Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Policy for Outbreak Reporting and Control, Including Major Outbreaks

Department / Service:	Infection Prevention and Control Department
Originator:	Eve Neale and Lara Bailey – Senior Infection Prevention and Control Nurse Advisors
Accountable Director:	Sarah Shingler – Director of Infection Prevention and Control
Approved by:	Trust Infection Prevention and Control Committee
Date of approval:	2nd November 2023
First Revision Due:	2nd November 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All locations where outbreaks may occur
Target staff categories	All staff working in areas where outbreaks may occur

Policy Overview:
This policy is designed to be used when an outbreak occurs which exceeds the capacity of the Infection Prevention and Control Team (IPCT) and local managers to control in a particular area either because of the numbers of individuals affected, spread, severity or sensitivity of the situation

Date	Amendment	By:
December 2019	The following policies have been incorporated into this overarching policy: WAHT-INF-005; WAHT-INF-031; WAHT-INF-013. New document approved at TIPCC. Addition of new equality impact assessment.	TIPCC

October 2023	Various amendments made to the policy: • Contents page updated. • Name of Accountable Director changed. • Appendices A-E updated. • Removed Appendices 5-7. • Consultation list updated. • Public Health England changed to UK Health Security Agency (UKHSA) throughout document.	TIPCC

Contents

1. Introduction

Outbreaks of infection vary greatly in extent and severity ranging from a few cases of diarrhoea and vomiting to larger outbreaks involving a vast number of people and resultantly cannot easily be defined.

The control measures required to manage and contain outbreaks will vary and the level of response will depend on the causative agent involved, as well as the number of people affected.

The guidance within this document is designed to minimise the effects of outbreaks by ensuring there are appropriate systems in place for early detection and management of outbreaks.

2. Scope of this document

This policy is designed to provide the initial framework for the investigation, management, and control of an outbreak of infection within Worcestershire Acute Hospitals NHS Trust (WAHT).

3. Definitions

Convalescence

A symptom-free interval, usually 48 hrs in the case of viral diarrhoea, which must be experienced by infected patients before they can be nursed without restrictions with non-infected cases.

Cohort ward or bay

A ward or bay within a ward, with dedicated toilet facilities, where patients of similar status can be grouped, e.g., all infected cases together, or all quarantined cases together.

Diarrhoea

A condition in which faeces are discharged from the bowels and in a liquid form (Type 5-7 stool on the Bristol Stool chart).

Healthcare associated infection (HCAI)

Infections that occur because of medical care, or treatment, in any healthcare setting.

Hypochlorite

Refers to sodium hypochlorite (bleach), a chlorine-based disinfectant and chlorine releasing agent. Sodium dichloroisocyanurate is another chlorine-based disinfectant in common use in care settings that may be referred to as ‘hypochlorite’, although

this is technically incorrect the two products have identical uses and are equally effective.

Infection Prevention and Control (IPC)

The practices and processes, in accordance with specific policies and procedures, employed to minimise infection. These should reduce risk of infection to individual patients; and reduce the risk of dissemination of organisms with the potential to cause spread of infection from patient to patient within the healthcare setting (e.g., MRSA or *Clostridiodes difficile*).

Infection Prevention and Control Team (IPCT)

A specialist multidisciplinary team providing practical, clinical advice to staff and service users on IPC issues. This includes implementation of preventative work such as policy, guidance, and education, as well as leading on the investigation and management of infection incidents such as data exceedances and outbreaks.

Outbreak

When two or more individuals have the same laboratory confirmed infection, or more individuals than expected have the same infection. These cases will be linked by a place and time.

An outbreak may be considered major either due to the number of cases or because of the severity of the disease. This policy defines the structure for the recognition and management of these situations.

NB: in the event of pandemic respiratory virus, the principles of this policy are applied.

Period of Increased Incidence (PII)

A PII refers to two or more new cases of known or suspected infection with an infectious organism or new onset of symptoms within a short period of time (usually within 48 hours) in a particular ward/department. This may/may not be due to chance and observation of this ward/department will prompt heightened surveillance until significance is established.

Terminal decontamination

Cleaning/decontamination of the environment following transfer/discharge of a patient, or when they are no longer considered infectious, to ensure the environment is safe for the next patient or for the same patient on return. The level of clean required is denoted by the organism and whether the area is vacated or occupied and will either be a RED clean using Hydrogen Peroxide Vapour (HPV) in vacated rooms/bays, VIOLET using Ultra-Violet-c (UV-c) or an AMBER clean using Chlorine Dioxide (Tristel) in occupied areas.

Ward closure

Usually when a ward is closed due to infection this means it is closed to admissions. Discharges to patients own homes can usually take place. Advice will be given in each outbreak. Dependant on the causative organism discharges to Nursing/Care homes may be restricted, specialist advice should be provided from IPC team.

4. Responsibility and Duties

Chief Nursing Officer (CNO)/ Director of Infection Prevention and Control (DIPC)/ Deputy Director of Infection Prevention and Control (DDIPC)

The lead Executive Director responsible for IPC and will delegate local operational responsibility to Directors of Nursing, Deputy Directors of Nursing, Matrons and Ward Managers. The DIPC/DDIPC will delegate responsibility for instigating ward closures to the IPCT.

Consultant Microbiologist/ Infection Control Doctor (ICD)

The individual taking day to day responsibility for declaration of ward closures.

Deputy DIPC/ Infection Prevention and Control Nurse (IPCN) Manager/ Senior Infection Prevention and Control Nurses (IPCNs)

Will lead on the management of ward closures, from outset to stand down, with appropriate advice to clinical, nursing and facilities staff.

Infection Prevention and Control Team (IPCT)

Will work at the direction of the Deputy DIPC/IPCN Manager/Senior IPCNs to ensure ward closures are managed appropriately and safely.

Individual Members of staff

All members of staff are required to follow advice and instructions of the IPCT with respect to actions related to outbreak management and ward closure.

Senior Managers

If senior management consider that the instructions from the IPCT must be over-ridden, then they must assume responsibility for subsequent consequences.

Clinical Site Management (CSM) Team

In the instance that a patient requires placement outside of their current situ, then CSMs are to be contacted and asked to source a suitable placement.

5. Policy Detail

5.1 Objectives

The objectives of this policy are to ensure prompt action:

- To recognise a major outbreak of communicable disease and ensure prompt action to investigate and control such an outbreak.
- To ensure that essential Trust activity continues
- To prevent its recurrence
- To maintain good communication with relevant agencies
- To maintain service continuity as far as is reasonably practicable.

5.2 Guiding Principles

For effective and efficient management of an outbreak, this plan is based on the following principles:

- Personal responsibility of named individual members of the OCT for managing defined aspects of the outbreak.
- Keeping the operation details of this plan up to date

5.3 Declaration of a Period of Increased Incidence (PII)

- Declaration of a PII may be made if the IPCT have concerns about an increased number of cases of infection within an area, where it is unclear if the cases are likely to be linked or if an outbreak exists.

- Control measures will be advised, and further investigation performed. The situation will then either be de-escalated, or an outbreak will be declared.

5.4 Outbreak Recognition

An outbreak of infection is suspected when there are two or more patients with the same organism or symptoms that share a common link e.g., timing of symptoms or location. It should also be considered where there is a single case of a significant organism or a particular organism over a period.

NB – Norovirus outbreak

In the absence of laboratory confirmation, the following criteria can be used as an indicator of a Norovirus outbreak:

1) average duration of illness of 12 to 60 hours
2) average incubation period of 24 to 48 hours
3) more than 50% of people with vomiting, **AND**
4) no bacterial agent found.

An outbreak of infection can affect both staff and patients. It is important that staff report suspicions of an outbreak to the IPCT promptly. It is important to seek advice at the earliest opportunity as any delay in identification may result in a serious incident.

5.5 Alerting

5.5.1 Internal Alerting

Contact the IPCT during working hours or out of hours, site matron to contact the On-Call Consultant Microbiologist via switchboard.

5.5.2 External Alerting

In the event of a notifiable communicable disease, the UKHSA must be notified of each individual case by the registered medical practitioner (RMP) for that patient (as per Notifiable Diseases Policy).

In the suspicion of a food-borne incident, the Environmental Health Officer (EHO) and local UKHSA Health Protection Team (HPT) should be notified.

5.6 Initial Investigation

A suspected outbreak is initially investigated by the IPCT. This includes determining the number of individuals affected, symptoms, likely source, and mode of spread.

Information gathered allows an assessment of the severity of the problem and initiation of immediate control measures.

5.7 Actions following Initial Investigation

Following initial investigation by the IPCT in conjunction with the ICD, one of the following conclusions will be made:

No outbreak – advice and reassurance will be provided to the clinical area.

Outbreak – the IPCT will continue to manage the progress of the outbreak. Outbreak management guidance will be provided to clinical staff.

An outbreak will be classed as levels 1, 2 or 3 (see below). Ward closure signage can be found on the intranet and is available via XEROX.

LEVEL 1 (Ward level)

An outbreak in a single ward / department.

LEVEL 2 (Hospital level)

An outbreak that extends across multiple areas of a site/hospital or affecting an entire site / hospital. This will impact operational capacity.

LEVEL 3 (Trust wide)

An outbreak affecting multiple sites across WAHTs, or which presents a significant risk to many patients, staff, or visitors, and/or requires significant control measures such as the closure of many wards / areas and/or threatens WAHTs ability to meet its emergency or elective commitments.

A Safety Learning Event must also be submitted by the Divisional Governance Team onto the risk management reporting system (DATIX).

In the event of an outbreak, the IPCT will discuss with the ICD and DIPC to decide if an Outbreak Control Team (OCT) needs to be convened.

5.8 Convening of the Outbreak Control Team (OCT)

The IPCT will arrange an emergency meeting as soon as possible after the recognition of an outbreak. Members of this group (Appendix A) will vary according to nature and circumstances of the outbreak. Roles and responsibilities of the OCT members are found in Appendix B. The OCT will adhere to the Terms of Reference (ToR) (Appendix C) and an agenda for meetings (Appendix D) will be formulated with subsequent outbreak minutes and action plans.

5.9 Objectives of the OCT

The purpose of the OCT is to assess the risk to patients and the public, ensure that the cause of the outbreak is investigated, and control measures are implemented as soon as possible.

The OCT will review the epidemiological, microbiological, and environmental evidence to verify an outbreak occurring and develop a strategy to deal with the

outbreak. An aide memoire of matters to be discussed at the OCT meetings is contained within Appendix E.

5.10 Management of the Outbreak

All outbreaks will be led by the IPCT and ICD with the support of the OCT if required. The IPCT will provide advice regarding the following:

- Laboratory investigations
- Epidemiological investigations
- Control measures

5.11 Communication

5.11.1 Internal Communication

Individual team members are responsible for disseminating information to their respective areas.

The Trust intranet and emails will be additional routes of communication with staff.

Heads of Department will be responsible for disseminating information to staff who are not on duty or working from home.

5.11.2 External Communication

The Trust Chief Executive (or Deputy) or Trust Communications Officer will be responsible for the release of information to relatives of patients affected.

The DIPC will be responsible for the provision of information to the Trust Chief Executive (or Deputy) who will authorise the Trust Communications Officer to report to the Press.

No information concerning the outbreak will be released to the Press or public from other Trust staff.

5.12 Service Continuity and Recovery

The Civil Contingencies Act (2004) requires Category 1 responders to “continue to exercise their functions in the event of an emergency so far as is reasonably practicable”; therefore, decisions to reduce activity should be made based on presenting conditions and not on a prescription written in a plan.

The Trust’s Business Continuity Management Plans will be activated during a major outbreak to ensure that essential services are maintained but in considering the organization’s ability to continue to work in the event of a major outbreak, the OCT will consider the following factors:

- Demand
- Capacity (staff & accommodation)
- Supplies
- Utilities

5.13 Defining the end of an Outbreak.

The OCT will determine and declare the end of an outbreak based on an ongoing risk assessment which takes account of the outbreak management actions. This is usually when there are no new cases and the incubation period for new cases of the causative organism has lapsed.

The OCT will then make recommendations based on the lessons identified to develop systems and procedures to prevent the future occurrence of similar incidents.

5.14 Interim and Final Reports

Final reports will be produced at the end of an outbreak by the Division involved, comprising of lessons that have been learnt and recommendations. Where several Divisions are involved, the investigation may be led by the IPCT. The report will be used to support the SI investigation in line with the Incident Reporting Policy and the Investigating Serious Incidents Policy.

6. Implementation

This policy is a long-standing policy and consequently already implemented. Any changes made to the policy will be disseminated according to the directions below.

7. Dissemination

Dissemination to:

- Divisions – through Divisional Governance Meetings where it will be recorded in minutes.
- Matrons – through Senior Nurse meetings
- Ward Sisters and Infection Prevention and Control Link Nurses – through relevant meetings
- All clinical staff – through Trust Brief
- All Medical Staff – through Clinical Directors

8. Training and Awareness

It is a mandatory requirement that all new Trust employees must attend a Trust corporate induction programme, which includes IPC training. It is the responsibility of the line manager to ensure that IPC issues are covered in all local inductions and that this is documented.

It is a mandatory requirement that all clinical and non-clinical staff update their infection control training annually, using and completing online or e-learning resources. It is the line manager's responsibility to ensure that this occurs.

Different modalities are available to facilitate compliance with mandatory training requirements. These include attendance at formal lectures, ad hoc teaching, and access to online training. Records of staff training are kept centrally on the ESR database and locally by Directorates as required.

9. Review

This policy will be reviewed by the Trust Infection Prevention and Control Committee (TIPCC) triennially or sooner if required and updated as necessary.

10. References

NHS England (2023) *National infection prevention and control manual (NIPCM) for England* [Online] Available at: https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/ [Accessed 03.07.2023]

National Institute for Health and Care Excellence (NICE) (2011) *Healthcare-associated infections: prevention and control*. [Online] Available at: https://www.nice.org.uk/guidance/ph36/chapter/introduction#what-is-a-healthcare-associated-infection [Accessed 03.07.2023]

Public Health England (PHE) (2012) *Guidelines for the management of norovirus outbreaks in acute and community health and social care settings* [Online] Available at: https://www.gov.uk/government/publications/norovirus-managing-outbreaks-in-acute-and-community-health-and-social-care-settingscute and community health and social care settings - GOV.UK (www.gov.uk) [Accessed 03.07.2023]

Public Health England (PHE) (2014) *Communicable Disease Outbreak Management.* [Online] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/343723/12_8_2014_CD_Outbreak_Guidance_REandCT_2__2_.pdf [Accessed 31.07.2023].

UK Health Security Agency (UKHSA) (Published 2014 Last Updated 2021) *Collection – Seasonal influenza: guidance, data and analysis.* [Online] Available at: https://www.gov.uk/government/collections/seasonal-influenza-guidance-data-and-analysis [Accessed 03.07.2023]

UK Cabinet Office (2004) Civil Contingencies Act 2004. [Online] Available at: https://www.legislation.gov.uk/ukpga/2004/36/contents [Accessed 29.09.23].

WAHT-CG-008 Incident Reporting Policy

WAHT-CG-009 Investigating Serious Incidents Policy

11. Background

11.1 Equality requirements

Please refer to supporting document number 1

11.2 Financial risk assessment

Please refer to supporting document number 2

11.3 Consultation process

Name	Designation
Dr E Yates	Consultant Microbiologist and Infection Control Doctor
Dr E Yiannakis	Consultant Microbiologist and Infection Control Doctor
Dr M Ashcroft	Consultant Microbiologist
Dr H Morton	Consultant Microbiologist
Ms H Lancaster	Chief Operating Officer
Dr C Blanchard	Chief Medical Officer
Dr J Berlet	Divisional Medical Director - SCSD
Dr J Trevelyan	Divisional Medical Director - Medicine
Dr D Raven	Divisional Medical Director – Urgent Care
Dr S Goodyear	Divisional Medical Director - Surgery

Dr B Kamalarajan	Divisional Medical Director – Women & Children's
Dr M Ling	Consultant for Infectious Diseases
Dr M Roberts	Consultant for Infectious Diseases
Dr C Chatt	Consultant in Communicable Disease Control
Ms K James	Lead Health Protection Practitioner (UKHSA)
Ms E King	Head of Facilities
Mr S Noon	Principle Engineer
Ms J Booth*	Deputy Director of Infection Prevention and Control
Ms E Fulloway	Infection Prevention and Control Nurse Manager
Ms K Howles	Senior Infection Prevention and Control Nurse
Ms A Roxburgh-Powell	Senior Infection Prevention and Control Nurse
Ms J Jacob	Infection Prevention and Control Nurse
Ms R Pitts	Infection Prevention and Control Nurse
Ms S Paul	Infection Prevention and Control Nurse
Ms N Thomas	Infection Prevention and Control Nurse
Ms M Hancock	Infection Prevention and Control Nurse
Ms M Bodily	Infection Prevention and Control Nurse
Ms H Weathall	Occupational Health Manager

This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Name	Committee
Ms S Shingler	Trust Infection Prevention and Control Committee (TIPCC)
	Circulated to all members of TIPCC

11.4 Approval process

This policy will be approved by TIPCC.

Appendices

Appendix A – Membership of the OCT

Appendix B – Responsibilities and Tasks of the OCT Members (Action Cards)

Appendix C – Terms of Reference of the OCT Meetings

Appendix D – Draft Agenda of OCT Meetings

Appendix E – Aide Memoire of Discussion Points for OCT Meetings

Supporting Documents

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire and Worcestershire Safe and effective health and care services

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Julie Booth**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Lara Bailey	**Senior Infection Prevention and Control Nurse**	**larabailey@nhs.net**
Date assessment completed	**02.10.2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Major Outbreak Policy

What is the aim, purpose and/or intended outcomes of this Activity?	To maintain patient and staff safety			
Who will be affected by the development & implementation of this activity?	❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	National Guidance			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	N/A			
Summary of relevant findings	N/A			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	L Bailey
Date signed	02.10.2023
Comments:	
Signature of person the Leader Person for this activity	
Date signed	30.10.2023 J Booth
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.