on the overall incidence of TB among new entrants and asylum seekers is outlined in Appendix 8.

There are around 97 million new arrivals to England each year, of whom around 270,000 are from countries with a high incidence of TB and plan to stay for more than six months. However, only about 68% of these arrivals are actually referred by the Immigration Service for medical examination, and it is not clear why the Immigration Service's rate of referral of priority cases is low. Of those referred, around 73,000 (40%) were X-rayed at their port of entry. As regards the outcomes, 173 people were referred for further investigation from Heathrow and 18 from Gatwick, and around 90-100 cases of TB were diagnosed. It was not possible to find out how many had smear positive TB (the sub-group that are infectious and thus pose a public health risk), or what other diagnoses were made.

The main conclusions that can be drawn from these statistics are:

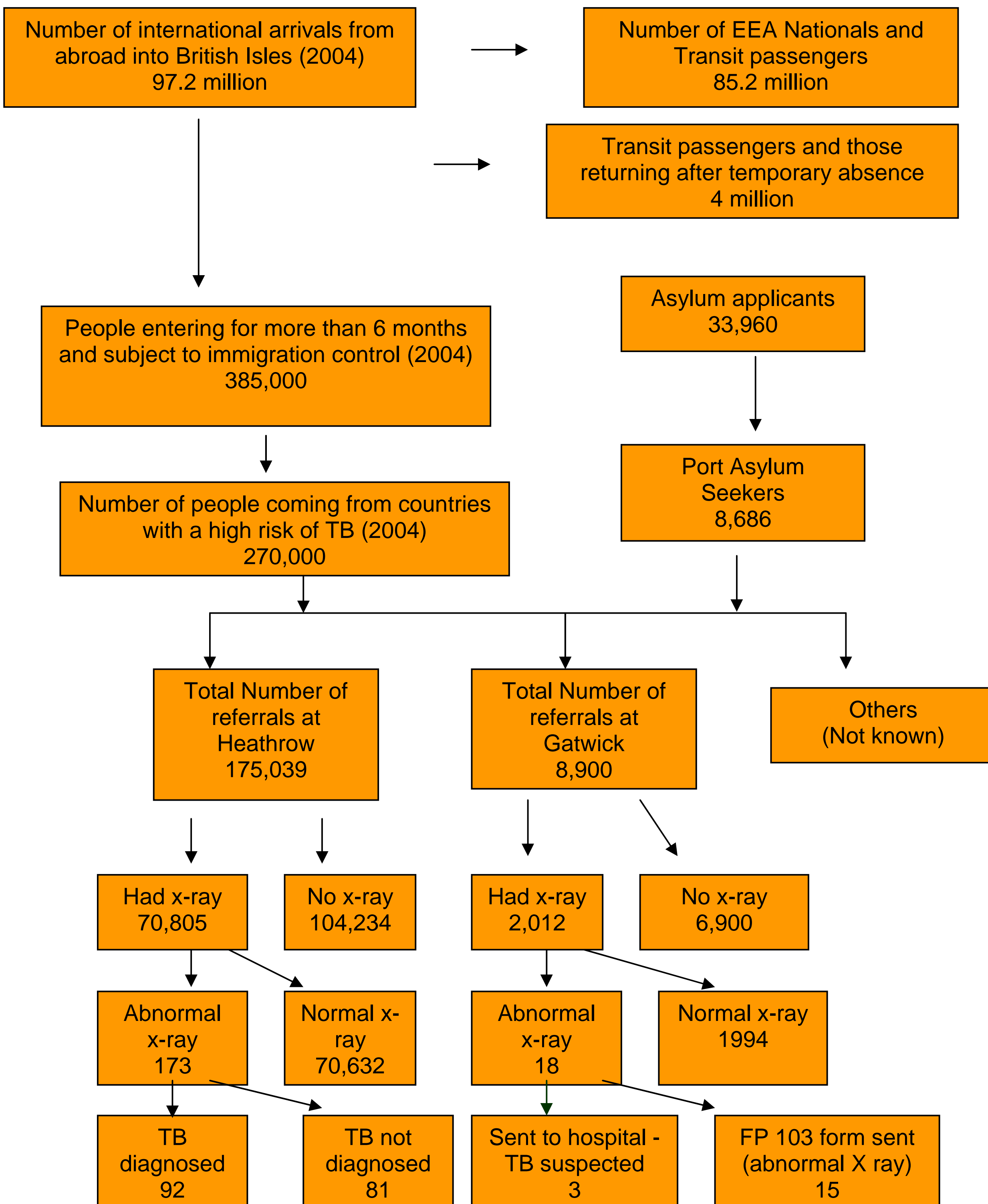
i. that nearly one third of all those arrivals who should (in line with current policy) be screened, are in fact not being referred for screening

ii. that the screening actually carried out identifies either for treatment, for refusal of entry or for temporary a relatively small number of TB cases

iii. there is no information on the numbers of cases of infectious TB that either are or could be detected by this system

iv. that even if all designated cases were in fact screened, perhaps 150 cases per year of TB would be identified; but it is unclear what proportion might be a public health risk. This is in relation to an annual incidence of TB in England of some 7000 cases per year

Figure 1



There is also policy as to how information on new arrivals is passed on to the NHS and CsCDC. Information is sent to the CCDC or PCT at the destination of the arriving passenger using a manual system based on the port health forms 101, 102 and 103. These forms are the basis for follow up of these arrivals. However, it is clear that compliance with the policy that arrivals from a high incidence country should be followed up, and offered further testing and any treatment required in the local community, is patchy and inconsistent. Many CsCDC did not have the time to organise follow up and when they did the addresses were often inaccurate. Most respondents were of the opinion that the current systems for port forms 101, 102 and 103 was not working well and that it needed modernising and overhauling.

The evidence on screening new entrants for TB

The following analysis starts from what appears to be the current *de facto* practice: that refusal of entry to the UK on grounds of TB is little, if ever used. This section therefore explores some of the issues and evidence regarding transmission of TB amongst new entrants and the value of screening; and then explores some key arguments and issues about what should happen in ports. Screening for TB at ports of entry for new entrants has often consisted of a chest X-ray at the time of arrival. This approach has been questioned, but in any case, current policy is to move to a system whereby those arriving from high risk countries are screened in the country of exit rather than the port of arrival.

There are two public health issues that need to be addressed. First, to what degree does immigrant associated TB pose a threat to public health; and related to this, could earlier diagnosis by screening produce public health benefits by reducing the period of infectivity? Second, how is TB in the immigrant population identified and treated; and related to this, could earlier diagnosis provide benefits for those already infected? The research evidence presented cast doubt on both of these issues. While a comprehensive screening programme might diagnose some cases earlier, there is evidence that migrant populations do delay seeking treatment for TB. So, screening at ports can only have a limited impact on the time of diagnosis of TB. This limits the potential benefits of a screening programme to the public health and to those individuals. The conclusion presented was that there is little if any, evidence to support migrant associated screening programmes for TB.

Further insights come from epidemiology and modelling studies. These indicate that new entrant screening is likely to make a very limited impact on overall TB control in this country. A health economics analysis recently performed by the National Institute for Clinical Excellence (NICE) (final results still awaited) suggests that even at a prevalence of disease of 4% (which is high compared with actual rates of disease found in new entrant screening programmes), new entrant screening is not cost effective. In the majority of cases the disease develops some time after arrival, mainly in the first few years but sometimes many years after arrival. This means that much more than just new entrant screening needs to be considered; a one off approach to TB in the foreign born has very limited value.

Finally, NICE recommends assessing new entrants from high risk countries so as to make BCG vaccination available to those under 35 who could benefit from it, and to ensure that

those with TB infection who would benefit from a clinical intervention receive one (Appendix 9). However, they make no recommendations about how such a comprehensive assessment programme might be organised. The review heard concerns that this could not happen in ports as the assessment requires a degree of continuity of care which ports cannot provide. Supporting this view, the working group of the Public Health Medicine Environmental Group (PHMEG) reported that early integration into the health service at the primary care level was the most likely way of both addressing the wide range of health needs and in ensuring the individual and public health importance of early TB diagnosis, prevention and treatment.

The majority of responders to the questionnaire felt that TB screening by X ray at ports should be stopped. Of the Health Protection Units who responded, 74% felt screening at ports should decrease or be stopped, 21% had no comments and only 5% wanted it to continue.

Conclusions and recommendations

- Port of arrival systems fail to screen all those individuals who should be offered screening. No consistent information was presented to the review about why this was the case, except that at Gatwick an absence of an X ray machine in one of the terminals was an issue
- It was not possible to document the numbers of cases of infectious TB detected via the current port systems, nor how much earlier all the cases of TB were detected than they would have been through routine NHS systems. However, the port systems only detect about 100 cases of TB a year
- The information systems that pass on information from the Immigration Service to local bodies (the Port Health Forms) to support screening are inefficient and ineffective
- New entrant screening (including that done for asylum seekers) is likely to make only a very limited impact on overall TB control in this country because the reduction in transmission and the benefit to the individuals themselves from early identification of disease at ports is probably very small
- There is little if any evidence to support the continuation of chest X-rays at the port of entry as a screening method
- Most of the responders to this review with an interest or expertise in TB were of the view that the TB screening at the ports should either be stopped or decreased
- Recently published NICE guidance (currently out for consultation) recommends that new entrants should be assessed and managed for tuberculosis at a primary care level or in a community setting
- This assessment cannot be done at the port of entry because tuberculin testing and reading cannot be done in a single day and new entrants cannot be delayed for this purpose
- As the country of exit system is implemented, the need for port of entry screening will progressively decrease
- Given the current policy of screening in the country of origin and the plans to evaluate this new programme, the review group was concerned to ensure that future policy is influenced by the experiences and evidence about the port of entry

screening system, and that future systems build on the NICE guidance when it is published

Recommendations:

10. there should be an urgent and focused review of the benefits of X ray screening for TB at ports, bearing in mind the emergent NICE guidance, the apparent inefficiencies of the current system and concerns about the lack of evidence of effectiveness of the current system

11. there should be a major overhaul of information systems at ports of entry to ensure that CsCDC and the NHS receive timely and appropriate information about new entrants. This will allow high risk entrants to be contacted and assessed by the NHS

12. the Immigration Service should continue to refer new entrants who are unwell to Medical Inspectors as they do now

13. new entrants at the ports with symptoms suggestive of TB should be referred to NHS facilities near the port of entry or their intended destination

EMERGENCY PLANNING

Introduction

All ports have emergency plans to cover a wide range of emergencies. The International Health Regulations (2005) which come into effect in June 2007 require the provision of an "*appropriate public health emergency response by establishing and maintaining a public health emergency contingency plan, including the nomination of a coordinator and contact points for relevant point of entry, public health and other agencies and services;* "

This section only covers emergencies of a public health nature in which it is reasonable to expect a lead to be taken by service providers. All parts of the NHS and LAs should have emergency plans in place for a variety of possible emergencies. These usually have core sections that are generic in nature and can be incorporated within emergency plans for ports. Just because an emergency occurs at a port does not mean that procedures used elsewhere will be inappropriate, and it is important to note that the Civil Contingencies Act has placed some specific responsibilities on these organisations.

A clear message from most of those giving oral evidence and those submitting written statements to the review was that it was essential to maintain the capacity and capability to manage exceptional situations. No port in England has staff on duty to cope with all possible situations. It follows that there must be surge capacity arrangements to accommodate these demands. There are a number of considerations:

- Emergencies generally fall into one of two types: the rising tide, where it is clear over a period of time that a situation is developing that requires an exceptional response, or those with no warning at all where there may be an immediate demand for exceptional levels of support

- Demand at ports may be generated by events:
  - within the UK, requiring health monitoring or interventions for out-bound passengers. (e.g. a large epidemic of meningococcal infection)
  - overseas, requiring health monitoring or interventions for in-bound passengers arriving from specific locations. (e.g. SARS in Hong Kong and Toronto) or
  - overseas, requiring health interventions for out-bound passengers with specific destinations. (e.g. typhoid in a holiday destination)

- Most events will be biological in origin, but events could include chemical, radiological or nuclear incidents

- Concern may focus on a single ship, train or plane arrival at one port or may require a sustained input at all ports for a longer period. In any event it is unlikely that there will be very much advance warning before enhanced services need to be deployed

- Planning needs to take account of the unscheduled need for either large numbers of staff or staff with specialist expertise, or both. The response needs to have appropriate expertise and be of a sufficient size to cope with the expected number of passengers in a timely manner. The expertise will need to include:
  - a sound knowledge of port health, including legal aspects
  - the ability to screen for and recognise particular problems
  - health protection knowledge so that risks to the public health are minimised
  - health care management of people affected

Finally, the review also heard clear advice that all emergency plans, including those for dealing with public health emergencies at ports, should be exercised on a regular basis.

Recommendations: (these only apply to public health emergencies at ports)

14. all ports should have emergency plans that are compatible with the local PCT/LA emergency plans, and which can cover public health emergencies. These plans need to be exercised annually and must include a means of providing surge capacity from the HPA, NHS and LA for a range of possible public health scenarios

15. employers should ensure that all staff involved in health activities at international travel terminals are aware of the emergency planning arrangements for their port, and of how to activate the port emergency arrangements

SURVEILLANCE

For public health purposes there are clear reasons for having access to information at ports. These might include a SARS type incident, or an infectious case of TB in a traveller on a long-range flight. This would allow tracing of individuals should they turn out to be contacts of cases and this would of course apply to all travellers, not just people subject to immigration control.

As a general principle, the information collected by airlines and ports should adhere to the requirements of the new WHO International Health Regulations (IHR) (Appendix 10). Article 5 has implications in that a capacity to detect and assess human illness events will be required, and while the IHRs are not specific about what needs to happen at ports – rather than within the country; it seems reasonable to assume that ports should have appropriate capacity and capability. Section c of Article 19 puts an obligation on states to furnish to WHO, as far as practicable, when requested in response to a specific potential public health risk, relevant data concerning sources of infection or contamination, including vectors and reservoirs, at its points of entry which could result in international disease spread.

So, in relation to article 5, the core capacities required at ports of entry are an ability to:

- detect events involving disease or death above an expected level
- report all available essential information immediately to the appropriate authority regarding these events. These should include non-notifiable diseases such as Legionnaires' disease. Information required should include the route of entry
- immediately implement preliminary control measures

At the moment, information on travellers entering the country is collated on various databases at ports. The SITA database (an international computer network that logs many aspects of aircraft movement) also includes passenger details. It does not however reliably record addresses or log patient illnesses and it wasn't clear how long the data were held. A further area of uncertainty is whether data on ill passengers are currently available at ports and whether these are kept systematically on any databases. Given the requirements of the new IHRs, there is a clear need to establish better systems.

In relation to section c of Article 19, in the event of a specific public health incident such as a case of avian flu (H5N1 flu strain) in a passenger, or an infectious case of TB, there would be a need to pass on appropriate information or advice to some passengers. In general, it would be perfectly acceptable for the carrier to be asked to pass on such advice. Under these circumstances, what matters is the ability and willingness of the carrier to do this. However, there are circumstances where the seriousness of the incident or circumstances is such that it would be more appropriate for the HPA or other public health organisations to make contact with passengers. To do this, the information that the organisations would need may include: name, age, address at destination, flight details before and after landing in the UK and countries visited. This might apply to all travellers not just people subject to immigration control. It is important that a system to be agreed between the airlines (through the Board of Airlines Representatives) and the Department

of Health to ensure that relevant information can be made available to the appropriate public health / health protection organisations in the event of such incidents in such a way that data protection requirements are met; and it would make sense for the HPA to be asked to lead on this process with key stakeholders.

Recommendation:

16. the HPA should lead a process with the DH and the Board of Airline Representatives (BAR) to agree a system whereby routine data systems can be established, and where data on travellers can be made readily available in response to a specific public health incident or risk

SKILLS MIX

Medical inspectors are medical practitioners appointed under the Immigration Act 1971 to carry out specific tasks, and the port medical officers of port health authorities are (of course) doctors. However, not all the tasks involved in these roles need a medical practitioner and delegation of some tasks could and should be considered within the relevant legislative and regulatory frameworks. This view is reinforced by other considerations:

- as the objectives of the service become more clear, then the skills required to deliver these can be more easily identified
- risk assessment at each port will have implications for the required skills mix as not all ports need the same service
- many respondents mentioned that other groups such as nurses should play a larger part in health activities at international travel terminals than is currently the case, and a clearer career pathway in health services in ports would also help succession planning - a current concern for some ports
- the relevant legislation has not been studied in detail, but, in the longer term, a change in the legislation might be needed to facilitate a more appropriate skills mix of practitioners to discharge the various health responsibilities. For example, “doctor” or “medical practitioner” could be replaced by “clinician” or “clinical practitioner”

Recommendations:

17. the skills mix within health activities at international travel terminals should reflect the needs of the service both generally and in each port. Delegation of tasks to other practitioners should be considered within the appropriate legislative and regulatory frameworks

18. if necessary, in the medium to longer term, a change in the legislation should be considered to facilitate a more appropriate skills mix to discharge the various responsibilities for health activities in ports

PROVISION OF FACILITIES AND ACCOMMODATION

The IHRs place obligations on the UK to provide adequate staff, equipment and premises, both on a day to day basis and in the event of a public health emergency of international concern. This section looks at how these arrangements need to be improved.

Findings

Immigration control facilities are required under the Immigration Control (Provision of Facilities at Ports) Order 2003 to be provided free by the port, but this order does not explicitly require the provision of facilities for medical inspection. Consequently, port managers sometimes demand payment for the accommodation and other facilities used for medical examinations. It seems to the Project Group that there is a clear statutory basis for requiring a port to provide such facilities free. Representatives of ports (in particular the British Airports Authority) did not agree that such a proposal was desirable.

Three related accommodation issues were also identified during the review:

- inadequate facilities in some smaller ports with designated medical rooms being taken over for other purposes, and doctors on call providing their own equipment
- concerns about transporting and escorting passengers for medical examination in large airports, particularly Gatwick, where the facilities were located in one terminal
- uncertainty about who would be responsible for providing necessary equipment in an emergency situation, for example for temperature screening had this been needed for SARS

Conclusions

The arrangements for the provision of facilities and accommodation in support of medical inspection are unsatisfactory. Medical examination, when required, is part of the statutory provision for immigration and is therefore necessary to enable the port to function as a point of entry for arrivals in the UK. The HO and DH should therefore develop proposals for ports to be required to provide facilities and accommodation for this function free of charge, under existing statutory powers. As for the port health service there is no statutory basis for requiring the port to provide facilities and accommodation free, although the provision of the service clearly supports the functioning of the port. In relation to how passengers requiring transport and escort within ports should be handled, it seems clear that the responsibility to resolve this falls on the Immigration Service. Finally, there needs to be further work on who would be responsible for providing necessary equipment, but the simplest way ahead would be for the port to provide a room and lighting, but for any of the equipment to be provided by the service provider.

Recommendation:

19. the HO and DH should develop proposals for free of charge facilities for medical inspection under existing statutory powers

QUALITY OF SERVICE PROVISION

The review group heard many concerns about service quality in relation to all health services in ports. These included not being certain of the purpose of the services, the absence of standards, variation in what was provided and in how it was provided. There was no career pathway for the medical inspection service, no clear training programmes and in general a sense that they fell outside the mainstream of clinical governance arrangements. As regards clinical care, at times this was provided by inappropriately trained staff or there simply was no service. All these issues need to be addressed, and the most important elements are about clarifying accountability and bringing the services into the mainstream. This will allow the extant clinical governance processes of the provider organisations to support these services. This is not an easy task, given the history of these services, but the earlier recommendations which argue for giving the HPA a central role in the coordination of health activities at international travel terminals will help considerably. They will allow the HPA to work with stakeholders to ensure that:

- service standards are developed
- audit and review processes happen
- staff competencies are described and
- training programmes are developed and delivered

Recommendation:

20. the HPA as part of its proposed responsibilities for health activities at international travel terminals, should develop a quality framework that is embedded in its clinical governance arrangements

FINANCIAL ISSUES

Introduction
Health activities at international travel terminals serve a number of different functions. These include protecting the public health, protecting the public purse from the costs associated with incidents of infection brought into the country and protecting the public purse from the possible costs of treating new entrants on the NHS for infectious and non-infectious diseases. This section examines what is known about expenditure on health activities at international travel terminals and makes recommendations for future financial management.

In undertaking this review it was not possible to obtain comprehensive financial information from all ports in England, but from the replies received it was clear that these estimates are a minimum figure, that funding comes from different sources and that it is hard to document all the sources and applications. Beyond the direct provision of services it was also clear that there are costs incurred by simply having a port within the local area as sick passengers and crew are referred to local clinical services for treatment.

Findings
At least £5.5 m is spent each year on health activities at international travel terminals in England. The division of expenditure between medical inspection and port health is unclear, partly because it is often the same staff in the same facilities providing both functions. The DH transferred £2.6m into the HPA budget at the start of the 2003/04 year to cover its health activities at international travel terminals, though the HPA's expenditure against that budget in 2003/04 was actually over £3 million.

There are multiple sources of finance for health activities at international travel terminals and different routes by which the money is spent in different locations. The main contributors are the DH, The HPA and individual PCTs. Some shared resources are provided by LAs and in a few cases some expenditure is actually paid for by the port itself.

The figures below are a minimum and should be regarded as informed estimates because there were many other ports for which no data was available.

Port	Medical Inspection £	Port Health £	Care for sick travellers £
Heathrow	2,031,000	376,000	1,000,000
Gatwick	1,024,000	114,000	46,000
Stansted	98,600	dna	dna
Manchester	72,000	22,000	dna
Dover	168,000 (for all functions)		
Ports in Cumbria & Lancashire	1,000	5,000	dna

Humber	200	15,747	dna
Ports in South West Devon	dna	2,000	dna
Blyth	dna	dna	1,000
Leeds / Bradford	200	750	dna
Total known expenditure	**3,227,000**	**535,497**	**1,582,497**

dna = data not available

PCTs also argued that they contributed at least another £2 m in direct costs, without taking into account staff salary costs for those who only work on port health for part of their time. Some ports make the provision of accommodation freely available, others charge the port health providers for it and at least one new airport in the UK has made no provision for port health accommodation.

Heathrow and Gatwick are the only ports in England to be equipped with X-ray facilities, and a large element of the expenditure at Heathrow and Gatwick is associated with the provision of X-ray facilities for staff, materials and maintenance. A conservative assumption is that the annual spend is around £1.5m based on about 75,000 X rays a year at £20 a time. Additional expenditure is incurred each autumn providing control measures for the large numbers of arriving students waiting to be screened at Heathrow.

The costs incurred in providing health activities at international travel terminals vary widely between ports because of the wide disparity in the level of service provided. In general, larger ports have higher costs because services are provided on a regular basis, while smaller ports only have an on demand service which may not be paid for directly, and where the costs may be hidden. As important, the quality of financial information varied widely, and it will be necessary to obtain more reliable data if financial resources are to be aligned to responsibilities.

Recommendation:

21. a national financial framework, aligned with responsibilities, should be developed to account for health expenditure in ports. This needs to take into account future patterns for commissioning health activities at international travel terminals, and should show where funds come from, on what activities they are spent, and where

PORT HEALTH RISK ASSESSMENT

Introduction

In many areas the risk assessment process can help shape safe and effective services, so given the range of risks at ports in England the group felt that a risk assessment process should be used to help the development of appropriate health activities at international travel terminals at individual ports. This view was widely supported by respondents, though there was less agreement as to who should undertake the risk assessment.

Since there was no disagreement about the principle of using risk assessment as the basis for service planning and provision, the review group developed a risk assessment tool (Appendix 11) from a model developed for communicable disease control that was thoroughly validated. It is not intended to exclude consideration of other risk factors that may be known to those responsible for health activities at international travel terminals. Its use in port health environments has not been validated, so it will need to be evaluated and modified accordingly.

As there are continual changes in passenger numbers, the range of countries from which people are arriving, the reasons for travel and the general health of travellers, the risks of imported infections at any port will change over time. To capture this dynamic aspect the risk assessment tool should be used on an annual basis by the service providers working together with the service commissioners and other stakeholders. Finally, the general principles of risk assessment can be applied to all health services at ports, and while this section focuses on port health, providers of other health services in ports should also use risk assessment processes.

Recommendations:

22. providers of health activities at international travel terminals should jointly undertake an annual risk assessment at each port with involvement of commissioners and other local stakeholders. This risk assessment should be used as the basis of the port health plan for the following year.

23. records of the Port Health risk assessment should be published and made available to those within the HPA responsible for port health

24. the risk assessment tool should be implemented, but evaluated and amended over the next one to two years

LIST OF RECOMMENDATIONS

The Project Group recommends that:

1. the DH, HPA and HO should publish a clearly written explanation of accountabilities and responsibilities for stakeholder organisations and staff. This should be accessible from the websites of all three organisations, be subject to regular joint review and be drawn to the attention of those with a need to know

2. the HPA should be given the responsibility and resources for ensuring that medical inspection under the 1971 Immigration Act is delivered appropriately and consistently in England. This could either be delivered directly (via staff employed to do this alone or as part of the job of staff with other responsibilities) or by commissioning a service from PCTs or (given the recent plans for NHS changes) from NHS Trusts or other providers. This would also allow the HPA to mainstream the clinical governance issues including training and standards

3. the HO should ensure that there are systems for monitoring the response made in immigration decisions to the advice of medical inspectors

4. if and when HPA assume responsibility for medical examinations (as recommended above) the *Instructions to Medical Inspectors* as a formal DH document may no longer be needed. Instead HPA, in agreement with its "customer" (the Immigration Service) and its "sponsor" (DH) should guide and direct these activities as appropriate

5. appropriate amendments should also be made to Immigration Directorate Instructions, which specify how the policies set out in immigration legislation including Immigration Rules should be implemented

6. the HPA should work together with LAs and PCTs to manage health protection activities at ports in ways which draw on the expertise of all organisations and their staff

7. the HO should make formal arrangements for the healthcare of sick travellers detained by the Immigration Service. In doing this, the HO may wish to note the arrangements used by customs and the police

8. SHAs and PCTs in whose areas the larger ports are should work with port authorities and stakeholders should review the health services available to sick travellers and develop any new services which may be needed; and at all ports to ensure that there are well understood arrangements for accessing NHS services when required

9. the HPA should work with partners to ensure that there is a single point of contact for port health and medical inspection services at all ports, and information about this route into these services should be made widely available

10. there should be an urgent and focused review of the benefits of X ray screening for TB at ports, bearing in mind the emergent NICE guidance, the apparent inefficiencies of the current system and concerns about the lack of evidence of effectiveness of the current system

11. there should be a major overhaul of information systems at ports of entry to ensure that CsCDC and the NHS receive timely and appropriate information about new entrants. This will allow high risk entrants to be contacted and assessed by the NHS

12. the Immigration Service should continue to refer new entrants who are unwell to medical inspectors as they do now

13. new entrants at the ports with symptoms suggestive of TB should be referred to NHS facilities near the port of entry or their intended destination

14. all ports should have emergency plans for public health emergencies that are compatible with the local PCT/LA emergency plans, and which can cover public health emergencies. These plans need to be exercised annually and must include a means of providing surge capacity from the HPA, NHS and LA for a range of possible public health scenarios

15. employers should ensure that all staff involved in services are aware of the emergency planning arrangements for public health emergencies at their port, and of how to activate the port emergency arrangements.

16. the HPA should lead a process with the DH and the Board of Airline Representatives (BAR) to agree a system whereby routine data systems can be established, and where data on travellers can be made readily available in response to a specific public health incident or risk

17. the skills mix within health activities at international travel terminals should reflect the needs of the service both generally and in each port. Delegation of tasks to other practitioners should be considered within the appropriate legislative and regulatory frameworks

18. if necessary, in the medium to longer term, a change in the legislation should be considered to facilitate a more appropriate skill mix to discharge the various responsibilities for health activities in ports

19. the HO and DH should develop proposals for free of charge facilities for medical inspection under existing statutory powers

20. the HPA as part of its proposed responsibilities for health activities at international travel terminals should develop a quality framework that is embedded in its clinical governance arrangements.

21. a national financial framework, aligned with responsibilities, should be developed to account for health expenditure in ports. This needs to take into account future patterns for commissioning health activities at international travel terminals, and should show where funds come from, on what activities they are spent, and where

22. providers of health activities at international health terminals should jointly undertake an annual risk assessment at each port with involvement of commissioners and other local stakeholders. This risk assessment should be used as the basis of the port health plan for the following year.

23. records of the port health risk assessment should be published and made available to those within the HPA responsible for port health

24. the risk assessment tool should be implemented, but evaluated and amended over the next one to two years

GLOSSARY

Authorised Officer	As described in the Ships and Aircraft Regulations. This is a role on behalf of PHAs in relation to the Regulations. It carries specific powers
Medical Inspection	Medical examination under the Immigration Act 1971 – the medical examination, at the request of an immigration officer and by a medical inspector, of a person subject to immigration control
Medical Inspector	A medical practitioner appointed to carry out medical examinations under the Immigration Act
Immigration Rules	Rules made by the Home Office under the Immigration Act 1971 containing detailed provisions for the exercise of immigration control
Immigration and Nationality Directorate Instructions (IDIs)	Detailed instructions to Immigration and Nationality Directorate staff on the implementation of immigration and nationality policy
International Health Regulations	Regulations of the World Health Organisation which are designed to prevent the global spread of infectious disease. The current IHR were agreed in 1969 (with some later amendments), and some of their requirements are implemented in England by means of the Regulations [ie the "port health regulations"]. New IHR were adopted by WHO in May 2005 and are generally due to be implemented from June 2007
Port Health	Activities carried out under the Regulations
Port Health Authority	Local authorities with responsibilities under the Regulations, including those which are formally constituted as Port Health Authorities
Port Health staff	All staff involved in delivering port health

Port Medical Officer	The medical officer in the Public Health (Aircraft) and (Ships) Regulations. Their role can be seen as the port side equivalent of the work and responsibilities of CsCDC on land side
Proper Officer	Proper officer is defined in section 74 of the Public Health (Control of Disease) Act 1984 as meaning the officer appointed by a local authority for a particular function under the Act This is a role on behalf of Local Authorities. Those related to human health are normally undertaken by CsCDC , but do not need to be
Public Health Act	The Public Health (Control of Disease) Act 1984
Screening	An activity designed to identify people at higher risk of having a disease. It is not a diagnostic procedure and is carried out on asymptomatic people
The Immigration Acts	The Immigration Act 1971 and the subsequent amendments to it particularly in the Immigration and Asylum Act 1999 and the Nationality, Immigration and Asylum Act 2002
The Instructions	The Instructions to Medical Inspectors issued by the Secretary of State for Health, most recently in 1992
The Regulations	The Public Health (Aircraft) Regulations 1979, the Public Health (Ships) Regulations 1979, and the Public Health (International Trains) Regulations 1994, made under powers in the Public Health (Control of Disease) Act 1984

LIST OF APPENDICES

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Appendix 1

PORT HEALTH SERVICES REVIEW 2005

STEERING GROUP MEMBERSHIP

Lindsey Davies	Department of Health
Jonathan Stopes-Roe	Department of Health
Richard Coker	Department of Health
Brian McCloskey	Health Protection Agency
Jonathan Duke-Evans	Home Office

Appendix 2

PORT HEALTH SERVICES REVIEW 2005

PROJECT GROUP MEMBERSHIP

Graham Bickler	Health Protection Agency, South East Regional Office
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Claude Seng	Health Protection Agency, North West London HPU
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Mike Mahony	Home Office, Immigration and Nationality Directorate
Linda Stowe	Home Office, Immigration and Nationality Directorate
Peter Thompson	Home Office, Immigration and Nationality Directorate

Appendix 3

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Appendix 4

PORT HEALTH SERVICES REVIEW JUNE 2005

Questionnaire

This questionnaire initially describes several specific issues and asks some questions about each of them. You do not need to answer all the questions. We would be grateful if you could expand on your answers as much as possible. If necessary, use additional sheets.

It continues with some open questions about the strengths and weaknesses of current services. Again, feel free to comment as appropriate.

It ends by asking you if there are other issues you wish to comment on that have not been covered by the earlier questions.

We will use your answers to provide aggregate data, but your reply will be publicly available unless you specify that some or all of it should be confidential, and we may use quotes from responses in the final report.

A. Specific issues and questions

i. Accountability

We recognise that multiple organisations are involved in Port Health (local authorities, Port Health Authorities, Ports, PMIs, PCTs, PMOs, HPA…..) with potentially confusing and overlapping responsibilities

i. Are current responsibilities and accountabilities clear?
ii. If not, how should they be clarified?
iii. If so, do you think that the arrangements are satisfactory; and if not, how should they be changed?
iv. Are you clear where authority lies for the various functions?
v. If not, how should this be clarified?
vi. If so, do you think that the arrangements are satisfactory; and if not, how should they be changed?

ii. The purpose of the service

The literature on Port Health describes a range of purposes of the service. One possible categorisation is:

- The assessment and care of ill travellers (though this is out-with the scope of the review, we recognise that medical and nursing staff involved in Port Health and Inspection of Immigrants often provide this service).
- The ability to respond appropriately to an actual or potential threat to the Public Health locally.
- The ability to respond appropriately to public health emergencies of international concern.

  i. Should we be clearer about the purpose of the service?
  ii. Is the categorisation above useful?
  iii. If not, can you suggest another one?

iii. TB Screening

There is a considerable literature on the benefits, effectiveness and cost-effectiveness of the current arrangements and processes. The government proposes to target health screening for TB for long stay migrants from high incidence countries at the entry clearance stage (in the country of origin). There are also asylum seekers to consider who will not be covered by these arrangements; and people from lower incidence countries.

  i. What arrangements should we make to screen immigrants, asylum seekers (and any other groups) for TB at ports of entry?
  ii. Are there better ways of using resources in relation to TB?

iv Language

The phrase 'Port Health' is used to mean different things by different people. It has been suggested that it would be helpful to produce a clear and consistent language in relation to port health services.

  i. Does this seem sensible, and do you have any suggestions in relation to it?

v Quality

It is clear that clinical governance processes need to be made more robust and it has been suggested that this would be easier if port health services were more clearly aligned to the NHS or the HPA. Also, concern has been expressed about the variations in standards in port health services across the country.

  i. Are these concerns justified?
  ii. How do we ensure ongoing quality improvement in Port Health Services?
  iii. How do we ensure a consistent service across the country?

vi Skill Mix

Various staff groups are involved in the port health service(s), and in the NHS there have been major changes in which professions can undertake which tasks.

  i. What would an appropriate skill mix be for Port Health Services?

vii. Administrative Arrangements

The current guidance for Port Inspectors requires the Medical Inspector of immigrants to generate forms to send to CsDC at the immigrant's destination. CsDC usually deal with these by informing the local PCT to ensure that new migrants are informed of the need to register with a GP. In some cases, the migrant needs to be followed up as abnormalities may be identified in the chest x-ray.

i. Is it clear who is responsible for each of these?
ii. If not, how could this be clarified and simplified?

viii. Risk Assessment

It is clear that the public health risks between different ports vary enormously, and it has been suggested that the precise nature of the port health and medical inspection service should depend on the risks at that port.

i. Would it be appropriate to propose that the Port Health and medical inspection services at any port should depend on the risk at that Port?
ii. If so, who would do the Risk Assessment and how would we quality assure it?

ix Practical Issues

This relates to the transport of staff and migrants within ports, the provision of equipment and the responsibility for providing rooms.

i. Is it clear who is responsible for these?
ii. If not, what do you suggest that we do about this?

x Surge Capacity

There are public health emergencies which require far greater numbers of port health staff than are normally available.

i. Does the ability to mount such a response currently exist in relation to Public Health Emergencies?
ii. If not, how can we ensure that it does?

xi Surveillance

There are legitimate public health needs for surveillance information at ports.

i. What items of information are needed for surveillance purposes?
ii. What arrangements should we have for this?

B. General Questions

Looking at Port Health Services in the widest sense – that is including the Home Office's responsibilities for the Inspection of Immigrants and the Local Authority Port Health role:

1. What works well?
2. What doesn't work well?
3. What should we do to improve the services?
4. Is there any blue skies thinking we should do?

C. Other Issues

Are there any other issues related to Port Health and medical inspection that you wish to comment on? This includes the resources required to deliver a high quality service and the responsibility for looking after sick travellers.

Thank you for taking the time to complete and return this questionnaire.

Appendix 5

PORT HEALTH SERVICES REVIEW 2005

Resources Questionnaire

The phrase 'Port Health Services' is often used to describe three different services:

1. The medical inspection of migrants under the 1971 Immigration Act
2. The wider public health support offered to Local / Port Health Authorities akin to the proper officer function that CsCDC provide to Local Authorities
3. Clinical care for sick travellers in ports

This review focuses on the first of these and covers the second. However, we recognise that there is confusion and that the individuals and organisations providing these services often provide all three even though there may only be a strict obligation to provide one or two of them. The questionnaire asks you to describe what is spent on each of them at your local port (the application) in as much as that is possible. We recognise that you may not be able to be precise, but we would prefer your best guess. We also ask you to describe the source of whatever is spent, noting that this might be from the HPA, the NHS, the Port or elsewhere.

1. Please state your name

2. Please state your organisation

3. Please state the port(s) that relate to your organisation

4. Applications

Please estimate the annual spend on the three functions at the port(s) in question. If you are able to categorise this into pay and non-pay (including facilities) then please do so:

4.1 The medical inspection of migrants under the 1971 Immigration Act

4.2 The wider public health support offered to Local / Port Health Authorities akin to the proper officer function that CsCDC provide to Local Authorities

4.3 Clinical care for sick travellers in ports

5. Sources

Please describe the source of the spend identified in question 4 above, and the amount in each category:

5.1 Health Protection Agency

5.2 Primary Care Trust

5.3 Local Authority

5.4 Port

5.5 Department of Health

5.6 Other (please describe)

6. Any comments or further information

Appendix 6

PORT HEALTH SERVICES REVIEW 2005

LIST OF RESPONDENTS

ORGANISATIONS

Adur, Arun and Worthing PCT
Association of Port Health Authorities (APHA)
Avon HPU
Bournemouth Teaching PCT
British Airports Authority (BAA)
British Council
British Ports Association
Carlisle and District PCT
Central Cornwall PCT
Charnwood and North West Leicestershire PCT
Cheshire and Merseyside HPU
Council for International Education (UKCOSA)
County Durham and Tees Valley HPU
Crawley LA
Crawley PCT
Cornwall HPU
Cumbria and Lancashire HPU
Dorset and Somerset HPU
Easington PCT
East and North Hertfordshire HPU
East Kent Coastal PCT
East Midlands Government Office
East Midlands North HPU
East Riding Council
East Yorkshire PCT
Eden Valley PCT
Essex HPU
Falmouth and Truro PHA
International Air Transport Association (IATA)
Gatwick Airport immigration Service
Great Yarmouth PCT
Greater Manchester HPU
Hampshire & Isle of Wight HPU
Health Protection Agency Centre for Infection
Hereford and Worcester HPU
Hillingdon PCT
HPA LaRS London Region
Hull City Council

Humber HPU
Kerrier District Council

Luton PCT
Newham LA
Norfolk HPU
North East Lincolnshire LA
North Lincolnshire LA
Northumberland PCT
Plymouth PCT
Public Health Medicine Environmental Group
South Yorkshire HPU
Shropshire and Staffordshire HPU
Solihull PCT
South London HPU
South West Devon PCT
South West London HPU
Southampton City PCT
Stanstead Airport Port Health Control Unit
Surrey and Sussex HPU
Sussex Downs and Weald PCT
Telford PCT
Thurrock PCT
Waveney PCT
West Hull PCT
West of Cornwall PCT

International Chamber of Shipping
London School of Hygiene and Tropical Medicine
Migrant Helpline
NHS Confederation
North Cumbria PCT
North East Lincolnshire PCT
North West London Hospitals NHS
Plymouth LA
Portsmouth City Teaching PCT
Royal College of Physicians (RCP)
Shepway PCT
Solihull LA
South Huddersfield PCT
South Manchester PCT
South West London SHA
South West Peninsula HPU
Southwark PCT
Suffolk Coastal PCT
Surrey and Sussex SHA
Teignbridge PCT
Thames Valley HPU
Uttlesford LA
West Cumbria PCT
West Midlands HPU

Appendix 7

PORT HEALTH SERVICES REVIEW 2005

ORGANISATIONS AND INDIVIDUALS THAT GAVE ORAL EVIDENCE

INDIVIDUALS

Roger Wiltshire	International Air Transport Association (IATA) London Office
Richard Coker	London School of Hygiene and Tropical Medicine
Mary O'Mahony	Health Protection Agency (HPA)
John Pullin	South West London SHA
Doug Bloomfield, John Averns, Sandra Westacott and John Curnow	Association of Port Health Authorities (APHA)
Lawrence Emerson	British Airports Authority (BAA)
John Watson and Jane Jones	Health Protection Agency (HPA)
Stephen Williams	Crawley PCT
Angela Tanner	Crawley Borough Council
Alex Gordon	Hillingdon PCT
Kathy Sparks and Shabeg Nagra	London Borough of Hillingdon
Robert Grant	National Collaborating Centre for Chronic Conditions, Royal College of Physicians

Appendix 8

Incidence of TB amongst new entrants

Most of those screened for TB at ports are migrants seeking admission to the UK under a recognised category of entry, not asylum seekers. Richard Coker in his working paper on asylum and migration states that under the current UK system most asylum seekers entering the country through Heathrow airport are probably screened for tuberculosis (using in the first instance a basic clinical examination and miniature X-ray). Of 41,470 asylum seekers who had X-rays between 1995-1999, 100 were found to have active tuberculosis, of whom 24 had the most infectious form, sputum smear positive (Callister et al 2002). Using this system, which is voluntary, only two individuals 'absconded' before further investigations were conducted to confirm or refute the diagnosis. In this study the prevalence of pulmonary tuberculosis in asylum seekers was 241/100,000, with rates from some regions such as sub Saharan Africa very high. Rates in asylum seekers from other regions such as the Middle East were however lower than rates in parts of London despite the countries of origin being high prevalence areas. As the authors note 'despite the relatively high prevalence rates in asylum seekers arriving at Heathrow Airport compared with average rates for the UK, the actual number of cases detected only represents a small proportion of all TB cases notified annually in England (less than 0.5 percent)' (Callister et al 2002).

However not all asylum seekers apply for asylum at ports, and since 2003 all asylum seekers at induction centres have been offered a health check including TB screening regardless of where they applied for asylum, which over 90% accept. Until recently all asylum seekers passing through induction centres were screened with Heaf tests, and where necessary, referrals to the local chest clinics. However, Heaf tests are now obsolete and personnel are being trained up to administer Mantoux tests. In the Dover induction centre, between April 2004 and January 2005, a total of 4,219 asylum seekers were screened for TB, of which 9 had active TB. In Leeds induction centre, between April 2004 and January 2005, a total of 777 asylum seekers were screened for TB, of which 1 had active pulmonary TB.

One study estimated that only one quarter of immigrants to the UK are traced and screened for tuberculosis (Hardie and Wilson 1993). Another study showed that port of arrival systems failed to identify 60 percent of new immigrants to one area of the UK (Ormerod 1998). Other evidence of transmission of TB using different research approaches, also offers insights. For example, using DNA fingerprinting a London based study aimed to assess the degree of recent transmission that occurred in London and which populations were most affected (Maguire et al 2002). The study found that approximately 14 percent of cases of tuberculosis resulted from recent transmission and that both being born in the UK and being black Caribbean ethnicity were independent risk factors. This research showed that most tuberculosis in London is caused by reactivation (from infection acquired years before) but that a small fraction of disease results from disease in recent immigrants.

Appendix 9

NICE guidance on the assessment of new entrants for TB

Based on the available evidence NICE has produced guidance as a consultation document, which gives clear recommendations on assessing new entrants (people recently arriving in or returning to the UK from high incidence countries). They suggest that the healthcare professionals responsible for new entrant screening, which will include primary care, should maintain a co-ordinated programme to:

- detect active tuberculosis and initiate treatment
- detect latent tuberculosis and initiate chemoprophylaxis
- provide BCG vaccination to those not infected and previously unvaccinated in high risk groups
- provide information and advice to all new entrants

The guidance also states that the assessment for, and management of, tuberculosis in new entrants should consist of:

- a health questionnaire including BCG history, current symptoms, previous TB, travel history and family history of, or close personal contact, with TB
- a chest X-ray and clinical examination for people with symptoms suggestive of TB
- tuberculin skin testing in asymptomatic individuals under 35 years, irrespective of BCG history
- chemoprophylaxis for people aged 35 with positive skin test inappropriate to their BCG history, with a normal chest X-ray and clinical examination
- information and advice for asymptomatic individuals aged over 35 years
- risk assessment for HIV, including HIV prevalence rates in the country of origin, which is then taken into account for tuberculin skin testing and BCG vaccination

The guidance recommends that new entrants should be identified for TB screening from the following information:

- port of arrival reports
- new registrations with primary care
- entry information from educational establishments and universities
- links with statutory and voluntary groups working with new entrants
- any healthcare professional working with new entrants who should encourage them to register with a GP

They also argue that new entrant screening for tuberculosis should be incorporated within larger health screening programmes for new entrants, linked to local services.

Appendix 10

Extracts from the International Health Regulations 2005

Article 5 Surveillance

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1.

2. Following the assessment referred to in paragraph 2, Part A of Annex 1, a State Party may
report to WHO on the basis of a justified need and an implementation plan and, in so doing, obtain an extension of two years in which to fulfil the obligation in paragraph 1 of this Article. In exceptional circumstances, and supported by a new implementation plan, the State Party may request a further extension not exceeding two years from the Director-General, who shall make the decision, taking into account the technical advice of the Committee established under Article 50 (hereinafter the "Review Committee"). After the period mentioned in paragraph 1 of this Article, the State Party that has obtained an extension shall report annually to WHO on progress made towards the full implementation.

3. WHO shall assist States Parties, upon request, to develop, strengthen and maintain the capacities referred to in paragraph 1 of this Article.

4. WHO shall collect information regarding events through its surveillance activities and assess their potential to cause international disease spread and possible interference with international traffic. Information received by WHO under this paragraph shall be handled in accordance with Articles 11 and 45 where appropriate.

Article 9 Other reports

1. WHO may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring. Before taking any action based on such reports, WHO shall consult with and attempt to obtain verification from the State Party in whose territory the event is allegedly occurring in accordance with the procedure set forth in Article 10. To this end, WHO shall make the information received available to the States Parties and only where it is duly justified may WHO maintain the confidentiality of the source. This information will be used in accordance with the procedure set forth in Article 11.

2. States Parties shall, as far as practicable, inform WHO within 24 hours of receipt of evidence of a public health risk identified outside their territory that may cause international disease spread, as manifested by exported or imported:
(a) human cases;
(b) vectors which carry infection or contamination; or
(c) goods that are contaminated.

Article 19 General obligations

[]
Each State Party shall…..(c) furnish to WHO, as far as practicable, when requested in response to a specific potential public health risk, relevant data concerning sources of infection or contamination, including vectors and reservoirs, at its points of entry, which could result in international disease spread.

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 morbidity or mortality?	*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.*

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.
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.*

Text in italics is there as a guide.