Public Health England

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News

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Updated NICE guidance on needle and syringe programmes

In February 2009, the National Institute for Health and Care Excellence (NICE) first issued guidance on the provision of Needle and Syringe Programmes (PH18) for the distribution of new sterile injecting equipment to people who inject drugs [1]. A survey of needle and syringe programmes commissioners and providers undertaken jointly by NICE and Public Health England in 2013 asked about the implementation of this guidance and an analysis of this data by the Centre for Public Health at Liverpool John Moores University has been published; it indicates that though this guidance had been widely used by commissioners and providers there were some issues with its implementation [2].

As part of its guidance review process, NICE in 2012 decided to update PH18. The update process has now been completed, and the updated guidance (PH52) published [3].
In addition to a restructuring of the guidance and other minor changes throughout – for example, parts of the guidance concerning the public health monitoring of needle and syringe programmes provision have been strengthened – there have been two major additions.
The first addition relates to the provision of needle and syringe programmes (NSP) to young adults. The original guidance focused on the provision of NSP to those aged over 18 years. The updated guidance includes a section on responding to the needs of the much smaller number of people aged less than 18 years who inject drugs.

The second major addition focuses on the provision of NSP to people who inject image and performance enhancing drugs (IPEDs) – such as anabolic steroids and melanotan. The original guidance was principally focused on meeting the needs of people who inject psychoactive drugs (such as heroin and crack). It did not specifically consider the needs of those who inject IPEDs. In recent years there has been increasing public health concern about the use and injection of IPEDs [4], and about the extent of blood borne virus and other infections in this population [5,6,7]. People who inject IPEDs are now the largest group of people using needle and syringe programmes in some areas and the updated guidance has a section specifically related to meeting the needs of this population.

To support the implementation of this guidance, PHE is co-hosting with NICE and the Local Government Association a seminar *Evidence into practice and policy: needle and syringe*

programmes – protecting people and communities in Birmingham on the 19 May (further information and registration details can be found at www.phe-events.org.uk/eipbirmingham).

References

1. "Needle and syringe programmes: providing people who inject drugs with injecting equipment (update)" (PH18), February 2009, http://guidance.nice.org.uk/PH18.

2. Bates G, Jones L, McVeigh J (April 2014). "Analysis of survey data on the implementation of NICE PH18 guidance relating to needle and syringe provision in England", Centre for Public Health, Liverpool John Moors University (Liverpool).

3. "Needle and syringe programmes: providing people who inject drugs with injecting equipment (update)" (PH52), April 2014,http://guidance.nice.org.uk/PH52.

4. Advisory Council on the Misuse of Drugs (September 2010). "Consideration of the anabolic steroids" (London: Home Office).

5. Hope VD, McVeigh J, Marongiu A, Evans-Brown M, Smith J, Kimergård A*, et al* (2013). "Prevalence of, and risk factors for, HIV, hepatitis B and C infections among men who inject image and performance enhancing drugs: a cross-sectional study". *BMJ Open*. September 12; **3**(9).

6. Hope VD, McVeigh J, Marongiu A, Evans-Brown M, Smith J, Kimergård A*, et al* (2014). "Injection site infections and injuries in men who inject image- and performance-enhancing drugs: prevalence, risk factors, and healthcare seeking". *Epidemiol Infect.* April 8: 1-9.

7. PHE (November 2013). "Shooting Up: Infections among people who inject drugs in the UK 2012: an update".

Ebola virus disease in West Africa

An outbreak of Ebola virus disease (EVD) in West Africa has continued to expand geographically [1] since first being recognised in Guinea in early February 2014. This is the first time that EVD has been proven in this part of Africa. The virus responsible is similar to a strain of Ebolavirus (previously known as Zaire ebolavirus) last detected in the Democratic Republic of Congo in 2009.

To date [2], Guinea has reported 158 cases including 101 deaths, occurring in several regions across the country. Cases have also been confirmed in neighbouring Liberia (five confirmed and 20 suspected), where initial cases were exposed in Guinea. Mali reports six suspected cases of EVD in Bamako (the capital) and neighbouring Koulikoro Region. In Sierra Leone no suspected cases have been confirmed. However, there were two probable cases who had died while in Guinea.

People are not at risk of becoming infected unless they have direct contact with blood/body fluids/tissues of dead or living infected persons or animals (non-human primates, other mammals and bats). Airborne transmission has never been documented.

An updated risk assessment has been published by ECDC [3]. The risk for tourists, visitors or UK expatriates remains very low. Neither Guinea nor Liberia are frequent travel destinations for UK citizens and most are business travellers rather than tourists. It remains unlikely, but not impossible, that travellers infected in Guinea or Liberia could arrive in the UK while incubating the disease and develop symptoms after their return. Anyone returning from affected areas who has a sudden onset of symptoms such as fever, headache, sore throat and general malaise within three weeks of their return should seek rapid medical attention and mention their recent travel.

In the event of a symptomatic person with a relevant travel history presenting to health care, the PHE Imported Fever Service (0844 7788990) should be contacted by infectious disease clinicians or microbiologists in order to discuss testing.

References

1. Maps of affected areas.
2. WHO update, 10 April.
3. ECDC Risk Assessment, 8 April.

Vaccine update for immunisation practitioners

The latest *Vaccine Update* bulletin for immunisation practitioners and other healthcare professionals provides information about the possible future addition of meningococcal B vaccine to the national child vaccination programme following publication of a Joint Committee on Vaccination and Immunisation (JCVI) position statement recommending this [2], subject to satisfactory supply arrangements being negotiated.

Other themes covered in *Vaccine Update* 214 are:

- change(s) to the programmes concerning HPV and pertussis for pregnant women;
- literature/posters on pertussis for pregnant women, and on meningococcal C vaccination for prospective university students;
- publication of an updated meningococcal Green Book chapter;
- information about vaccine availability and supply arrangements during the Easter holiday period;
- seasonal flu vaccine; an alternative to the currently administered DTaP/IPV/Hib vaccine; advice on correct MenC vaccine dispensing/immunisation for children and adolescents; and on the avoidance of vaccine wastage;
- current myths about HPV and CFS.

References

1. *Vaccine Update* (issue 214, April 2014). Downloadable from the PHE website: https://www.gov.uk/government/organisations/public-health-england/series/vaccine-update.

2. DH/PHE guidance, 21 March 2014. "Meningococcal B vaccine: JCVI position statement", 21 March 2014.

Chemicals, poisons and environmental hazards / Radiation

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Estimating local mortality burdens associated with particulate air pollution

The increase in mortality risk associated with long-term exposure to particulate air pollution is one of the most important, and best-characterised, effects of air pollution on health. A new PHE report presents estimates of the size of this effect on mortality in local authority areas in the UK, building upon the attributable fractions reported as an indicator in the public health outcomes framework for England [1,2]. It discusses the concepts and assumptions underlying these calculations and gives information on how such estimates can be made. The estimates are expected to be useful to health and wellbeing boards when assessing local public health priorities, as well as to others working in the field of air quality and public health.

The estimates of mortality burden are based on modelled annual average concentrations of fine particulate matter ($PM_{2.5}$) in each local authority area originating from human activities. Local data on the adult population and adult mortality rates is also used. Central estimates of the fraction of mortality attributable to long-term exposure to current levels of anthropogenic (human-made) particulate air pollution range from around 2.5% in some local authorities in rural areas of Scotland and Northern Ireland and between 3 and 5% in Wales, to over 8% in some London boroughs. Because of uncertainty in the increase in mortality risk associated with ambient PM2.5, the actual burdens associated with these modelled concentrations could range from approximately one-sixth to about double these figures.

Thus, current levels of particulate air pollution have a considerable impact on public health. Measures to reduce levels of particulate air pollution, or to reduce exposure of the population to such pollution, are regarded as an important public health initiative.

References

1. *Estimating local mortality burdens associated with particulate air pollution* PHE-CRCE-010, 9 April 2014, ISBN 978-0-85951-753-9 [931 KB]. Downloadable from the PHE health protection website: Home › Publications › Environment › PHE CRCE scientific and technical report series.

2. “Report on local mortality associated with particulate air pollution”, PHE press release, 10 April 2014.

Environmental Radon Newsletter 72

Public Health England's Centre for Radiation, Chemical and Environmental Hazards has published *Environmental Radon Newsletter* 72 [1] which includes articles and news covering:

- Radon and house sales.
- Radon and the risk from lung cancer.
- Reducing risks to tenants in social housing.
- Plans for the forthcoming PHE radon forum to be held at Chilton on 7 November 2014.
- Details of the ongoing programme for inter-laboratory testing of radon detector performance.

Reference

1. *Environmental Radon Newsletter* 72: PHE website: http://www.ukradon.org/information/newsletter.

Free subscription, downloads and further information is available from the PHE's UK reference site on radon at: www.ukradon.org.

Back issues at: http://www.ukradon.org.uk/information/newsletterarchive.

Infection reports

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Enteric

General outbreaks of foodborne illness in humans, England and Wales: weeks 9-13/2014

Preliminary information has been received about the following outbreaks.

PHE Centre/ Health Protection Team	Organism	Location of food prepared or served	Month of outbreak	Number ill	Cases positive	Suspect vehicle	Evidence
Sussex, Surrey and Kent	Not known	Golf club	March	30	Not known	Not known	Not known
South Wales	Salmonella (non-typhimurium, non-enteritidis)	South Wales laver bread supplier	March	12	Not known	Laver bread	D
Bedfordshire, Hertofrdshire and Northamptonshire	Not known	Three Lakes Restaurant	March	Not known	Not known	Not known	Not known
Avon, Gloucestershire & Wiltshire	Not known	Hotel in Tewkesbury, Gloucestershire	March	28	Not known	Not known	Not known

D = Descriptive epidemiological evidence: suspicion of a food vehicle in an outbreak based on the identification of common food exposures, from the systematic evaluation of cases and their characteristics and food histories over the likely incubation period by standardised means (such as standard questionnaires) from all, or an appropriate subset of, cases.

Common gastrointestinal infections, England and Wales, laboratory reports: weeks 9-13/2014

Laboratory reports	Number of reports received					Total reports	Cumulative total	
	09/14	10/14	11/14	12/14	13/14	9-13/14	1-13/14	1-13/13
Campylobacter	989	968	944	929	771	4601	11645	11019
Escherichia coli O157*	1	4	6	4	13	28	59	64
Salmonella †	87	85	94	77	19	362	989	1135
Shigella sonnei	25	20	16	21	13	95	258	168
Rotavirus	105	143	166	195	190	799	1459	7373
Norovirus	141	128	109	118	132	628	1938	3008
Cryptosporidium	37	58	54	57	67	273	503	698
Giardia	67	49	72	74	53	315	859	777

*Vero cytotoxin–producing isolates: data from CIDSC's Laboratory of Gastrointestinal Pathogens (LGP), PHE Colindale.
† Data from CIDSC-LGP.

Less common gastrointestinal infections, England and Wales, laboratory reports: weeks 1-13/2014

Laboratory reports	Total reports 1-13/2014	Cumulative total to 13/2014	Cumulative total to 13/2013
Astrovirus	79	79	107
Sapovirus	54	54	36
Shigella boydii	15	15	21
Shigella dysenteriae	4	4	11
Shigella flexneri	123	123	149
Plesiomonas	9	9	13
Vibrio spp.	10	10	9
Yersinia spp	19	19	6
Entamoeba histolytica	10	10	12
Blastocystis hominis	39	39	46
Dientamoeba fragilis	7	7	14

Salmonella infections (faecal specimens) England and Wales, reports to Public Health England (salmonella data set): March 2014

Details of 309 serotypes of salmonella infections recorded in February are given in the table below. In March 2014, 174 salmonella infections were recorded.

Organism	Cases: March 2014
S. Enteritidis PT4	6
S. Enteritidis (other PTs)	76
S. Typhimurium	47
S. Virchow	3
Others (typed)	177
Total salmonella (provisional data)	**309**

Suspected and laboratory-confirmed reported norovirus outbreaks in hospitals, with regional breakdown: outbreaks occurring in weeks 9-13/2014

The hospital norovirus outbreak reporting scheme (HNORS) recorded 66 outbreaks occurring between weeks 9 and 13, 2014, 61 of which (92%) led to ward/bay closures or restriction to admissions. Forty outbreaks (61%) were recorded as laboratory confirmed due to norovirus.

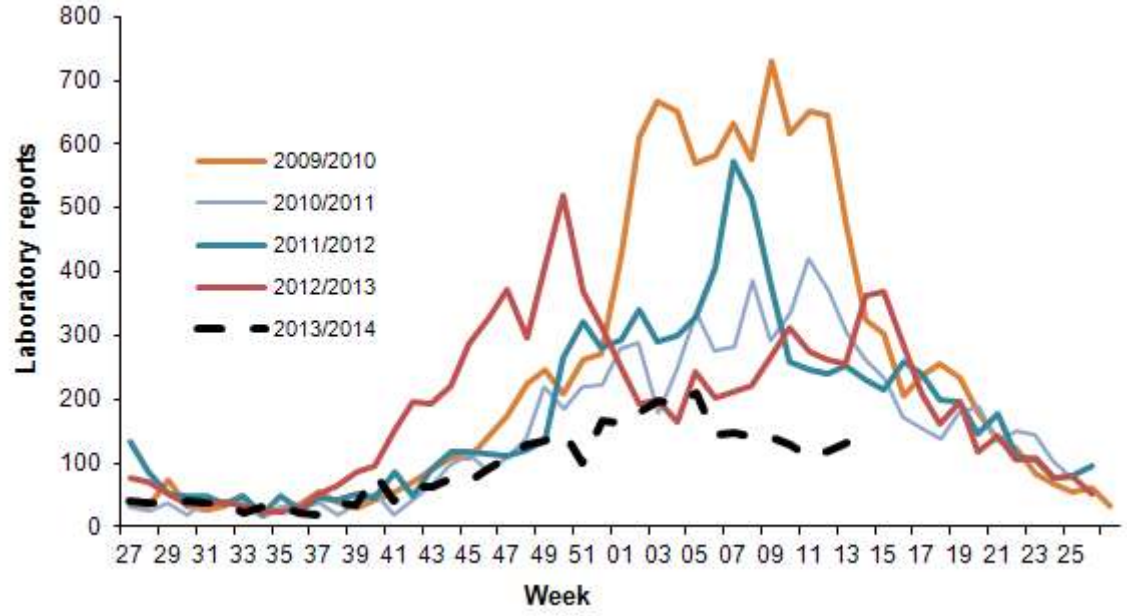
For the calender year 2014– between week 1 (January 2014) and week 13 (week beginning 24 March) – 277 outbreaks have been reported. Ninety-three per cent (257) of reported outbreaks resulted in ward/bay closures or restrictions to admissions and 70 per cent (194) were laboratory confirmed as due to norovirus.

Suspected and laboratory-confirmed reported norovirus outbreaks in hospitals, with regional breakdown: outbreaks occurring in weeks 9-13/2014

Region/ PHE Centre	Outbreaks between weeks 9-13/2014			Total outbreaks 1-13/2013		
	Outbreaks	Ward/bay closure*	Lab-confirmed	Outbreaks	Ward/bay closure*	Lab-confirmed
Avon, Gloucestershire and Wiltshire	5	5	1	34	34	21
Bedfordshire, Hertfordshire and Northamptonshire	–	–	–	–	–	–
Cheshire and Merseyside	1	1	1	1	1	1
Cumbria and Lancashire	2	2	1	10	10	6
Devon, Cornwall and Somerset	5	5	3	25	24	13
Greater Manchester	–	–	–	5	5	4
Hampshire, Isle of Wight and Dorset	8	8	2	15	15	8
Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire	4	4	3	20	19	15
London	–	–	–	6	6	5
Norfolk, Suffolk, Cambridgeshire and Essex	–	–	–	–	–	–
North east	4	4	4	25	21	18
Sussex, Surrey and Kent	6	6	2	10	10	6
Thames Valley	5	5	3	7	7	3
West Midlands	12	12	6	43	42	23
Yorkshire and the Humber	14	9	14	76	63	71
Total	**66**	**61**	**40**	**277**	**257**	**194**

* Note: not all outbreaks result in whole wards closures, some closures are restricted to bays only.

Seasonal comparison of laboratory reports of norovirus (England and Wales)



In the current season to date † (from week 27, 2013, to week 13, 2014), there were 3695 laboratory reports of norovirus. This is 48% lower than the average number of laboratory reports for the same period in the seasons between 2007/08 and 2011/2012 (7126)*. The number of laboratory reports in the most recent weeks will increase as further reports are received.

† The norovirus season runs from July to June (week 27 in year one to week 26 in year two) in order to capture the winter peak in one season.

* Last season – 2012/2013 – the season began earlier than normal so comparisons between this current and last season would not be valid.

Current weekly norovirus laboratory reports compared to weekly average 2006/2010