

Newsletter

GLOUCESTERSHIRE LOCAL MEDICAL COMMITTEE MAY 2010 Edition

Dr. Andrew Seymour
LMC Chairman
Andrew.Seymour@glos.nhs.uk

Shelina Jetha
LMC Manager
shelina@gloslmc.com

Mike Forster
LMC Lay Secretary
mike@gloslmc.com

Sue O'Sullivan
Administration
sue@gloslmc.com

LMC Website: <http://www.gloslmc.com>

Tel: 01452 310706

Fax: 01452 386503

In the current era of goodwill and potentially constructive political dialogue we would emphasise that the LMC is not for or against any party; it stands for the rights of GPs. This is very necessary, as we are entering a period when funding is going to become much more limited, and we will be needing to discuss with practices the realities of politico-medical life. The new Coalition Government has just published its intentions for the next 5 years, and an extract of items that may be of interest to practices is at Annex A.

BMA's EMPLOYER ADVISORY SERVICE

The BMA now runs a service to advise partners and their practice managers about many employer-related matters. This is a privilege of BMA membership, but it is enough, probably, even if only one partner is a member. They say they have extensive knowledge of the medical arena, and will be able to save you from many expensive HR errors.

INFECTIOUS DISEASE NOTIFICATION

With effect from 6th April the rules for notifying the 'proper officer' have been clarified. The list of diseases has been extended. The reporting is now expressed to be a duty and thus no fee attaches. Full details are at Annex B.

SMARTCARDS

CfH introduced a new version of software about 9 months ago to be able to work with the new generation of smart cards that were to be introduced about now – but no-one was told about it so it was not installed on practice

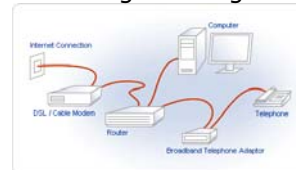
systems. If you use the new smartcards on the old software they won't work, so there is now a concerted effort to upgrade all practices giving priority to those about to change to the new cards.

LMC RATE

With effect from 1 April 2010 the LMC rate is £65, a £2 rise from £63.

INTERNET CONNECTIONS

Many of you have told us how slow you find the N3 connection. Two solutions are being investigated. We understand that it might be technically possible to customise the router to service two connections. That way the N3 connection would be reserved for the NHS traffic and all else could go over a generic connection service hired by the practice at a reasonable monthly rate. However, there is a lot of work still to be done to identify the feasibility of this. The more idealistic solution would be



GP-COIN but the PCT is so far unable to find the extra funding for this. Our thanks go to those practices that contributed to the recent survey.

SWINE FLU

The Swine Flu DES will not be continuing in its full form in 2010/11. However, GPs can opportunistically vaccinate at risk patients, and receive £5.25 for doing so, but they won't get any other DES concessions.

LEARNING DISABILITIES LIST

There is a concern that the uptake by Learning Disability Patients of cervical screening is only 20%. With the aim of sending out targeted information to encourage LD patients to take up the offer of cervical screening the Gloucestershire Primary and Community Care Audit Group would like to have access to lists of patients from the LD DES. In the interests of patient care the LMC supports this.

MAX'S MUSINGS

The General Election is now over, and we in UK are now a ConDemNation, or something.

The saying that 'the writing is on the wall' is nothing to do with Banksy and his ilk, but rather a reference to the biblical story of the fall of Babylon in the time of Belshazzar. The writing that appeared on that wall was interpreted



as meaning 'You have been weighed in the balance and found wanting.' If it appeared today (and could be interpreted) it

might apply to the last government (which has fallen), or to the cost of the NHS (which may well have to fall) or even to the extent and quality of clinical care (but which we hope will never fall).

We have now all been told that NHS funding is being protected from cuts by the government, but at the same time the QIPP programme is taking off with the avowed intention of finding economies and efficiencies which will allow the available funding to go further. We are in for some interesting times. If you read Annex A to this Newsletter you will see how interesting they could become.

And finally

- The patient lives at home with his mother, father and pet turtle, who is presently enrolled in day care three times a week.
- The patient expired on the floor uneventfully.
- You can also rinse with slat water.



This newsletter was prepared by Mike Forster, LMC Lay Secretary, & the LMC Office

EXTRACTS FROM 'The Coalition: our programme for government'

http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_187876.pdf

The following are extracts from the above document that may be of interest to GP practices. Paragraph numbering has been inserted by the LMC to reflect the order of the plain bullet points in the original document. This should make it easier to refer to / find them. The Government's headline statement for each area is repeated in full.

2. BUSINESS

The Government believes that business is the driver of economic growth and innovation, and that we need to take urgent action to boost enterprise, support green growth and build a new and more responsible economic model. We want to create a fairer and more balanced economy, where we are not so dependent on a narrow range of economic sectors, and where new businesses and economic opportunities are more evenly shared between regions and industries.

4. We will review IR 35, as part of a wholesale review of all small business taxation, and seek to replace it with simpler measures that prevent tax avoidance but do not place undue administrative burdens or uncertainty on the self-employed, or restrict labour market flexibility.

3. CIVIL LIBERTIES

We will be strong in defence of freedom. The Government believes that the British state has become too authoritarian, and that over the past decade it has abused and eroded fundamental human freedoms and historic civil liberties. We need to restore the rights of individuals in the face of encroaching state power, in keeping with Britain's tradition of freedom and fairness.

5. We will extend the scope of the Freedom of Information Act to provide greater transparency.

6. CRIME AND POLICING

The Government believes that we need radical action to reform our criminal justice system. We need police forces that have greater freedom from Ministerial control and are better able to deal with the crime and anti-social behaviour that blights people's lives, but which are much more accountable to the public they serve.

8. We will make hospitals share non-confidential information with the police so they know where gun and knife crime is happening and can target stop-and-search in gun and knife crime hot spots.

(There are also many proposals with regard to alcohol sales and consumption.)

7. CULTURE, OLYMPICS, MEDIA AND SPORT

The Government believes that a vibrant cultural, media and sporting sector is crucial for our well-being and quality of life. We need to promote excellence in these fields, with government funding used where appropriate to encourage philanthropic and corporate investment.

12. We will introduce measures to ensure the rapid roll-out of superfast broadband across the country. We will ensure that BT and other infrastructure providers allow the use of their assets to deliver such broadband, and we will seek to introduce superfast broadband in remote areas at the same time as in more populated areas. If necessary, we will consider using the part of the TV licence fee that is supporting the digital switchover to fund broadband in areas that the market alone will not reach.

(LMC Comment: Bearing in mind the slowness of the N3 connection this could be a Good Thing!)

8. DEFENCE

The Government believes that we need to take action to safeguard our national security at home and abroad. We also recognise that we need to do much more to ensure that our Armed Forces have the support they need, and that veterans and their families are treated with the dignity that they deserve.

5. We will ensure that injured personnel are treated in dedicated military wards.

9. DEFICIT REDUCTION

The Government believes that it is the most vulnerable who are most at risk from the debt crisis, and that it is deeply unfair that the Government could have to spend more on debt interest payments than on schools. So we need immediate action to tackle the deficit in a fair and responsible way, ensure that taxpayers' money is spent responsibly, and get the public finances back on track.

9. We will reduce spending on the Child Trust Fund and tax credits for higher earners.

11. ENVIRONMENT, FOOD AND RURAL AFFAIRS

The Government believes that we need to protect the environment for future generations, make our economy more environmentally sustainable, and improve our quality of life and well-being. We also believe that much more needs to be done to support the farming industry, protect biodiversity and encourage sustainable food production.

6. We will take forward the findings of the Pitt Review to improve our flood defences, and prevent unnecessary building in areas of high flood risk.

13. EUROPE

The Government believes that Britain should play a leading role in an enlarged European Union, but that no further powers should be transferred to Brussels without a referendum. This approach strikes the right balance between constructive engagement with the EU to deal with the issues that affect us all, and protecting our national sovereignty.

2. We will ensure that there is no further transfer of sovereignty or powers over the course of the next Parliament. We will examine the balance of the EU's existing competences and will, in particular, work to limit the application of the Working Time Directive in the United Kingdom.

14. FAMILIES AND CHILDREN

The Government believes that strong and stable families of all kinds are the bedrock of a strong and stable society. That is why we need to make our society more family friendly, and to take action to protect children from excessive commercialisation and premature sexualisation.

6. We will refocus funding from Sure Start peripatetic outreach services, and from the Department of Health budget, to pay for 4,200 extra Sure Start health visitors.
7. We will investigate a new approach to helping families with multiple problems.
8. We will publish serious case reviews, with identifying details removed.

16. GOVERNMENT TRANSPARENCY

The Government believes that we need to throw open the doors of public bodies, to enable the public to hold politicians and public bodies to account. We also recognise that this will help to deliver better value for money in public spending, and help us achieve our aim of cutting the record deficit. Setting government data free will bring significant economic benefits by enabling businesses and non-profit organisations to build innovative applications and websites.

1. We will require public bodies to publish online the job titles of every member of staff and the salaries and expenses of senior officials paid more than the lowest salary permissible in Pay Band 1 of the Senior Civil Service pay scale, and organograms that include all positions in those bodies.

6. We will introduce new protections for whistleblowers in the public sector.

22. NHS

The Government believes that the NHS is an important expression of our national values. We are committed to an NHS that is free at the point of use and available to everyone based on need, not the ability to pay. We want to free NHS staff from political micromanagement, increase democratic participation in the NHS and make the NHS more accountable to the patients that it serves. That way we will drive up standards, support professional responsibility, deliver better value for money and create a healthier nation.

1. We will guarantee that health spending increases in real terms in each year of the Parliament, while recognising the impact this decision will have on other departments.
2. We will stop the top-down reorganisations of the NHS that have got in the way of patient care. We are committed to reducing duplication and the resources spent on administration, and diverting these resources back to front-line care.
3. We will significantly cut the number of health quangos.
4. We will cut the cost of NHS administration by a third and transfer resources to support doctors and nurses on the front line.
5. We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.
6. We will strengthen the power of GPs as patients' expert guides through the health system by enabling them to commission care on their behalf.
7. We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust (PCT). The remainder of the PCT's board will be appointed by the relevant local authority or authorities, and the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.
8. The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.
9. If a local authority has concerns about a significant proposed closure of local services, for example an A&E department, it will have the right to challenge health organisations, and refer the case to the Independent Reconfiguration Panel. The Panel would then provide advice to the Secretary of State for Health.
10. We will give every patient the right to choose to register with the GP they want, without being restricted by where they live.
11. We will develop a 24/7 urgent care service in every area of England, including GP out-of-hours services, and ensure every patient can access a local GP. We will make care more accessible by introducing a single number for every kind of urgent care and by using technology to help people communicate with their doctors.
12. We will renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas.
13. We will make the NHS work better by extending best practice on improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and where possible enabling community access to care and treatments.
14. We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.
15. We will prioritise dementia research within the health research and development budget.
16. We will seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests.

25 May 2010

17. Doctors and nurses need to be able to use their professional judgement about what is right for patients and we will support this by giving front-line staff more control of their working environment.
18. We will strengthen the role of the Care Quality Commission so it becomes an effective quality inspectorate. We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.
19. We will establish an independent NHS board to allocate resources and provide commissioning guidelines.
20. We will enable patients to rate hospitals and doctors according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.
21. We will measure our success on the health results that really matter – such as improving cancer and stroke survival rates or reducing hospital infections.
22. We will publish detailed data about the performance of healthcare providers online, so everyone will know who is providing a good service and who is falling behind.
23. We will put patients in charge of making decisions about their care, including control of their health records.
24. We will create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them, paid for using money saved by the NHS through our pledge to stop the rise in Employer National Insurance contributions from April 2011.
25. We will reform NICE and move to a system of value-based pricing, so that all patients can access the drugs and treatments their doctors think they need.
26. We will introduce a new dentistry contract that will focus on achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.
27. We will provide £10 million a year beyond 2011 from within the budget of the Department of Health to support children's hospices in their vital work. And so that proper support for the most sick children and adults can continue in the setting of their choice, we will introduce a new per-patient funding system for all hospices and providers of palliative care.
28. We will encourage NHS organisations to work better with their local police forces to clamp down on anyone who is aggressive and abusive to staff.
29. We are committed to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers.
30. We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers.

24. POLITICAL REFORM

The Government believes that our political system is broken. We urgently need fundamental political reform, including a referendum on electoral reform, much greater co-operation across party lines, and changes to our political system to make it far more transparent and accountable.

14. We will improve the civil service, and make it easier to reward the best civil servants and remove the least effective.
27. We will make the running of government more efficient by introducing enhanced Departmental Boards which will form collective operational leadership of government departments.

25. PUBLIC HEALTH

The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health.

25 May 2010

1. We will give local communities greater control over public health budgets with payment by the outcomes they achieve in improving the health of local residents.
2. We will give GPs greater incentives to tackle public health problems.
3. We will investigate ways of improving access to preventative healthcare for those in disadvantaged areas to help tackle health inequalities.
4. We will ensure greater access to talking therapies to reduce long-term costs for the NHS.

28. SOCIAL CARE AND DISABILITY

The Government believes that people needing care deserve to be treated with dignity and respect. We understand the urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face.

2. We will break down barriers between health and social care funding to incentivise preventative action.

N.B. The deficit reduction programme takes precedence over any of the other measures in this agreement, and the speed of implementation of any measures that have a cost to the public finances will depend on decisions to be made in the Comprehensive Spending Review.

The Government fully supports the devolution of powers to Northern Ireland, Scotland and Wales. **As a result of devolution, many decisions made by UK Ministers or in the Westminster Parliament now apply to England only.** The Northern Ireland Executive, the Scottish Executive and the Welsh Assembly Government make their own policy on their devolved issues. **This document therefore sets out the agreed priorities for the Coalition Government in Westminster.**

INFECTIOUS DISEASE NOTIFICATION CHANGES FROM 6TH APRIL 2010

(With thanks to Thames Valley Health Protection Unit and Wessex LMCs)

The Health Protection (Notification) Regulations 2010 have changed from 6th April 2010.¹

There is no change in the requirement for a Registered Medical Practitioners to notify the proper officer of the local authority for individual cases of specified diseases. However, there have been a number of changes to the list of specified diseases which are listed under Schedule 1 (see first column of Appendix 1).

The Regulations **also** require GP to **notify** the proper officer of the local authority in which the patient resides when they have "reasonable grounds for suspecting" that the patient:

- has an infection not included in Schedule 1 which in the view of the GP which presents, or could present, significant harm to human health (e.g. emerging or new infections); or
- is contaminated (such as with chemicals or radiation) in a manner which, in the view of the GP presents, or could present significant harm to human health; or
- has died with, but not necessarily because of a notifiable disease, or other infectious disease or contamination that presents, or could present, or that presented or could have presented, significant harm to human health.

GPs should not wait for laboratory confirmation or results from other investigations in order to notify a case of suspected infection or contamination. There are clear time limits for notification by the GP, including provision for urgent reporting:

- **Urgent** (see Appendix 1 for guidance) – as soon as possible after clinical suspicion or diagnosis, and always **within 24 hours**. Verbal notification needs to be followed by written notification (including fax or email) **within three days**.
- **Non urgent** – GP notifies the proper officer in writing (including fax or email) **within three days**.

The fee for notification is no longer payable.²

Written notifications (see Appendix 2) must be provided within three days of suspicion or diagnosis or following an urgent verbal notification and may be sent in the following ways:

- By post
- By fax **within three days** to Environmental Health Gloucestershire County Council on 01452 396340
- By e-mail within three days (**note this is only for non-urgent notifications**) to heretohelp@gloucester.gov.uk

Note the regulations on what information to provide. Please ensure you provide a contact number at which you will be available (preferably a mobile number) in order that you can be contacted to speak to you about your case. Email notifications must be password protected and the password sent in a subsequent email.

Changes in the law regarding the separate laboratory **notification systems for diagnostic laboratories** will come into force in **October 2010**.

¹ http://www.opsi.gov.uk/si/si2010/uksi_20100659_en_1

² Health Protection Legislation (England) Guidance 2010 section 3.8 to be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114510

APPENDIX 1 TO
ANNEX B TO
GLOS LMC NEWSLETTER
DATED 25 MAY 2010

NOTIFIABLE DISEASES, WITH EXPLANATORY NOTES AND GUIDANCE ON THE NEED FOR URGENT NOTIFICATION³

NB: This table is for guidance only and each case should be considered individually.

Schedule 1 notifiable diseases	Definition / comment	Likely to be urgent?
Acute encephalitis		No
Acute meningitis	Viral and bacterial.	Yes, if suspected bacterial infection.
Acute poliomyelitis		Yes
Acute infectious hepatitis	Close contacts of acute hepatitis A and hepatitis B cases need rapid prophylaxis. Urgent notification will facilitate prompt laboratory testing. Hepatitis C cases known to be acute need to be followed up rapidly as this may signify recent transmission from a source that could be controlled.	Yes
Anthrax		Yes
Botulism		Yes
Brucellosis		No – unless thought to be UK-acquired
Cholera		Yes
Diphtheria		Yes
Enteric fever (typhoid or paratyphoid fever)	Clinical diagnosis of a case before microbiological confirmation (e.g. case with fever, constipation, rose spots and travel history) would be an appropriate trigger for initial public health measures, such as exclusion of cases and contacts in high risk groups (e.g. food handlers).	Yes
Food poisoning	Any disease of infectious or toxic nature caused by, or thought to be caused by consumption of food or water (definition of the Advisory Committee on the Microbiological Safety of Food).	Clusters and outbreaks, yes. For specific organisms see Table 2.
Haemolytic uraemic syndrome (HUS)		Yes

³ This table is taken from Health Protection Legislation (England) Guidance 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114589.pdf Table 1 pages 25 et seq

Infectious bl**dy diarrhoea	See also HUS in Schedule 1 and VTEC in Schedule 2.	Yes
Invasive group A streptococcal disease and scarlet fever		Yes, if IGAS. No, if scarlet fever
Legionnaires' Disease		Yes
Leprosy		No
Malaria		No, unless thought to be UK-acquired
Measles		Yes
Meningococcal septicaemia		Yes
Mumps	Post-exposure immunization (MMR or HNIG) does not provide protection for contacts.	No
Plague		Yes
Rabies	A person bitten by a suspected rabid animal should be reported and managed urgently, but if a patient is diagnosed with symptoms of rabies, they will not pose a risk to human health.	Yes
Rubella	Post-exposure immunisation (MMR or HNIG) does not provide protection for contacts.	No
SARS		Yes
Smallpox		Yes
Tetanus		No, unless associated with injecting drug use
Tuberculosis		No, unless healthcare worker or suspected cluster or multi drug resistance
Typhus		No
Viral haemorrhagic fever (VHF)		Yes
Whooping cough		Yes, if diagnosed during acute phase
Yellow fever		No, unless thought to be UK-acquired

NB: Registered Medical Practitioners are also required to notify suspected cases of other infections ("other relevant infection") or contamination ("relevant contamination") that present, or could present, significant harm to human health.

APPENDIX 2 TO
ANNEX B TO
GLOS LMC NEWSLETTER
DATED 25 MAY 2010

**INFORMATION TO BE PROVIDED BY THE GP TO ENVIRONMENTAL HEALTH
IN THE EVENT OF FINDING A NOTIFIABLE DISEASE**

The following information has to be provided:

If patient is alive⁴	If patient is dead⁵
Patient's name	Patient's name
Patient's date of birth	Patient's date of birth
Patient's sex	Patient's sex
	Date of patient's death
Patient's home address including postcode	Patient's home address including postcode
Patient's current residence (if not at home address)	Patient's place of residence at the time of death (if different from home address)
Patient's telephone number	
Patient's NHS number	Patient's NHS number
Patient's occupation (if relevant)	Patient's occupation at time of death (if relevant)
Name, address and postcode of patient's place of work or education (if relevant)	Name, address and postcode of patient's place of work or education at the time of death (if relevant)
Patient's relevant overseas travel history	Patient's relevant overseas travel history
Patient's ethnicity	Patient's ethnicity
Contact details for a parent of the patient (where the patient is a child)	
The disease or infection which the patient has or is suspected of having or the nature of the patient's contamination or suspected contamination;	The disease or infection which the patient had or is suspected of having had or the nature of the patient's contamination or suspected contamination
The date of onset of the patient's symptoms	The date of onset of the patient's symptoms
The date of the reporting doctor's diagnosis	The date of the reporting doctor's diagnosis
Name, address and telephone number of the reporting doctor.	Name, address and telephone number of the reporting doctor.

⁴ The Health Protection (Notification) Regulations 2010 section 2

⁵ Ibid. Section 3

CAUSATIVE AGENTS, WITH EXPLANATORY NOTES AND GUIDANCE ON THE NEED FOR URGENT NOTIFICATION⁶

As regards urgency, the key consideration will be the likelihood that an intervention is needed to protect human health and the urgency of such an intervention. The likelihood of the diagnosis of an infection being considered urgent may also increase if it is part of a known or suspected cluster, or in someone with increased risk of transmission such as enteric infection in a food handler.

NB: This table is only for guidance and each case should be considered individually.

Notifiable organisms	Definition / comment	Likely to be urgent?
<i>Bacillus anthracis</i>		Yes
<i>Bacillus cereus</i>	Only if associated with food poisoning	No, unless part of a known cluster
<i>Bordetella pertussis</i>		Yes if diagnosed during acute phase
<i>Borrelia</i> spp		No
<i>Brucella</i> spp		No, unless thought to be UK-acquired
<i>Burkholderia mallei</i>		Yes
<i>Burkholderia pseudomallei</i>		Yes
<i>Campylobacter</i> spp		No, unless part of a known cluster
Chikungunya virus		No, unless thought to be UK-acquired
<i>Chlamydophila psittaci</i>		Yes if diagnosed during acute phase or part of a known cluster
<i>Clostridium botulinum</i>		Yes
<i>Clostridium perfringens</i>	Only if associated with food poisoning	No, unless known to be part of a cluster
<i>Clostridium tetani</i>		No, unless associated with injecting drug use
<i>Corynebacterium diphtheriae</i>	Notify without delay, before results of toxigenicity tests are known	Yes
Junin virus		Yes
Kyasanur Forest disease virus		Yes
Lassa virus		Yes
<i>Legionella</i> spp		Yes
<i>Leptospira interrogans</i>		No
<i>Listeria monocytogenes</i>		Yes
Machupo virus		Yes
Marburg virus		Yes
Measles virus		Yes

⁶ This table is taken from Health Protection Legislation (England) Guidance 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114589.pdf Table 2 page 35 et seq

Notifiable organisms	Definition / comment	Likely to be urgent?
Mumps virus		No
<i>Mycobacterium tuberculosis</i> complex		No, unless healthcare worker or suspected cluster or multi-drug resistance
<i>Neisseria meningitidis</i>	Excluding asymptomatic cases (e.g. throat carriage)	Yes
Omsk haemorrhagic fever virus		Yes
<i>Plasmodium falciparum, vivax, ovale, malariae, knowlesi</i>		No, unless thought to be UK-acquired
Polio virus	Wild or vaccine types	Yes
Rabies virus	Classical rabies and rabies-related lyssaviruses	Yes
<i>Rickettsia</i> spp		No, unless thought to be UK-acquired
Rift Valley fever virus		Yes
Rubella virus		No
Sabia virus		Yes
<i>Salmonella</i> spp	Including <i>S. Typhi</i> and <i>S. Paratyphi</i>	Yes, if <i>S. Typhi</i> or <i>S. Paratyphi</i> or suspected outbreak or food handler or closed communities such as care homes No, if sporadic case of other <i>Salmonella</i> species
SARS coronavirus		Yes
<i>Shigella</i> spp		Yes, except <i>Sh. sonnei</i> unless suspected outbreak or food handler or closed communities such as care homes
<i>Streptococcus pneumoniae</i>	Invasive i.e. from blood, cerebrospinal fluid or other normally sterile site	No, unless part of a known cluster
<i>Streptococcus pyogenes</i>	Invasive i.e. from blood, cerebrospinal fluid or other normally sterile site, or associated with necrotising soft tissue infection	Yes
Varicella zoster virus		No
Variola virus		Yes
Verocytotoxigenic <i>Escherichia coli</i>	Including <i>E. coli</i> O157	Yes
<i>Vibrio cholerae</i>		Yes
West Nile Virus		No, unless thought to be UK-acquired
Yellow fever virus		No, unless thought to be UK-acquired
<i>Yersinia pestis</i>		Yes