UK HEALTH DEPARTMENTS

**PROTECTING HEALTH CARE WORKERS AND PATIENTS FROM HEPATITIS B**

RECOMMENDATIONS OF THE ADVISORY GROUP ON HEPATITIS

AUGUST 1993
GLOSSARY

Hepatitis B surface antigen (HBsAg)
HBsAg is found during the latter part of the incubation period and acute phase of hepatitis B infection. Its persistence is associated with failure to clear virus from the body. Patients remaining HBsAg positive for more than 6 months are regarded as having developed the chronic carrier state. HBsAg disappears in about 1-2% of chronic carriers per year.\(^1\)

Antibody to hepatitis B surface antigen (anti-HBs)
Development of anti-HBs is generally associated with disappearance of infectious virus in those recovering from natural infection. It is also made in response to hepatitis B immunisation. It is a marker of immunity against the virus.

Hepatitis B e antigen (HBeAg)
HBeAg is associated with the presence of infectious virus. Whilst carriers of the hepatitis B virus are HBeAg positive their blood contains a high concentration of virus and is likely to transmit infection. Some carriers may have persistent HBeAg whilst others may develop antibodies to it after a variable period.

Antibody to HBeAg (anti-HBe)
The blood of carriers who develop anti-HBe is of low infectivity. In a minority of subjects who are anti-HBe positive, detectable hepatitis B virus DNA (HBV DNA) may persist in association with evidence of abnormal liver function. This may indicate a slightly increased risk of transmission. However, no standardised test for routine use is yet available for HBV DNA testing and evidence suggests that the majority of anti-HBe positive subjects do not have significant levels of HBV DNA.

Natural immunity
Almost all those who have been infected by the hepatitis B virus develop antibody to the core of the virus (anti-HBc). This marker is not found in subjects who have vaccine induced immunity. It is found in chronic carriers of the virus who also have HBsAg and it is also found in those who have cleared the virus and in whom HBsAg is no longer detectable. The latter group is referred to as “naturally immune”.
KEY RECOMMENDATIONS

1. All health care workers should follow general infection control guidelines and adopt safe working practices to prevent hepatitis B transmission in health care settings (paragraph 3.1).

2. All health care workers who perform exposure prone procedures, including independent contractors – such as GPs and dentists – working outside the hospital setting, and all medical, dental, nursing and midwifery students should be immunised against hepatitis B, unless immunity to hepatitis B as a result of natural infection or previous immunisation has been documented. Their response to the vaccine should subsequently be checked. Current advice recommending the immunisation of all health care personnel who have direct contact with blood or blood-stained body fluids or with patients’ tissues remains applicable (paragraphs 4.1 and 4.6).

3. Health care workers who are HBeAg positive should not perform exposure prone procedures in which injury to the worker could result in blood contaminating the patient’s open tissues (paragraph 3.4).

4. Health care workers who are hepatitis B surface antigen (HBsAg) positive but who are not HBeAg positive need not be barred from any area of work unless they have been associated with transmission of hepatitis B to patients whilst HBeAg negative (paragraphs 3.9 and 3.10).

5. Staff whose work involves exposure prone procedures and who fail to respond to the vaccine should be permitted to continue in their work provided that they are not e antigen (HBeAg) positive carriers of the virus. Inoculation incidents must be treated and followed up in accordance with current guidance2,3 (paragraph 5.7).

6. Health Authorities and Trusts should ensure that members of staff employed or taking up employment or other health care workers contracted to provide a service which involves carrying out exposure prone procedures are immunised against the hepatitis B virus, that their antibody response is checked and that carriers of the virus who are HBeAg positive do not undertake such procedures (paragraph 7.1).

7. Occupational health departments should be involved in developing local procedures for managing HBV infected health care workers (paragraph 7.2).

8. Employers should make every effort to provide alternative employment should this be needed (paragraph 7.4).

9. A UK Advisory Panel has been set up to be consulted when specific occupational advice is needed and cannot be obtained locally (section 8).
This guidance is designed to prevent the transmission of hepatitis B from health care workers to their patients and vice versa. It focuses upon health care workers involved in exposure prone procedures and is not intended to provide comprehensive guidance on the immunisation of health care workers against hepatitis B. It has been produced in conjunction with the Health Departments’ Advisory Group on Hepatitis. It is applicable to all health care workers who carry out exposure prone procedures, whether they are new appointees or already in post, including independent contractors – GPs and dentists. Health care workers are defined as “persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health care setting”.

1. INTRODUCTION

1.1 Departmental guidance on hepatitis B infected health care workers was issued in 1981. It confirmed earlier advice that members of staff found to be carriers of the hepatitis B surface antigen (HBsAg) should not work in renal dialysis units but placed no restriction on the clinical duties of carriers working in other departments “except in the very rare situation where an individual has been shown to be responsible for spreading infection with hepatitis B virus (HBV).”

1.2 The guidance stated that expert advice should be given to any member of staff found to be a carrier on how to avoid transmitting the infection to others, particularly in the presence of “markers of high infectivity.” Any carrier who appeared to have been the source of hepatitis B infection in patients was to perform “only those activities in which the possibility of further transfer is remote”.

1.3 Since 1981 there have been a number of well-documented outbreaks of hepatitis B following transmission from health care workers to their patients. Members of the Advisory Group on Hepatitis (listed at annex 1) have considered the need to issue revised guidance and this advice is based upon their conclusions and recommendations.

1.4 The prevalence of HBV differs widely according to the area and age of the given population. Approximately 1 in 1000 people in the UK are carriers of the hepatitis B virus. In certain inner city areas the prevalence may be as high as 1%. Of these about 10% may be in the highly infective category who are hepatitis B e antigen (HBeAg) positive.
2. RISK OF TRANSMISSION OF HEPATITIS B TO PATIENTS FROM HEALTH CARE WORKERS WHO CARRY THE HEPATITIS B VIRUS

2.1 Transmission of HBV from health care workers to their patients is known to occur. Whilst it is recognised that all HBsAg carriers are potentially infectious, all reported outbreaks have involved HBeAg positive health care workers. By contrast, no outbreaks have been associated with HBsAg positive health care workers who are not e-antigen positive (ie either anti-HBe positive or with no e-markers) although this does not preclude the possibility of sporadic transmission.

2.2 It is likely that documented outbreaks are only a proportion of the real figure. Because of the long incubation period it may be difficult to trace the source of infection and the fact that several cases share a common source may thus escape detection. These difficulties are accentuated by the fact that over 70% of infections with HBV are subclinical.

2.3 A review of reports from other countries confirms the association between outbreaks and HBeAg positive health care workers. Most of these outbreaks have involved cardiovascular surgeons, gynaecologists, and dentists. Relatively few reports have involved general surgeons and hardly any reports have implicated other types of health care worker.

2.4 Studies of outbreaks associated with surgery and gynaecology show that the patients most at risk are those undergoing major surgery. In one study of a gynaecological outbreak 6 247 out of 268 patients who had been operated on by a carrier surgeon were screened for evidence of infection. 9 per cent showed evidence of recent hepatitis B infection, about a quarter of whom had clinical jaundice. In the group of patients undergoing major surgery or caesarean section, however, 20 per cent showed evidence of infection and 5 per cent became jaundiced. Only one patient undergoing a medium-risk procedure (cone biopsy or forceps delivery with episiotomy) showed evidence of infection (1%) and there was no evidence of infection in 37 patients undergoing low risk procedures (dilatation and curettage or termination of pregnancy).

3. GENERAL PRINCIPLES ON WHICH TO BASE SPECIALIST OCCUPATIONAL ADVICE

3.1 This guidance does not obviate the need for routine infection control measures and safe working practices to prevent transmission of blood-borne viruses in the health care setting 2, 7, 8 to be followed at all times (see box).

3.2 Epidemiological data suggests that health care workers most likely to transmit infection are those who are HBeAg positive and who are involved in carry-
**INFECTION CONTROL MEASURES TO PREVENT TRANSMISSION OF BLOOD-BORNE VIRUSES IN THE HEALTH CARE SETTING**

1. Apply good basic hygiene practices with regular hand washing.
2. Cover existing wounds or skin lesions with waterproof dressings.
3. Avoid invasive procedures if suffering from chronic skin lesions on hands.
4. Avoid contamination of person by appropriate use of protective clothing.
5. Protect mucous membrane of eyes, mouth and nose from blood splashes.
6. Prevent puncture wounds, cuts and abrasions in the presence of blood.
7. Avoid sharps usage wherever possible.
8. Institute safe procedures for handling and disposal of needles and other sharps.
9. Institute approved procedures for sterilization and disinfection of instruments and equipment.
10. Clear up spillages of blood and other body fluids promptly and disinfect surfaces.
11. Institute a procedure for the safe disposal of contaminated waste.


...ing out exposure prone procedures as defined in paragraph 3.4 below. Whilst most documented cases involve surgeons and dentists, other health care workers may also be a source of infection if injured during a procedure with the result that their blood might come into contact with a patient’s open tissues.

**HBeAg positive health care workers**

3.3 Although all breaches of the skin or epithelia by sharp instruments are by definition invasive, many clinical procedures are considered to pose no risk of transmission of virus from an infected health care worker to the patient as they do not provide an opportunity for the blood of the health care worker to come into contact with the open tissues of the patient. Procedures where such an opportunity exists are defined as exposure prone (see 3.4) and must not be performed by an HBeAg positive health care worker.

3.4 Exposure prone procedures are those where there is a risk that injury to the worker may result in the exposure of the patient’s open tissues to the blood of the worker. These procedures include those where the worker’s gloved hands may be in contact with sharp instruments, needle tips and sharp tissues (spicules of bone or teeth).
inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. **Such procedures must not be performed by a health care worker who is either HIV or hepatitis B e antigen positive.** The working practices of each infected health care worker must be considered individually and when there is any doubt expert advice should be sought in the first instance from a specialist occupational health physician who may in turn wish to consult the Advisory Panel on infected health care workers (see section 8).

3.5 Procedures where the hands and fingertips of the worker are visible and outside the patient’s body at all times, and internal examinations or procedures that do not require the use of sharp instruments, are not considered to be exposure prone provided routine infection control procedures are adhered to at all times including the wearing of gloves as appropriate and the covering of cuts or open skin lesions on the worker’s hands. Examples of such procedures include the taking of blood, setting up and maintaining IV lines, minor surface suturing, the incision of abscesses or uncomplicated endoscopies. However, as stated in paragraph 3.4, the final decision about the type of work that may be undertaken by an infected health care worker should be made on an individual basis taking into account the specific working practices of the worker concerned.

3.6 Normal vaginal delivery in itself is not an exposure prone procedure. When undertaking a vaginal delivery an infected health care worker must not perform procedures involving the use of sharp instruments such as infiltrating local anaesthetic or suturing of a repair or episiotomy. Neither can they perform an instrumental delivery requiring forceps or suction since these may need an episiotomy and subsequent repair. In practice, this means an infected health care worker may only undertake a vaginal delivery if it is certain that a second midwife or doctor will also be present during the delivery who is able to undertake all such operative interventions as might arise during the course of the delivery.

3.7 Existing recommendations currently exclude all staff who are carriers of the hepatitis B surface antigen from working in renal dialysis units. It is now recommended that such restrictions should only apply to those who are HBeAg positive.

3.8 A UK Advisory Panel for health care workers with blood-borne viruses (see section 8) has been established to provide further advice to occupational or personal physicians in case of continuing doubt about what activities the worker may or may not continue to undertake.
HBsAg positive health care workers who are not HBeAg positive

3.9 There are no documented outbreaks involving transmission from HBsAg positive health care workers who are not HBeAg positive. Most of these will have detectable anti-HBe. A few who are HBsAg positive have neither HBeAg nor anti-HBe. This is often referred to as an absence of e-markers and although it is associated with significant infectivity in transmission from mother to baby there is no epidemiological evidence linking HBsAg positive health care workers without e-markers to outbreaks of infection.

3.10 HBsAg positive health care workers who are not HBeAg positive need not be barred from any area of work. In accordance with existing guidance they should receive expert advice on avoiding transmission of infection to others. Should a HBsAg positive health care worker who is not HBeAg positive be associated with the transmission of infection to a patient the restrictions outlined at paragraphs 3.4 – 3.7 would be applicable.

3.11 The preceding paragraphs refer to the risk of transmission from a health care worker to a patient. It is important to stress that there is a far greater risk of infection from patient to health care worker and therefore such workers should be immunised against hepatitis B and routine infection control guidance should be followed at all times with all patients as in 3.1.

4. IMMUNISATION OF STAFF AGAINST HEPATITIS B

4.1 It is recognised that those whose work involves exposure prone procedures (as defined in paragraph 3.4) or renal haemodialysis, including medical, dental, nursing and midwifery students, are at risk of transmitting hepatitis B to their patients. Unless they are known to be naturally immune to HBV, they should be immunised and their response to immunisation should then be checked.

4.2 The response to vaccine should be checked 2-4 months after completion of the primary course. An anti-HBs level of 100 miu/ml is considered to reflect an adequate response to the vaccine and to confer protective immunity. In the absence of natural immunity levels of anti-HBs between 10 and 100 miu/ml indicate a response to the vaccine but one that may not necessarily confer long-lasting immunity and which may require boosting. The specificity of levels of anti-HBs below 10 miu/ml cannot be assured and such levels cannot be considered as evidence of a response to the vaccine. If there is a delay in checking the response, a booster dose should be given before anti-HBs titres are measured as levels of antibody gradually fall after immunisation.
4.3 About 10% of people do not respond to a primary course of vaccine. Lack of response is commoner in those over the age of 40 and those who are immunocompromised. Some people fail to respond to vaccine because they are carriers of the hepatitis B virus (see paragraph 5.1).

4.4 In non-responders who are not carriers of the virus, booster doses may improve the response. Newer vaccines are also being developed with the aim of improving response rates. A single booster dose is recommended in poor responders (anti HBs 10-100 miu/ml measured 2-4 months after the primary course) and a repeat course in non-responders (anti-HBs<10miu/ml measured 2-4 months after the primary course).

4.5 Recommendations about subsequent booster doses in those who have responded to the primary course of vaccine are contained in “Immunisation against Infectious Disease” which also contains advice about adverse effects of and contraindications to vaccine.

4.6 In line with existing guidance, it is also desirable that hepatitis B vaccine should be given to all staff who are at risk of acquiring hepatitis B occupationally because they are at risk of injury from blood-stained sharp instruments, contamination of surface lesions by blood or blood-stained body fluids or of being deliberately injured or bitten by patients.

5. FOLLOW-UP OF IMMUNISATION IN STAFF CARRYING OUT EXPOSURE PRONE PROCEDURES

5.1 Those whose work involves exposure prone procedures and who fail to respond to a full course of vaccine should be referred for specialist advice and counselling. Consent should be sought for further testing to find out who are vaccine non-responders and who are hepatitis B carriers.

5.2 Staff who are found to be HBeAg positive are regarded as being at risk of transmitting hepatitis B to their patients in the course of exposure prone procedures. They should receive advice regarding the duties they may continue to perform. They should not carry out exposure prone procedures unless laboratory tests indicate that they are no longer at risk of transmitting infection in the health care setting (see paragraphs 3.9 and 3.10). Local advisers may wish to seek the help of the Advisory Panel (section 8) in making this assessment. Spontaneous loss of HBeAg with development on anti-HBe occurs in about 5-15% of those infected as adults each year and a further 1-2% lose HBsAg. Those infected as adults may respond well to treatment with interferons and the carrier state may be reversed in up to 40% of those treated.

5.3 Advice regarding the duties that HBeAg positive health care workers may continue to perform may be sought initially from a physician, medical microbiologist or clinical virologist with experience of hepatitis B but arrangements should be made to seek advice from a specialist.
occupational physician as soon as possible. Occupational health services which do not employ a specialist occupational physician should refer individuals to a specialist occupational health physician in another unit. The Association of National Health Service Occupational Physicians has produced a list of senior specialists who can be contacted by those working in occupational medicine in the field. The close involvement of occupational health departments in developing local procedures for managing HBV-infected health care workers is strongly recommended.

5.4 In order to minimise the scope for ambiguity and conflict of interest it is recommended that all matters arising from and relating to the employment of HBeAg positive health care workers are co-ordinated through a consultant in occupational health medicine. Further it is recommended that all Health Authorities and NHS Trusts need to take steps to identify such a consultant who should also be available for consultation by general medical and dental practitioners and their employees and should liaise with local private sector hospitals and offer such a service to them if the private hospital wishes.

5.5 Every effort should be made to persuade staff of the benefits of immunisation and to explain the importance of testing to see whether they have responded to the vaccine and to avoid putting patients at risk. The restrictions imposed upon HBeAg positive staff should also apply to those who refuse immunisation or subsequent monitoring unless they are already known to be naturally immune or their status as e-antigen negative carriers has been unequivocally established.

5.6 Physicians who are aware that infected health care workers under their care have not followed advice to modify their practice must inform the General Medical Council, General Dental Council or the UK Central Council for Nursing, Midwifery and Health Visiting. In the case of health care workers not covered by one of these statutory bodies the health care worker’s employing authority should be informed.

5.7 Staff in post who are vaccine non-responders and who have no markers of previous hepatitis B infection are at risk of acquiring infection. They may continue without restriction of practice provided that inoculation incidents are reported, treated and followed up in accordance with standard guidelines. Employing authorities have a duty to educate staff to report inoculation incidents promptly.

6. MEDICAL, DENTAL, NURSING AND MIDWIFERY STUDENTS
6.1 Immunisation of students is recommended not only for their own protection but because, if they become carriers of hepatitis B, they may transmit infection when carrying out exposure prone procedures. It is therefore recommended that medical, dental, nursing and midwifery students should be immunised against hepatitis B when they start training and that their response to the vaccine should be checked.

6.2 Those failing to respond to the vaccine should be referred for expert advice and further testing as suggested in paragraphs 5.1 and 5.2. This will enable appropriate careers advice to be given to those who are carriers of the virus, to vaccine non-responders and to any refusing immunisation.

7. RESPONSIBILITIES OF EMPLOYERS AND RIGHTS OF HEALTH CARE WORKERS

7.1 Under health and safety at work legislation employers are responsible for their employees and members of the public, and employees are responsible to each other and members of the public. Health Authorities and Trusts should ensure that members of staff employed or taking up employment or contracted to provide a service involving exposure prone procedures are immunised, that their antibody response is checked and that e-antigen positive carriers of the hepatitis B virus are not involved in carrying out such procedures.

7.2 It is extremely important that HBV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. Occupational physicians, who work within strict guidelines with respect to confidentiality, have a key role in this process. They should be responsible for providing immunisation and checking immunity to hepatitis B and are also able to act as advocate for the health care worker and advisor to the employer. The close involvement of occupational health departments in developing local procedures for managing HBV infected health care workers is strongly recommended.

7.3 Occupational health notes are separate from other hospital notes. Occupational physicians are ethically and professionally obliged not to release notes or information without the consent of the individual. There are occasions when an employer may need to be advised that a change in duties should take place, but HBV status itself will not normally be disclosed without the health care worker’s consent. Where patients are, or have been, at risk, however, it may be necessary, in the public interest, for the employer to have access to confidential information.

7.4 Health care workers must be assured that their status and rights as employees are safeguarded and that their employers will make every effort to arrange suitable alternative work should this be necessary. Opportunities for retraining should be available. Occupational health
physicians should act as advocates for the worker on issues of retraining and redeployment.

7.5 Hepatitis B is a Prescribed Industrial Disease for health care workers. Benefits are also available under the NHS Injury Benefits Scheme for NHS staff who become infected in the course of their work. The terms of both schemes are set out in annex 2.

7.6 Independent contractors – general medical and dental practitioners – who do not have direct access to occupational health schemes should discuss occupational issues with their physician, who may be able to put them in touch with an occupational health department. The Association of NHS Occupational Physicians will also put independent contractors in touch with a nearby occupational physician or the individual's physician may contact the Advisory Panel or the Faculty of Occupational Medicine for advice.

8. SOURCE OF SPECIALIST ADVICE TO HEALTH CARE WORKERS AND THEIR PHYSICIANS

8.1 The remit and membership of the UK Advisory Panel which provides advice for HIV infected health care workers is being extended to cover other blood-borne viruses, especially hepatitis B (see annex 3). It can provide confidential specific occupational advice to personal physicians of health care workers infected with hepatitis B, to their occupational health physicians and to Professional Bodies more generally.

8.2 The Panel will be available to be consulted when the general guidelines provided in this document cannot be applied to particular cases, when health care workers or their professional advocates dispute the advice given locally or where special circumstances exist. Physicians seeking the Panel's advice should ensure the anonymity of the referred health care worker.

8.3 The Panel would also be available to advise individual health care workers how to obtain guidance on their working practices.

9. FOLLOW-UP OF PATIENTS TREATED BY AN HBV INFECTED HEALTH CARE WORKER

9.1 Health Authorities and NHS Trusts will be aware of procedures for the notification and follow up of patients who have undergone exposure prone procedures performed by a health care worker infected with hepatitis B. A suitably experienced Consultant Virologist or Medical
Microbiologist will normally be able to advise on this with reference, where appropriate, to the PHLS Communicable Disease Surveillance Centre in England and Wales or its equivalent elsewhere.

9.2 Rarely there may be cases of doubt about what follow up procedures are necessary, if any, and the UK Advisory Panel will be available to advise on this.

REFERENCES


ANNEX 1

MEMBERSHIP OF THE ADVISORY GROUP ON HEPATITIS

Professor J Banatvala (Chairman) Professor of Virology, St Thomas’ Hospital, London
Dr E Boxall  Regional Virus Reference Laboratory, East Birmingham Hospital
Dr M Contreras  Director, North London Blood Transfusion Service
Dr J Craske  Deputy Director, Regional Public Health Laboratory, Manchester
Dr J Heptonstall  Consultant Medical Microbiologist, Hepatitis Section, PHLS Communicable Disease Surveillance Centre, London
Dr R Lane  Director, Bio Products Laboratory, Herts
Professor H C Thomas  Professor of Medicine, St Mary’s Hospital, London
Dr R S Williams  Consultant Physician, Kings College Hospital, London
Professor A Zuckerman  Dean, Royal Free Hospital School of Medicine, London

ANNEX 2

COMPENSATION FOR OCCUPATIONALLY INFECTED HEALTH CARE WORKERS

DSS INDUSTRIAL INJURIES BENEFIT SCHEME
1. Industrial Injuries Disablement Benefit can be paid where a person contracts viral hepatitis, known as Prescribed Disease B8, which includes Hepatitis A and Hepatitis B. As part of the qualification the claimant must have worked in an environment where they have had contact with human blood or blood products, or a source of viral hepatitis.

2. Anyone who is an employed earner is covered by the industrial injuries scheme. Generally speaking an employed earner is a person who works for payment under a contract of services. They do not have to have paid any National Insurance contributions.

3. Benefit may be payable if a person becomes disabled or unable to work as a result of an accident at work or suffers one of the diseases on a prescribed list known to be a risk in particular jobs, provided that work took place after 4 July 1948.

4. The amount payable depends on how badly a person is disabled, and can be paid after 15 weeks (90 days, excluding Sundays) have passed since the first day of disablement by the disease. A person does not have to have time off work in order to qualify. Benefit is not normally payable if the disability or loss of faculty is assessed at less than 14% (this does not apply to certain respiratory diseases). Separate disabilities, caused as a result of work, can be added together to make up the 14%.

5. Claim forms for benefit are obtainable from local Social Security offices. There are a number of stages in the handling of a claim:

   - the Social Security office makes enquiries of the persons employer to confirm the accident or exposure to situations/substances which might cause the prescribed disease and the employment details.

   - if the Adjudication Officer (AO) is satisfied they refer the case to an adjudicating medical authority who examines the person concerned. They decide, in the case of a prescribed disease, whether the person is suffering from that disease. They then decide the extent and period of any disability and refer the case back to the AO.

   - the AO decides whether benefit is payable.
6. Claimants have a right of appeal against decisions made at any stage in the process.

7. Benefit is payable on top of any other National Insurance Benefits a person gets (but may affect a War Pension or Income Support), and there is no requirement to be off work to receive benefit.

8. Leaflets and advice on Industrial Injuries Benefits can be obtained from local Social Security offices.

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NATIONAL HEALTH SERVICE INJURY BENEFITS SCHEME

1. The NHS Injury Benefits Scheme provides temporary or permanent benefits for all NHS employees who lose remuneration because of an injury or disease attributable to their NHS employment. The scheme is also available to medical and dental practitioners.
2. Under the terms of the scheme it must be established that the injury or
disease was acquired during the course of work. Hepatitis B cases will
be treated no differently. The scheme’s administrators would deal
sympathetically with applications but work related infection would have
to be established. A record of a specific injury and evidence of
seroconversion are not regarded as essential but would be helpful in
proving causation. Any health care worker who suspects
contamination by a hepatitis B infected patient is encouraged to have a
serum sample taken at the time of injury for storage and possible future
testing and follow-up samples at appropriate intervals.

3. Each claim would be considered on its merits. The administrators
would look carefully at the circumstances surrounding the claim, taking
note of the duties undertaken in the employment and the claimant’s
description of how he or she thought the infection was contracted, and
the medical evidence available. The Department’s medical advisers
would then consider all the information against the ways in which
infection may be contracted. Where doubt existed, further expert
medical opinion would be sought and the claimant referred to a
Consultant specialising in viral hepatitis who would be asked to
determine on balance of probability whether it was more likely than not
that the infection had been acquired in the course of NHS employment.

4. Injury benefits are payable to infected workers, whether symptomatic or
not, and are intended to compensate for loss of earning ability. For
those having to give up their employment, the scheme provides a
guaranteed income of up to 85% of pre-injury NHS earnings. The
benefits are inflation proofed. Temporary allowances are taxable but
the permanent allowance payable on retirement from service is not. If
employment has to be terminated because of the relevant injury or
disease, a lump sum is also payable and where death occurs
dependants’ benefits are payable.

ANNEX 3

UK ADVISORY PANEL FOR HEALTH CARE
WORKERS INFECTED WITH BLOOD BORNE
VIRUSES

1. Constitution of Panel
The following specialties are represented:

- Anaesthetics
- Dentistry
- General Practice
- HIV disease
- Midwifery
- Nursing
- Obstetrics and Gynaecology
- Occupational health
- Surgery
- Virology

The panel also includes lay members. New members will be appointed to provide expertise on viral hepatitis and its epidemiology. The Secretariat is provided by the Department of Health.

2. **Contact with the Panel**

2.1 Physicians, occupational physicians and others wanting specialist occupational advice should write to the Secretariat at the address below. The worker’s identity should not be revealed in any way. Confidentiality of all information concerning individual referrals will be maintained by the Secretariat and members of the Panel.

2.2 Cases will be considered by selected members of the Panel, including an Occupational Physician, depending on the worker’s specialty.

2.3 Address of Secretariat:
Department of Health
Health Promotion (Medical) Division 1
Room 732
Wellington House
133-155 Waterloo Road
London
SE1 8UG
Telephone 071 972 4378