Llywodraeth Cymru
Welsh Government

The Communicable Disease Outbreak Plan for Wales

('The Wales Outbreak Plan')

September 2012

Preface

In recent years, there have been multiple plans in Wales for the investigation and control of communicable disease. All these have contained very similar guidance. Whilst it has been recognised that each individual plan was robust and fit for purpose, the presence of several plans for use in outbreaks has caused confusion as to which plan should be followed. Therefore, at the request of the Welsh Government, a multi-agency working group was convened in 2008 to draw the plans together into one generic template.

This model plan ("The Wales Outbreak Plan") is the result of that work. It should be used as the template for managing all communicable disease outbreaks with public health implications across Wales. It has been developed from the amalgamation of the following plans:

- **Plan for handling Major Outbreaks of Food Poisoning (2004)**
- **The Emergency Framework for health-related incidents and outbreaks in Wales and Herefordshire potentially caused by contaminated drinking water ("Water Framework"**) (January 2008) (which in turn replaced the older ***Cryptosporidium*** **plan**)
- **Model Plan for the Management of Communicable Disease Outbreaks in Wales (1995 and draft update 2007)**

The "Wales Outbreak Plan" consists of a generic template and appendices containing details pertinent to all outbreaks. After these, there are more appendices containing the technical operational detail needed for managing specific issues. In the case of cross-border outbreaks, all those led by Wales will be managed in accordance with this plan.

Hospitals have their own outbreak plans for internal outbreaks on their premises. However, if an outbreak has any potential public health implications, then this plan takes precedence in control of the outbreak. Appendix 6 describes these arrangements.

Within the former "Water Framework", there was a section on managing water incidents which was separate to managing water borne outbreaks, but used the same generic principles. This section has been retained in the Water Specific Appendices.

When to use this plan

The "Wales Outbreak Plan" describes arrangements in outbreaks where the Outbreak Control Team (OCT) is the decision-making body in controlling the outbreak.

Where an outbreak crosses the border and affects people living in one or more of the other UK countries, the Outbreak Control Team arrangements may differ, for example, the Team may be chaired by a representative of an agency outside Wales, but the principles of this plan should still apply and the Welsh response should be guided by the requirement to protect the public's health.

There will be rare occasions where an outbreak or incident may develop into an overwhelming communicable disease emergency or there is suspicion of a bioterrorism event. In such a scenario, the Wales Resilience Emergency Planning structures may need to be invoked and the Outbreak Control Team would need to consider escalation to involve the Local Resilience Forum (LRF) Chair.

The Chair of the Local Resilience Forum (usually a senior police official) would advise on the need to invoke these structures and would convene a Strategic Coordination Group to oversee the response if necessary. A separate document, the **Wales Framework for Managing Major Infectious Disease Emergencies,** describes the overarching arrangements that will apply. In these exceptional circumstances there are also specific UK plans for bioterrorism or other particular infectious disease threats which take precedence over this plan.

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Abbreviations

CCDC	Consultant in Communicable Disease Control
CDSC	Communicable Disease Surveillance Centre
CMO	Chief Medical Officer of Wales
CSSIW	Care and Social Service Inspectorate Wales
DCWW	Dŵr Cymru Welsh Water
DEFRA	Department for Environment, Food and Rural Affairs
DML	Director of Public Health Wales Microbiology Laboratory
DPP	Director of Public Protection (Director of Environmental Health or nominated Deputy)
DWI	Drinking Water Inspectorate
EA	Environment Agency
EDPH	Executive Director of Public Health (of the Health Board)
EHO	Environmental Health Officer
FSA	Food Standards Agency
HB	Health Board
HPA	Health Protection Agency
IMT	Incident Management Team
LA	Local Authority (including Port Health Authority)
NHS	National Health Service
OCT	Outbreak Control Team
PCT	Primary Care Trust
PO	Proper Officer
STAC	Scientific and Technical Advice Cell

1. INTRODUCTION

1.1. This document sets out arrangements for managing all outbreaks of communicable disease in Wales. This is the model for all outbreaks led by or within Wales.

1.2. The plan is comprised of two parts. Part 1 is the generic plan for how all outbreaks led by Wales will be handled. Part 2 is the incident/disease specific appendices providing additional technical detail for certain specified circumstances.

1.3. Responsibility for managing outbreaks is shared by **all** the organisations who are members of the Outbreak Control Team (OCT). Core OCT Members are responsible for ensuring that all relevant organisations are co-opted on to the OCT (see Appendix 1: Outbreak Control Team). This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak to a successful conclusion. Others can make a request to join the OCT if there is a case to do so but the final decision on membership resides with the core OCT.

1.4. An outbreak is usually declared jointly by the DPP, the Consultant in Communicable Disease Control (CCDC) and the Director of Microbiology/Consultant Microbiologist after these individuals have jointly considered the facts available. However, any one of these can declare an outbreak if required.

1.5. The core members of all OCTs are the Directors of Public Protection (DPP), the CCDC, the Director of Microbiology/Consultant Microbiologist, Lead Officer for Communicable Disease of the LA and the Executive Director of Public Health (EDPH) for the Health Board (HB).

1.6. This plan is intended to be a framework for these organisations to discharge their duties in relation to the management and control of communicable disease outbreaks. To facilitate this, the appendices contain procedures, guidance and other information that these organisations may refer to as appropriate.

1.7 Where an outbreak affects people in other UK countries, it is expected that all relevant outbreak control partners in each area will work together to perform the duties jointly of the OCT. This will include the appointment of the Chair of the OCT, appropriate spokespeople, and agreeing any joint communications to be issued.

2. MANAGEMENT AND ORGANISATION ARRANGEMENTS FOR HANDLING OUTBREAKS

2.1. The primary objective in the management of an outbreak is to protect public health by identifying the source of the outbreak and implementing

necessary measures to prevent further spread or recurrence of the infection. The protection of public health takes priority over all other considerations and this must be understood by all members of the OCT.

2.2. The secondary objective is to improve surveillance, refine outbreak management, add to the evidence collection and learn lessons to improve communicable disease control for the future.

2.3. The successful management of outbreaks is dependent upon good and timely communication between the LA, the HBs and Public Health Wales and all interested parties.

2.4. On occasions when there are cross boundary interests, e.g. place of residence in one LA and place of employment/schools/other associations in a different LA, the investigation processes would usually be undertaken by the LA where the individual is resident. If exclusion is necessary this would usually be undertaken by the LA where the risk is located i.e. place of employment, school, etc following discussions with the resident LA. This will apply to cases, contacts and controls. Active communications between all the LAs involved are essential and all LAs will collaborate fully in the investigation process.

3. DETERMINATION OF AN OUTBREAK

Detection and Assessment

3.1 Where it appears to any one of the DPP, CCDC or the Director of Microbiology Laboratory (DML)/Consultant Microbiologist that an outbreak may exist, immediate contact will be made with the other two parties. The three parties will jointly consider the facts available and will determine whether or not an outbreak does exist. Any one of the parties can declare an outbreak, if required. The CCDC will inform the Director of Public Health (DPH) (or another senior representative of the relevant HB) of the situation.

3.2 In reality, there are many minor outbreaks and clusters of disease that occur in Wales every year that are managed satisfactorily without the formal declaration of an outbreak and the convening of an OCT. When a decision has been made not to formally declare an outbreak, it is the duty of the three parties above to keep the situation under review to determine if the formal declaration of an outbreak and an OCT is needed subsequently.

Declaration

3.3 The decision to declare an outbreak and to subsequently convene an OCT as necessary may be made jointly by the three parties or by any one of the above parties. Even if the other parties do not agree there is an outbreak, there is a duty on them to attend the OCT meeting and formally explain their opinion and to discuss this further.

3.4 The establishment of an OCT as soon as possible will normally be considered if an outbreak is characterised by one or more of the following:

a) immediate and/or continuing communicable disease health hazard significant to the population at risk;
b) one or more cases of serious communicable disease;
c) large numbers of cases or numbers greater than expected;
d) involvement of more than one LA .

3.5 Core membership of the OCT will be in accordance with Appendix 1 (OCT)

3.6 If a microbiologist in any hospital local to the outbreak is not involved in the discussions, then the Lead Infection Control Specialist for the local hospital(s) to the outbreak (for example Infection Control Doctor, Consultant Microbiologist or lead Infection Control Nurse) should be informed promptly of the situation by the CCDC.

Outbreak Control Team

3.7 The Chair of the OCT will be appointed at the first meeting. The Chair will normally be the DPP or the CCDC as appropriate, but there may be occasions when it is more appropriate that another core member of the OCT is appointed as Chair.

3.8 It shall be the duty of the Chair to ensure that the OCT is managed properly and in a professional manner.

3.9 Responsibility for handling the outbreak **must** be given to the OCT by the parent organisations, and representatives **must** be of sufficient seniority to make and implement decisions and to ensure that adequate resources are available to undertake outbreak management.

Communication

3.10 It is essential that effective communication be established between all members of the team and maintained throughout the outbreak in accordance with Appendix 3 (Tasks of the Outbreak Control Team) and 4 (Media Relations). The Chair will ensure that minutes will be taken at all meetings of the OCT and circulated to participating agencies. The minute taker is accountable to the Chair for this function.

3.11 It is recommended that whenever possible, the OCT should meet in person rather than communicate through teleconferencing. It is recognised that this may not always be practical for every meeting or in some areas, but face to face meetings should be utilised when possible, particularly when difficult decisions are being considered.

3.12 Use of communication through the media may be a valuable part of the control strategy of the outbreak. The OCT should consider the risks and benefits of pro-active versus reactive media engagement in any outbreak.

3.13 A member of the OCT should be asked to liaise with the manager of any premise/organisation involved in the outbreak to explain how an OCT works and the potential consequences of declaring an outbreak.

Conclusion

3.14 The OCT should consider how best to communicate with cases about:

- the declaration of the end of the outbreak and
- the release of the OCT report

Appendix 10 contains advice on such communication

3.15 At the conclusion of the outbreak the OCT will prepare a written report. The minutes and report should be anonymised as far as possible.

Evaluation

3.16 After the conclusion of the outbreak, the OCT should undertake an evaluation of the outbreak. The evaluation should be based on the template in Appendix 11 and be included in the OCT report. The timing of the evaluation can be flexible; OCTs may find it helpful to have time to reflect on the outbreak prior to carrying out the evaluation.

4. OUTBREAK REPORT

4.1 Where an OCT is convened a record of proceedings will be made and circulated to a distribution list agreed by OCT members. In the event of a significant outbreak a report will in addition be circulated to Communicable Disease Surveillance Centre (CDSC) in Wales, to the Welsh Assembly Government, the Health Board, the Food Standards Agency (FSA) (where food is the implicated vehicle), Drinking Water Inspectorate (DWI) (where drinking water is the implicated vehicle), all local authorities involved and any other parties as deemed appropriate by the OCT.

4.2 This report will contain details of the investigation, compilation of the results and conclusions. Minutes of all outbreak control team meetings will usually be appended. However it is recognised that in some outbreaks the minutes contain material such as extensive individual identifiable /commercially sensitive information which it may not be appropriate to distribute widely in the public domain. In these cases minutes should not be appended to OCT reports but should still be available (suitably redacted) on request.

4.3 The suggested format is contained in Appendix 9 (Format for Outbreak Reports).

4.4 Where an OCT is not convened the CDSC green form will be sent to CDSC (Wales) and the Welsh Government by the CCDC. In addition, local authorities will complete the Outbreak Report Form and send it to CDSC (Wales).

4.5 The OCT report is owned jointly by all the organisations represented on the OCT. The OCT should agree when and how the report is to be first released, paying due consideration to impending legal proceedings and freedom of information issues.

5. REVIEW

5.1. This Plan will be reviewed formally every 3 years or sooner if it has been identified that changes are required.

5.2. The review will include a consultation between the relevant parties and any other organisations or individuals as appropriate regarding organisational arrangements for the management of an outbreak.

5.3. Simulation exercises to test the efficiency and effectiveness of the plan will be held at least every two years in the event of the plan not having been activated during that time.

5.4. Records of the Plan review and any amendments shall be kept and summarised in the Outbreak Plan.

Appendix 1: Outbreak Control Team

1. MEMBERSHIP OF THE OUTBREAK CONTROL TEAM

Core Members (All Outbreaks)

- Director of Public Protection (or their nominated officer of sufficient seniority)
- Consultant in Communicable Disease Control
- Director Microbiology Laboratory/Consultant Microbiologist
- Lead Officer for Communicable Disease of the LA
- Executive Director of Public Health of the Health Board

Additional Core Members (Some Outbreaks)

- LA Secretariat
- Resource Team provided by:

    a) Local Authority;
    b) Public Health Wales;
    c) Microbiology Laboratory; and
    d) Health Board.

- Regional Epidemiologist/CDSC
- Public Relations Officer

Co-opted Members as necessary

e.g.:

- Animal Health
- Meat Hygiene Service
- Public Analyst
- Food Examiner
- Water Company plc
- Environment Agency
- Health and Safety Executive
- Representatives from other Outbreak Control Teams/LAs
- Food Standards Agency Wales
- Care and Social Services Inspectorate Wales (CSSIW)
- Port Health
- Infection Control Team
- Immunisation Co-ordinator
- Drinking Water Inspectorate
- Healthcare Inspectorate Wales
- Veterinary Laboratory Agency
- Others as appropriate

2. DUTIES OF THE OUTBREAK CONTROL TEAM

These may include:

1. Appointing a Chair (bearing in the mind the advantages of continuity).
2. Taking minutes to record decisions and actions.
3. Reviewing evidence and confirming that there is an outbreak or a significant incident which requires Public Health intervention.
4. Defining cases and identification of cases or carriers as appropriate.
5. Identifying the population at risk.
6. Identifying the nature, vehicle and source of infection by using microbiological, epidemiological and environmental health expertise.
7. Stopping the outbreak if it is continuing.
8. Developing a strategy to deal with the outbreak and allocating individual and organisational responsibilities for implementing action.
9. Investigating the outbreak, implementing control measures and monitoring their effectiveness, using laboratory, epidemiological and environmental health expertise.
10. Ensuring adequate human and other resources are available for the management of the outbreak.
11. Ensuring that in the absence of a team member a competent deputy is made available.
12. Ensuring appropriate arrangements are in place for out of hours contact with all members.
13. Preventing further cases elsewhere by communicating findings to national agencies.
14. Keeping relevant local agencies, the general public and the media appropriately informed.
15. Providing support, advice, and guidance to all individuals and organisations directly involved.
16. Considering the potential staff training opportunities of the outbreak (attendance at the OCT is at the discretion of the Chair).
17. Identifying and utilising any opportunities for the acquisition of new knowledge about communicable disease control.
18. Declaring the conclusion of the outbreak and preparing a final report.
19. Evaluating lessons learnt.

3. ROLES AND RESPONSIBILITIES OF OCT MEMBERS

3.1 At the first meeting of the OCT, **all** members (whether core or co-opted) will agree to work to this plan. No organisation will attend in an observer capacity. **The primary duty of each member of the OCT is to play their part in the control of the outbreak and protect public health.** All other duties will be secondary.

3.2 The OCT will work without undue interference. Each member will recognise the roles and duties of other members, particularly where an outbreak crosses LA boundaries or involves a hospital(s).

3.3 Members of the OCT must declare any interest in any organisation or premises which is the subject of the Outbreak investigation. This is

likely to occur if the premises are owned by the HB, Public Health Wales or LA. Anyone who declares such an interest should not chair the OCT. Where an interest is declared the Chair of the OCT shall ensure that any member of the OCT attends as a member of the OCT and not as duty holder of the premises. A person having an interest in the premises and being part of an OCT shall have no vote in determining a policy or action by the OCT. Alternatively, the Chair of the OCT may require the nomination of an additional person from that organisation to the OCT.

3.4 Any OCT member, whether core or co-opted, **must** disclose any relevant information about any organisation or premises they regulate which is the subject of the outbreak investigation.

3.5 In the early stages of an investigation, it is not always apparent whether any serious criminal offence has been committed. However the OCT is reminded that the police may conduct an investigation where there is an indication of the commission of a serious offence. The police investigation may overlap with the work of the OCT and may need to be considered in the wider context of managing the outbreak. Any information collected in the outbreak therefore may be used as evidence in a criminal prosecution.

Director of Public Protection

1. Together with the CCDC and Local DML/Consultant Microbiologist to jointly consider the facts, declare an outbreak and convene the OCT.

2. To provide facilities and resources for the OCT including administrative support for team meetings, if appropriate.

3. Where necessary, to organise an outbreak control centre or helpline.

4. Where appropriate, to make available staff to assist in the investigation of the outbreak as required by the OCT.

5. To provide specialist information or action on environmental health aspects of any disease control.

6. To initiate case finding as appropriate.

7. To arrange for the prompt inspection of premises considered to be implicated in any outbreak and to receive reports thereon.

8. To consider the use of statutory powers as appropriate.

9. To make available to other LAs any extra resources or assistance they may require.

10. To inform the Chair/Leader of the Council and Chief Executive of the Authority of the outbreak and action taken in response

11. At an early stage in the investigation to inform the FSA of any outbreak where food is implicated providing suitable and sufficient initial information

12. To liaise with FSA where regional or national withdrawal of food may be required.

13. To liaise with other DsPP and the Welsh Assembly Government if the outbreak is wider than of local significance.

14. Where appropriate, to carry out environmental investigations and where necessary to exercise powers of entry, closure or prosecution.

15. To liaise with other bodies including government departments such as the Welsh Government, DEFRA, FSA and government agencies such as the Environment Agency, Drinking Water Inspectorate, Health & Safety Executive, Veterinary Laboratory Agency and other bodies, such as Dwr Cymru, as appropriate.

16. Where appropriate, to arrange for the transport of clinical and/or environmental specimens to recognised laboratories for examination.

17. Where appropriate, to investigate the availability of cleansing and/or other treatment of premises, articles, equipment, land and animals, seeking specialist advice as appropriate.

18. To provide local information including that on vulnerable groups, businesses and institutions where appropriate.

19. To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

Consultant in Communicable Disease Control

1. Together with the DPP and Local DML/Consultant Microbiologist jointly consider the facts, to declare an outbreak and convene the OCT.

2. To provide facilities and resources for the OCT including administrative support for team meetings, if appropriate.

3. Where necessary, to organise an outbreak control centre or helpline.

4. Where appropriate, to make available staff to assist in the investigation of the outbreak as required by the OCT.

5. To provide expert medical and epidemiological advice to the OCT on the management of the outbreak including the interpretation of the clinical data, methodology of investigation and control measures to minimise spread and prevent recurrence.

6. To initiate case finding as appropriate.

7. To inform the Chief Medical Officer at Welsh Government, the HB's EDPH and Public Health Wales Director of Health Protection of the outbreak.

8. To consult and liaise with CDSC (Wales) and with other CCDC's.

9. To assess and collate epidemiological information and to carry out epidemiological studies.

10. Where appropriate, to arrange for medical examination of cases and contacts and the taking of clinical specimens.

11. Where appropriate, to arrange immunisation and/or prophylaxis for cases, contacts and others at risk.

12. To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

Director of Public Health Wales Microbiology Laboratory / Consultant Microbiologist

1. Together with the CCDC and the DPP jointly consider the facts, to declare an outbreak and convene the OCT.

2. To provide expert microbiological advice to the OCT on patient management, interpretation of clinical data, methodology of investigation, collection of specimens and control measures required to minimise spread and prevent recurrence.

3. To provide an outbreak number for outbreaks on request from the DPP or the CCDC.

4. To arrange prompt examination/analysis and reporting of clinical and/or environmental samples, as required.

5. To advise on the inspection of premises and other implicated settings as appropriate and collection of appropriate samples, as required.

6. Where necessary, to provide certificates of examination/analysis in respect of samples submitted for examination.

7. Where appropriate, to arrange for any further testing or typing of organisms identified or isolated.

8. To liaise with other public health, hospital and reference laboratories.

9. The local Microbiology Laboratory will normally:

i) provide suitable specimen containers and request forms;
ii) provide laboratory testing facilities;

iii) arrange for any special investigations required to be carried out by reference laboratories;
iv) be responsible for arranging transport of specimens/isolates to reference laboratories; and
v) provide both rapid and written confirmation of results.

10. To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

Communicable Disease Surveillance Centre (Wales)

1. To provide expert epidemiological advice and assistance to the OCT for the investigation and management of the outbreak.

2. To liaise with the HPA Centre for Infections and where appropriate other national and international public health agencies.

3. Where trainees are seconded to Public Health Wales, CDSC will agree with the CCDC the nature and extent of their role in an outbreak.

4. Where appropriate, to assist in the dissemination (or collection) of information about the outbreak to colleagues in Wales and elsewhere.

5. To consider and utilise any opportunities for training of public health and environmental health staff in outbreak management.

6. If CDSC staff are involved in field investigations the OCT may expect:

   i) expert advice from a consultant;
   ii) a field visit by a public health trainee either on short or long-term attachment accompanied, if appropriate, by a consultant;
   iii) support with study design and assistance with questionnaire development, interviews, data processing and analysis;
   iv) attendance at initial OCT and subsequent meetings as necessary;
   v) a preliminary and final report of CDSC's involvement including recommendations for action;
   vi) copies of outbreak master file data or other material collected by CDSC, if requested;
   vii) assistance in preparing a scientific report for publication, if appropriate; and
   viii) advice on improving local surveillance.

7. To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

Health Board Executive Director of Public Health

1. To ensure that a senior representative of the HB is always available to respond in the event of an outbreak.

2. To attend (or nominate a sufficiently senior member of staff to attend) OCT meetings.

3. To enable the OCT (usually via the CCDC) to call on and deploy resources controlled/contracted by the HB at short notice to investigate and control communicable disease outbreaks, including skilled staff and resources (e.g. for urgent immunisation sessions / clinical examinations / chemoprophylaxis) as necessary.

4. To provide/facilitate access to patients suffering from infection, their health records, clinical colleagues and information held on databases if necessary for outbreak investigation and control.

5. To disseminate information to the public or health professionals locally as directed by the OCT.

6. To liaise with other HB EDPHs if required.

7. To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

Appendix 2 : Roles of LAs, HBs, Public Health Wales and Other Agencies

1. Local Authorities

1.1 LAs have statutory responsibility for notifiable infectious disease in their locality (which includes the control of food poisoning) under the Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008, and the Health Protection (Notification) (Wales) Regulations 2010.

1.2 LAs have duties as an enforcing authority under the Health and Safety at Work etc. Act 1974. They also have an important role in the control of some zoonoses as the licensing authority for animal establishments. LAs also have duties under the Water Industry Act 1991, sections 77-79, relating to the wholesomeness of public water supplies. They also have responsibility for private water supplies under the Private Water Supplies (Wales) Regulations 2010.

1.3 The Local Government Act 1972 enables the LA to appoint individuals as Proper Officer's (PO) to carry out certain functions of the LA. It also enables the LA to delegate powers to individual officers in order to ensure the effective and efficient operation of its functions.

1.4 The LA normally appoints the DPP as a PO with delegated authority to sign notices, issue licences and to lay information and make complaints to the Justices for the prosecution of offenders without reference to the LA, in respect of relevant environmental health legislation.

1.5 The LA normally appoints and authorises the Public Health Wales' CCDC as PO under the terms of the Public Health (Control of Disease) Act 1984. LAs may appoint a sufficient number of Alternate POs who will act in the absence of the PO. All PO appointments will be made in writing and confirm specifically the enactments in which they will act.

1.6 The PO normally reports to the LA through the DPP.

1.7 The CCDC when acting as PO does so as an officer of the LA.

1.8 Other suitably qualified public health professionals in Public Health Wales may be appointed and authorised as alternates to act in the absence of the PO.

2. Health Boards

2.1 The HB has a number of responsibilities in relation to the public health function, and has overall responsibility for the health of the population within its geographical boundaries. These responsibilities include: the direct provision of healthcare through hospitals and community services; the commissioning of other services relating to health including disease

prevention; involvement in promoting health and a role in relation to primary care provision.

2.2 The HB has the services of an appropriately qualified CCDC with executive responsibility for the surveillance, prevention and control of communicable disease within the HB's boundary. CCDCs are appointed as PO of the LAs within the HB area for communicable disease control purposes. Alternate PO CCDCs are available if the CCDC who normally covers the relevant HB is unavailable. (Note: 'Control' includes surveillance and prevention as well as control).

2.3 The HB will collaborate with all relevant agencies (including LAs, Public Health Wales and others) to ensure that appropriate arrangements are in place for the prevention, surveillance and control of communicable disease for their population and ensure that the responsibilities for these are clearly defined.

2.4 In the event of an outbreak, the HB will provide all necessary support to the OCT. This includes ensuring that the CCDC has access to patients suffering from infection and to advice from clinical colleagues as required.

2.5 The HB may commission health care services through formal contracts with other health care providers. Contracts should ensure that satisfactory infection control arrangements are in place, including a requirement that the CCDC be informed of any notifiable disease, or infection problems, with implications for the public health.

2.6 Outbreaks may occur in hospitals managed by the HB. Most hospital outbreaks have minimal or no wider public health implications and will be dealt with using that hospital's own internal outbreak plan. However, if an infectious disease outbreak within a hospital has any potentially serious public health implications, responsibility for outbreak control passes to an OCT convened in accordance with this plan (as specified in Appendix 6 :Hospital Outbreaks with Potential public health Implications).

3. Public Health Wales

3.1 The following elements within the Health Protection Division of Public Health Wales currently have a role in the prevention, surveillance and control of communicable disease:

a) the CCDC and health protection team;
b) the Microbiology Laboratories;
c) the Communicable Disease Surveillance Centre,

3.2 <u>The CCDC and the health protection team</u>
This group supports the HB in the discharge of its duties. It is one of the initial points of contact for any possible outbreak, conducts the initial investigation as appropriate and participates in the OCT. It will liaise and communicate with the HB, WAG and others where appropriate.

3.3 <u>The Microbiology Laboratories</u>
Public Health Wales Microbiology Laboratories are responsible for

maintaining a national capability for the detection, diagnosis, treatment, prevention and control of infections and communicable disease.

3.4 The Public Health Wales network of laboratories provides comprehensive laboratory facilities for the identification of infection and infectious agents in humans and the environment.

3.5 The Communicable Disease Surveillance Centre (Wales)

CDSC provides epidemiological expertise for population surveillance, investigation of outbreaks and development of strategies for prevention and control. It also offers training for public health doctors and Environmental Health Officers (EHOs) in outbreak management.

3.6 CDSC (Wales) conducts surveillance in Wales, and provides expert epidemiological advice and assistance in the control of outbreaks upon request.

3.7 CDSC should be involved in the following types of incident:

a) outbreaks of unknown cause involving severe morbidity or mortality;
b) outbreaks due to relatively rare pathogens;
c) outbreaks suspected to involve other districts or be the herald of a large scale incident;
d) outbreaks which are attracting public or national media concern;
e) outbreaks of particular interest to national surveillance.

3.8 CDSC may also ask to assist with incidents that provide opportunities for training or advancing public health knowledge.

3.9 In national or international outbreaks, CDSC may be best placed to co-ordinate the outbreak investigation with the co-operation of CCDC and DPP.

4. Food Standards Agency

4.1 The Food Standards Agency (FSA) is an independent Government department set up by an Act of Parliament in 2000 to protect the public's health and consumer interests in relation to food. The FSA in conjunction with local authorities has developed a Framework Agreement on LA Food Law Enforcement. The Framework Agreement requires local authorities to set up, maintain and implement a documented procedure which has been developed in association with all relevant organisations in relation to the control of outbreaks of food related infectious disease in accordance with relevant central guidance.

4.2 The FSA will, when notified by a LA of an outbreak of food related infectious disease which has wider implications, offer support to LAs during their investigations. The response of the Agency will be dependent upon the particular circumstances and may include provision of scientific advice and communication links with local authorities in other parts of the United Kingdom. The Agency will, where necessary, facilitate the issue of a food alert or a RASFF (Rapid Alert System for Food and Feed).

4.3 The FSA has responsibility for enforcing hygiene legislation in some meat plants (including slaughterhouses and cutting plants) and will, where such premises are implicated in an outbreak, arrange prompt inspection of premises and offer full co-operation with the investigation.

5. Care & Social Service Inspectorate Wales (CSSIW)

5.1 CSSIW has responsibility for registering and inspecting nursing and residential care homes under the Registered Homes Act 1984 and regulations made there under. The inspection teams of CSSIW ensure that standards of care as laid down in regulations are in place in each premises. CSSIW will also ensure that adequate infection control arrangements are in place.

6. Health Protection Agency (HPA)

6.1 The HPA is made up of a number of centres, namely the Centre for Radiation, Chemical and Environmental Hazards, Local and Regional Services, the Centre for Infections and the Centre for Emergency Preparedness and Response. However, the remit of the HPA in Wales is limited to those services which are not provided by Public Health Wales.

6.2 With regard to the management of communicable disease outbreaks, this includes specialist and reference microbiology tests and services provided in HPA laboratories, and expert advice from the Centre for Infections. Access to the HPA and its services for these functions is usually made though Public Health Wales Microbiology Laboratories.

6.3 In addition, the HPA provides expert advisory services to Wales for chemical and radiological issues via the Centre for Radiation, Chemical and Environmental Hazards, which is made up of a number of specialist centres. Services provided include expert advice on human health effects from chemicals in water, soil, air and waste as well as information and support to the NHS and health professionals on toxicology. There is a specialist centre for Chemical Hazards and Poisons in Cardiff.

7. Water Companies

7.1 The number of private water supplies in Wales means that careful consideration is needed to ensure all relevant water sources are identified. Water companies have statutory duties under the Water Industry Act 1991 to supply safe and wholesome water, as defined in the Water Quality Regulations, within their respective regions. When a breach of a water quality standard has occurred that might have a potential impact on public health, water companies are required to inform the relevant Local Authorities and CCDCs and to agree, and undertake, the appropriate investigations and mitigation measures to control or prevent potential risk e.g. Boil Water Notices. In the event of a continuing risk to the safety of public water supplies and an escalation to ‘Incident’ or ‘Outbreak’ status, the water companies shall appoint one or more senior responsible officers to the Incident Management Team (IMT) or OCT to fulfil specific operational and customer related requirements.

7.2 The water company representative(s) will have sufficient authority and knowledge to:

a) Understand the cause, effects and extent of the issue and inform the IMT/OCT fully of any events before the incident or outbreak was declared
b) Make the appropriate operational decisions on behalf of the IMT or OCT and ensure that they are immediately and fully implemented by the water company
c) Provide the IMT or OCT with a water company perspective on the management of the incident
d) Be adequately briefed and ensure that the IMT or OCT are made aware of, and have access to, all relevant water quality and operational data
e) Facilitate the diversion and commitment of water company resources i.e. equipment and manpower to manage the incident
f) Inform customer communications and other stakeholder briefings and, if necessary, enlist the support of the media communications personnel within the Company. This will include agreeing 'lines to take' for customer call centres and sharing this with the IMT/OCT.
g) Share any necessary information from their customer database.
h) Ensure that all alliance partners and other experts, contractors, etc. assist the IMT/OCT and ensure that any relevant information is shared with all members.

8. Drinking Water Inspectorate (DWI)

8.1 DWI acts for and on behalf of the Secretary of State and Welsh Ministers to ensure that water companies in England and Wales meet their statutory obligations relating to drinking water quality. In this capacity DWI has a technical audit role for public water supplies, including inspection, investigation and powers of enforcement, plus a technical advice role to Ministers and other Government bodies. In addition the Chief Inspector of Drinking Water has independent powers of prosecution relating to the duties of water companies under the Water Industry Act 1991.

Appendix 3 : Tasks of the Outbreak Control Team

The following tasks should be considered in order to deal effectively with an outbreak. The step-by-step approach does not imply that each action must follow the one preceding it. In practice, some steps must be carried out simultaneously and not all steps will be required on every occasion.

3.1. Preliminary Phase

1. Consider whether or not cases have the same illness and establish a tentative diagnosis.

2. Establish case definition (clinical and/or microbiological).

3. Determine if there is a real outbreak.

4. Case finding and establishing single comprehensive case list.

5. Collect relevant clinical and/or environmental specimens for laboratory analysis.

6. Conduct unstructured, in-depth interviews of index cases.

7. Conduct appropriate environmental investigation including inspection of involved or implicated premises and other relevant environments including land, water, air, plant or equipment.

8. Identify population at risk and a representative(s) of that population.

9. Identify anything, including people, water, location, premises, equipment and food, posing a risk of further spread and Initiate immediate control measures.

10. Form preliminary hypotheses on the cause of the outbreak.

11. Make decision about whether to undertake detailed analytical studies.

12. Assess the availability of adequate resources to deal with the outbreak.

3.2. Descriptive Phase

1. Identify and investigate the food distribution chain/water supply network or other potential routes of transmission.

2. Identify as many cases as possible.

3. Describe cases by 'time, place and person'.

4. Construct epidemic curve.

5. Collect clinical and/or epidemiological and/or environmental data from affected and unaffected persons using a standardised questionnaire.

3.3. Collation

1. Calculate attack rates.

2. Confirm factors common to all or most cases.

3. Categorise cases by 'time, place or person' associations.

4. Test and review hypotheses.

5. Collect further clinical, environmental or any other relevant specimens for laboratory analysis.

6. Ascertain source and mode of spread.

7. Carry out analytical epidemiological study.

3.4. Control Measures

1. Control the source: animal, human or environmental.

2. Control the mode of spread by:

   a) Isolation, exclusion, screening and/or monitoring of cases and contacts
   b) Protection of contacts by immunisation or prophylaxis
   c) Giving infection control and other advice to cases and contacts
   d) Examination, sampling and detention and where necessary seizure, removal and disposal of foodstuffs
   e) Giving advice in respect of closure and/or disinfection of premises
   f) Giving advice on prohibition of defective processes, procedures or practices
   g) Or any other measure that needs to be taken

3. Monitor control measures by continued surveillance for disease.

4. Declare the outbreak over.

3.5. Communication

1. Consider the best means of communication with internal & external colleagues, stakeholders, patients/cases and carers, and the public, including the need for an incident room and/or helplines

2. Ensure appropriate information and advice is given to the public, especially

those at high risk

3. Ensure accuracy and timeliness

4. Include all those who need to know

5. Use the media constructively

6. Liaise with all relevant agencies including:

   a) Other LA's/Port Health
   b) Other Health Boards
   c) CDSC (Wales)
   d) HPA
   e) General Practitioners
   f) Education and Social Services Departments
   g) Public Analyst
   h) Government Agencies e.g. DEFRA, Environment Agency
   i) Welsh Government
   j) Divisional Veterinary Officer
   k) Water Company plc
   l) Health and Safety Executive
   m) FSA
   n) CCSIW
   o) DWI
   p) Community Health Councils
   q) Consumer Council for Water

7. Prepare a written report.

8. Disseminate information on any lessons learnt from managing the outbreak

Appendix 4: Media Relations

1. The OCT will endeavour to keep the public and media as fully informed as necessary without prejudicing the investigation and without compromising any statutory responsibilities or legal requirements and without releasing the identity of any patient/case.

2. At the first meeting of the OCT arrangements for dealing with the media should be discussed and agreed. This should include a nominated spokesperson(s) and a process for arranging press conferences and releasing press statements.

3. Early and proactive engagement with the media and public should be the usual practice in most outbreaks. Even when the source is not identified, and/or there are no public health messages yet identified, an early and proactive public statement is strongly recommended. (For example: that a potential outbreak exists, an OCT has been established and agencies are working together).

4. There are a few outbreaks in which **all** the following conditions apply:
   - The at risk group has been identified in full
   - The at risk group has been communicated with directly
   - There are no wider public health implications **and**
   - Proactive media engagement is likely to have significant disadvantages.

   In these rare cases, **if** the OCT makes the decision not to undertake proactive engagement with the media, the OCT should formally discuss and document the rationale for this decision in the OCT minutes.

5. Press statements should be prepared and agreed by the OCT or a small subgroup previously agreed by the OCT.

6. Press statements on behalf of the OCT will normally only be released by the Public Relations Officer nominated by the OCT. If the OCT considers this inappropriate, or the nominated Public Relations Officer is not available, the Team will nominate an alternative spokesperson.

7. **No other member of the OCT or the participating agencies will release information to the press or arrange press conferences without the agreement of the Team.**

8. With the agreement of the OCT, press spokespersons will be appointed for specific purposes.

8. Notwithstanding the above, in the case of food poisoning outbreaks, all media statements should be prepared having regard to the provisions contained in the current Food Law Code of Practice.

9. Copies of press statements will be sent to the Welsh Government and other organisations as appropriate.

10. Consideration should be given as to whether it would be appropriate to purchase local media space to provide clear public health messages in the event of a large outbreak with significant implications to the public generally

Appendix 5: Cross Boundary Outbreaks

1. The CCDC must inform the office of the Chief Medical Officer (CMO) of the Welsh Government of any cross boundary outbreak and should invite the CDSC to assist in its investigation and management.

2. Regardless of where the cases lie, the OCT will take responsibility for the investigation, management and control of the outbreak. All involved LAs will participate fully in the OCT process.

3. The initial meeting of the OCT will normally be chaired by the CCDC or DPP for the most appropriate LA on the information available at the time. The Chair for the remainder of the outbreak will usually stay with this individual unless agreed otherwise.

4. There will be a duty on the chair of the OCT to invite officers from local authorities and relevant agencies to be part of the OCT where appropriate.

5. Other involved authorities will be invited to participate at an appropriate level and to provide resources at a proportionate level.

6. The organisation of cross boundary arrangements between LAs will be in accordance with 2.4 (page 9) in the main plan.

Appendix 6: Hospital Outbreaks with Potential Public Health Implications

1. In HBs, ultimate responsibility for infection prevention and control lies with the Chief Executive and is normally delegated to an Executive Director. The operational responsibility for infection prevention and control is then delegated to the Lead Infection Control Specialist (for example Infection Control Doctor, Consultant Microbiologist or lead Infection Control Nurse). The delivery of infection control support is through the Infection Control Team, led by the Lead Infection Control Specialist. The Infection Control Team is responsible for investigating incidents and outbreaks, reporting to the executive lead for infection prevention and control and ultimately the Chief Executive.

2. Most hospital outbreaks have minimal or no public health implications and will be dealt with using the hospital's own internal outbreak plan. However, if an infectious disease outbreak within a hospital has any potentially serious public health implications, it will be managed using this plan (The Wales Outbreak Plan).

3. The Lead Infection Control Specialist will make an initial assessment of the extent and importance of any infectious disease incident and will report to the CCDC in a timely manner, any incident of potential public health importance. The CCDC will inform the DPP of the relevant LA. The CCDC, the Lead Infection Control Specialist and the DPP (as appropriate) will then agree (in consultation with others as required) any further action necessary with regard to the public health implications. This discussion will not prevent any immediate action which is required to manage the outbreak by any one of these parties.

4. If it is agreed that there are potentially serious public health implications arising from the incident and an outbreak is declared, this plan will be followed, supplemented by the hospital outbreak plan as required. Due regard should be had as to the statutory obligations of the LA in respect of certain diseases of public health importance.

5. It is expected that all hospital outbreak policies will stipulate that the local CCDC should be informed whenever a hospital OCT is convened regardless of the circumstances. The CCDC will assess whether there are any potential public health implications associated with any hospital outbreak. If any are identified, action should proceed as laid out in paragraph 3 and 4 above.

6. Whilst it is difficult to be prescriptive as to what constitutes a potentially serious public health implication, the following are suggestive features:

   a) the outbreak has significant implications for the community;
   b) involves many cases of notifiable disease;
   c) involves even small numbers of a disease which constitutes a serious public health hazard;
   d) Involves food or water borne transmission of infection.

7. If the use of this plan cannot be agreed, the issue should be referred to the Chief Executive of the HB involved.

8. Whenever this plan is activated, the lead organisation for media and public communications will be agreed at the OCT meeting. All media and public communications will be agreed jointly between the organisations involved and will follow the principles laid out in appendix 4.

Appendix 7: Out of Hours Service and Emergency Arrangements

1. All core members must make suitable and sufficient arrangements for providing an effective service to deal with incidents and outbreaks at all times outside normal office hours. These will include:

    - In the evening and night times after normal office hours have finished
    - At weekends
    - During bank holidays
    - During extended periods of office closures, e.g. Christmas, Easter.

2. The arrangements must include references to communications, resources and equipment, and enforcement activity administration.

3. All core members will ensure that effective communication systems are in place and take responsibility for updating contact points whenever necessary.

4. All core members should ensure that the resources necessary for out-of-hours actions can be quickly put into place. This should include:

    - Meeting rooms
    - Administration support
    - Officers with necessary competencies and delegated authority.

Appendix 8: Points of Contact

To be completed by each organisation locally

Appendix 9: Format for Outbreak Reports

All reports and other documents produced by the OCT must comply with the requirements of the Data Protection Acts 1994 and 1998. For that purpose reports and other documents will anonymise any sensitive personal information and references to patients and businesses will be numerical and alphabetical, respectively.

1. Executive Summary

2. Introduction/Background: Brief narrative of circumstances of outbreak

3. Investigation:

a) Case Definition
b) Epidemiological
c) Microbiological
d) Environmental
e) Chemical

4. Results:

a) Epidemiological
b) Microbiological
c) Environmental
d) Chemical

5. Control Measures

6. Conclusions/Recommendations:

a) a statement on the causes of the outbreak, including any failures of procedures or breaches of legislation
b) identification of culpable persons or businesses
c) referrals to other agencies for their actions
d) comments on the conduct of the investigation, evaluation and lessons learnt
e) comments on any training needs identified by the investigation and performance against agreed standards

7. `Appendices:

a) Minutes of OCT meetings if appropriate
b) OCT evaluation of the outbreak (Appendix 11)
c) Results of statistical analyses
d) Epidemiological Report
e) CDSC Report form

Appendix 10: Communication for Release of Outbreak Reports

1. All outbreaks are different. The decision about how to handle the release should start with an **assessment of the media/political and public significance of the outbreak.**

2. In all significant outbreaks there should be a brief **Communications Plan** around the release of the report. (*Note :The declaration of the end of a significant outbreak may require a similar type of communication planning)*

3. The plan should include consideration of communication with:

    a) Cases
    b) Public and media
    c) NHS partners
    d) other public agencies
    e) Politicians
    f) Board members

4. The media options around release include:

    a) Nothing (if outbreak has not been featured in the public domain)
    b) Web story
    c) Press release (consider including FAQs if the outbreak is complex to guide reporters to key facts)
    d) Press briefing (however, the right spokespeople are necessary before considering such a briefing)

5. Whatever option is used, it is important to reinforce the message that the OCT report is a **multi-agency** report.

6. If the OCT report is to be released to the media and the public proactively, then communication with cases/relatives about OCT report release should consider the following:

    a) EHOs are often the key individuals in communicating with cases/relatives in many outbreaks. They should be supported in assessing the appropriate approach which may be different for individual cases depending on (for example) outcome of illness, degree of contact with OCT members, previous appearances in the press, whether they would welcome contact and also the total number of cases in outbreak (issues of practicality).
    b) Health literacy issues should be considered in any approach made
    c) Cases do not necessarily need the report, particularly if it is complex. Consider the following options as alternatives to simply sending the report:
        - A letter signposting key findings and that the report has been published and how to obtain it- possibly together with the press FAQs
        - Verbal contact by telephone/personal visit

- E-mail contact with the above and an electronic link to the report

7. All methods of communication should clarify the point that the report is first and foremost a scientific document not intended for a general audience.

8. EHOs and Health Protection Teams members should consider acquiring e-mail addresses routinely for cases on interview if appropriate.

9. As a general principle, avoid Mondays for report release and check key spokespeople available for day of release.

10. There is the potential for use of social media (secure web pages for cases, outbreak twitter account etc) for communications with some cases in the future.

Appendix 11: Template for outbreak /significant incident evaluation

Introduction

1. The Chair of the Outbreaks and Incidents subgroup of the Welsh Government Health Protection Committee should be sent a copy of all OCT reports. Those from significant outbreaks should be formally reviewed to fulfil the following objectives:

a) To draw out key positive and negative elements of the outbreak/ incident response;
b) To consider ways to enhance and improve the response;
c) To consider future challenges in achieving improvements; and
d) To draw out learning points for future outbreak response.

2. The OCT's own evaluation plays a key role in informing this process. Therefore, after the conclusion of an outbreak, the OCT should undertake its own internal evaluation, using the template below and include this in full in the OCT report.

Outbreak evaluation template[1]

3. The OCT evaluation should cover the following headings:

a) Cause of the outbreak,
b) Surveillance and detection of the outbreak
c) Preparedness for the outbreak,
d) Management of the outbreak,
e) Control measures

4. The specific issues under each heading that should be evaluated include:

a) timeliness of detection and response,
b) effectiveness,
c) cost,
d) lost opportunities,
e) new/revised policies

As appropriate, pertinent findings from the evaluation should inform the discussion, conclusion and recommendations sections of the OCT report.

[1]Template adapted from: World Health Organisation. Outbreak control. Evaluation. In: World Health Organisation. *Communicable disease control in emergencies. A field manual*. Geneva: WHO; 2005. Section 4.5, p.128-9. Available at: http://www.who.int/infectious-disease-news/IDdocs/whocds200527/ISBN_9241546166.pdf [Accessed 28th Feb 2012]

Appendix 12: Authorisation

1. The Local Government Act 1972 allows local authorities to appoint POs to perform certain functions to discharge the duties that a LA has to carry out. Determined by the specific policies of each individual Council, certain powers will be delegated to the DPP to enable to the discharge of the communicable disease function. Section 1 of the Public Health (Control of Disease) Act 1984 requires local authorities to execute the provisions of that Act. To assist the DPP in the performance of the function, the DPP will appoint EHOs and authorise them to carry out specific functions. Each EHO will be authorised by a committee minute or report depending on the level of delegation within that authority.

2. Similarly, the LA can appoint a medically qualified person to act as a PO to assist in discharging the functions of the Act and associated regulations. Guidance was given on this matter in circular WHRC(73)33. The appointment and level of authorisation will be confirmed by a committee minute or delegated power as appropriate. In addition, the LA should appoint other medically qualified persons to act when the PO is not available. These “Alternate Proper Officers” must be similarly appointed and authorised. Guidance was given on this matter in circular WHC(94)27.

Appendix 13: Lead Officer

1. Lead Officer in Communicable Disease

1.1 The development of the Lead Officer for Communicable Disease concept has 2 functions namely:

a) the appointment of officer(s) within LAs who have specific expertise and responsibilities in the Communicable Disease function; and
b) to work with others as a cohort of specialists in the Communicable Disease function to be used on various locations in Wales to assist in the investigation, control and management of outbreaks of Communicable Disease.

1.2 The initiative is supported by all LAs in Wales, and given approval by the DPP in Wales and included in Welsh Government CMO's Communicable Disease Strategy, published in July 2001.

1.3 This is part of the continuing development of the communicable disease function in LAs and in particular the implementation of the Communicable Disease Outbreak Plan, and is considered to be an important aspect of a LA 's role in providing effective and sufficient resources to enable it to respond to major outbreaks of communicable diseases.

1.4 The CMO's Communicable Disease Strategy has recommended the adoption of the principle of a "**Lead Officer**" and the Welsh Government has provided a level of funding, through Public Health Wales, to facilitate the training of Lead Officers in all LAs in Wales.

2. Lead Officer

2.1 Each LA in Wales will appoint a named "Lead Officer" for communicable disease. This officer will be an existing employee of a LA working in the communicable disease/food safety section within the public protection department.

Qualifications

2.2 The Lead Officer will normally be a qualified EHO with a degree in Environmental Health or the EHORB Diploma and preferably additional qualifications in a related subject. The Lead Officer should have extensive experience in the Communicable Disease function as a field officer and preferably in a management/supervisory role. Although communicable disease is not limited to food poisoning, the Lead Officer should have (or have easy access to advice from an officer with) extensive experience in food safety.

2.3 Job Description

1. To provide expert advice and information on all aspects of the communicable disease function within the LA
2. To advise on specific aspects of investigation of serious or major incidents of communicable disease
3. To provide advice and support to the Chair of the OCT during major outbreaks of Communicable Disease.
4. To lead the investigative processes for such outbreaks on behalf of the LA.
5. To assess the effectiveness and progress of such investigations.
6. To be available for secondment to another LA following a request from that authority. This secondment is to assist that authority in the performance of tasks outlined in this document.

2.4 It is anticipated that this officer will be a named person in the Communicable Disease Outbreak Plan but will **not** assume the responsibility of chairing the OCT convened to manage and control the outbreak. This function has already been dealt with in the Plan.

3. Further aspects to consider

3.1 Level of appointed person:

The person designated "Lead Officer" should be the officer who normally carries out the investigative work in an outbreak situation. The Lead Officer would not normally be a person at the head of the organisation whose role is essentially managerial neither should they be a recently qualified officer.

3.2 Type of specialism required.

It is anticipated that the Lead Officer will be or have had experience in the Food Safety/Communicable Disease functions.

3.3 Additional qualifications are not required but are desirable and additional training will be provided by the LA as described above.

4. Arrangements for Collaborative Working

4.1 A further aspect of a LA's competence to successfully control and manage a communicable disease outbreak is to have sufficient number of trained staff available when required. It is possible that either because of job vacancies, holidays or sick absence or because the outbreak is so large that an individual authority may be unable to provide sufficient internal staff resources. It is in these instances that resources may be obtained from a neighbouring LA through a process of collaborative working.

4.2 The collaborative working may take several forms, namely:

a) to assist in the various investigative processes of the outbreak investigation;
b) to carry out other routine Communicable Disease investigation work which is not part of the substantive outbreak; or
c) the secondment of an officer to assist in the control and management of an outbreak

4.3 To facilitate this process, local authorities should have in place appropriate administrative processes to enable these collaborative actions to occur as soon as they are required. Issues such as travelling arrangements, costs, indemnify, authorisation must be resolved by the LAs involved. Any such arrangements must be explicit and date limited

Appendix 14: FOOD SPECIFIC APPENDIX

Appendix 14. 1 : Legal Responsibilities

1. Background

1.1 The specific statutory responsibilities, duties and powers which are significant in the handling of an outbreak of food poisoning are set out in the Public Health (Control of Disease) Act 1984, the Health Protection (Local Authority Powers) Wales Regulations 2010, Health Protection (Part 2A Orders) (Wales) Regulations 2010 and the Health Protection (Notification) (Wales) regulations 2010, the Food Safety Act 1990, the Public Health (Ships) Regulations 1979, the Public Health (Aircraft) Regulations 1979 and the International Health Regulations 2005.

1.2 The responsibilities, duties and powers are placed either upon the LA or upon a PO or an authorised officer of the LA.

1.3 The Food Standards Agency has a statutory duty to monitor the performance of food enforcement authorities. This includes a Local Authority's handling of cases and outbreaks, of food borne illness. There may be occasions where Agency officials will need to visit a LA in connection with an outbreak – where this need arises, the Agency will have regard to the priority of managing the incident and will do everything possible to ensure that the roles of the official co-opted to the OCT and the official undertaking any monitoring are kept separate.

2. Definitions

2.1 **Food Poisoning (CMO (92) 14.WO)** - Any disease of an infectious or toxic nature caused by or thought to be caused by the consumption of food or water.

3. Guidance

3.1 The guidance listed below will assist in the management and control of a food poisoning outbreak. It is recommended that documents below (3.2, 3.3 and 3.4) are kept with and used alongside this outbreak plan. Document 3.2 in particular is a key document in the control of an outbreak. Other documents listed should be used where appropriate.

3.2 **Preventing person-to-person spread following gastrointestinal infections:** guidelines for public health physicians and environmental health officers – Communicable Disease and Public Health Vol 7, No 4 December 2004.

This guidance is directed at doctors and EHOs for the purpose of controlling infection in general populations. It covers advice for enteric precautions, specifies 'at risk' groups and gives guidance on exclusions in specified cases.

3.3 **Management of Outbreaks of Foodborne Illness in England and Wales - Food Standards Agency:** This guidance provides a framework for health professionals to assist them in the management of outbreaks of infectious disease caused by ingestion of microbiologically contaminated food. It is designed to assist the OCT in dealing with an outbreak and provides an aide memoir for medical and nursing staff, environmental health professionals, scientists and others involved in the investigation.

3.4 **Food Handlers: Fitness to Work. A Practical Guide for Food Business Operators 2009** - Food Standards Agency

This guidance helps managers and staff to prevent infected food handlers spreading illness through food that they work with.

3.5 **The Investigation of Sporadic Cases of *E. coli O157* - South East Wales Communicable Disease Task Group 2004 (as reviewed in 2006).**

This document is intended for use by Environmental Health Officers when dealing with sporadic cases of *E. coli O157* however, some of the investigative suggestions and controls are transferable and useful to utilise to an *E. coli O157* outbreak situation.

Appendix 15: WATER SPECIFIC APPENDIX

Appendix 15: Health Related Incidents in Wales Potentially Caused by Contaminated Drinking Water

15.1 Introduction

1. The Water Specific Appendices are derived from the guidance document *The Emergency Framework for health-related incidents and outbreaks in Wales & Herefordshire potentially caused by contaminated drinking water*.

2. This guidance was developed by a multi-agency group including representations from LAs, Public Health Wales, Dwr Cymru and an independent expert advisor.

15.2 Purpose

1. This Appendix sets out a multi-agency process for potential health-related incidents which involve public drinking water supplies **(for communicable disease outbreaks involving water, the Wales Outbreak Plan at the front of this document should be followed).** It is designed to guide those involved, encouraging collaboration between agencies and bringing clarity of process and responsibility. It will inform the detailed procedures of the numerous organizations involved in protecting public health and resolving drinking water-related issues. Its implementation will facilitate rapid and effective responses to emergency situations.

2. The Appendix does not override national and local resilience plans or the statutory duties of individual organisations. It does not describe the detailed internal procedures of the water companies and the reporting requirements to the DWI.

3. The original document was endorsed by the Steering Group of the Water Health Partnership for Wales as a guidance document for use throughout Wales and Herefordshire.

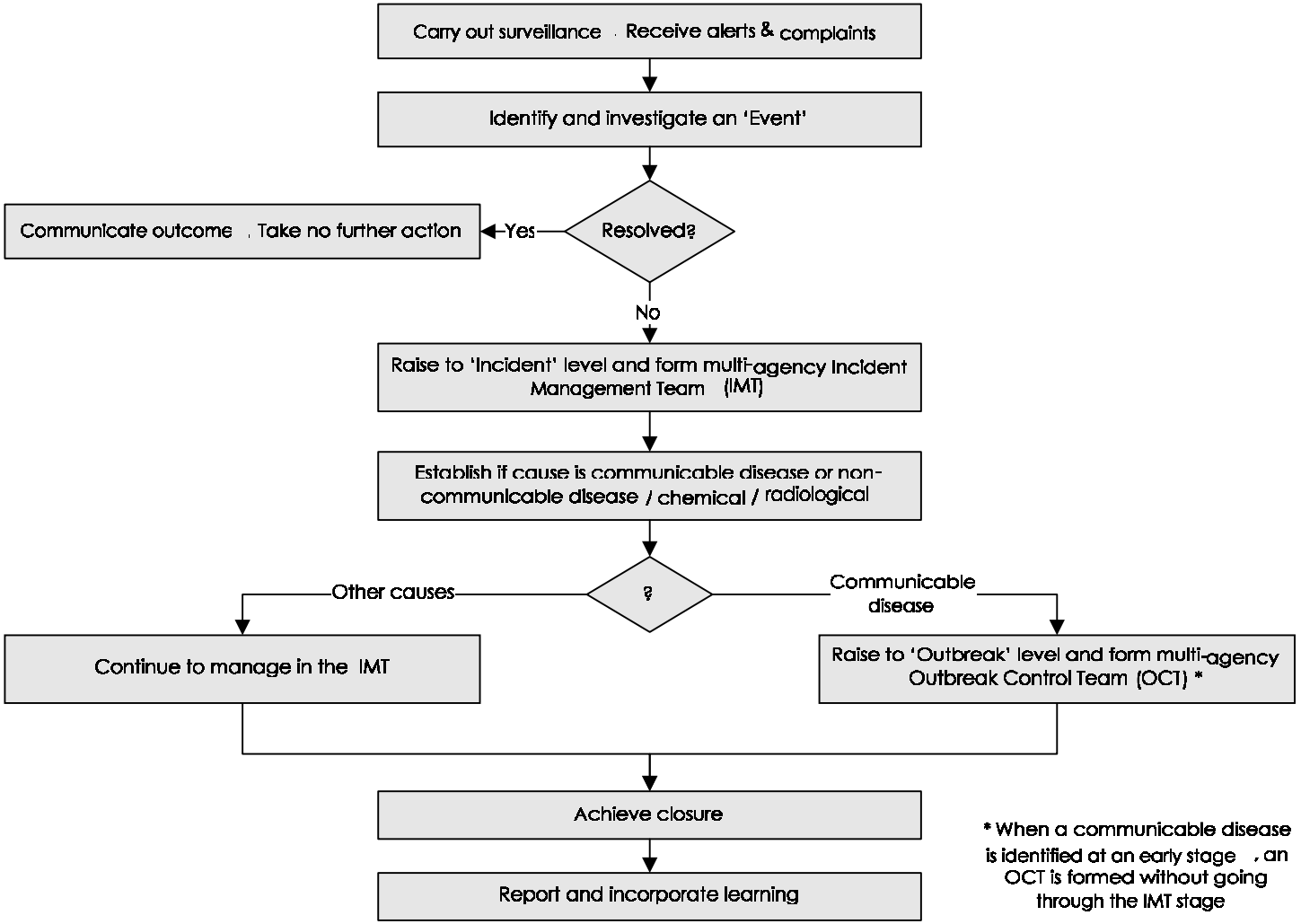
15.3 Responsibilities

1. Responsibility for managing the public health aspects of events, incidents and outbreaks involving water is shared by LAs, HBs and Public Health Wales, with the full assistance of the relevant Water Company and their service providers, plus other experts or relevant consultants. This Appendix outlines those responsibilities and the process by which these organisations effectively work together.

2. In Herefordshire (as part of England), Primary Care Trusts (PCTs) and the HPA take the responsibility of the HBs and Public Health Wales respectively.

15.4. High-level Process Map

The process map below describes the basic steps in the overall process. Three sheets of more detailed maps are included on page 49-51.



15.5 Incident Management

1. The primary objective in an incident is to protect public health by identifying the source of the contamination, implementing the necessary measures to minimise exposure and prevent further spread or recurrence. Given the number of private water supplies in Wales it is important that careful consideration is given to ensure the relevant water source is identified. Success is dependent upon effective and timely communication between LAs, HBs, Public Health Wales and water companies and other involved parties. Informal discussion of potential problems, including consideration of immediate control measures, is encouraged at an early stage.

2. When an event[1] appears to have a significant potential impact on public health, it is escalated to an incident and an Incident Management Team (IMT) formed[2]. Any party can notify other parties of an incident with potential public health implications and initiate an IMT. An 'incident' is a sub-set of 'event' including but not limited to:

    a) Any sudden and unexpected breach of the Water Supply (Water Quality) Regulations which is a potential danger to human health
    b) Any unusual deterioration in water quality[3].
    c) Any evidence of unusual and unexplained clustering of cases in the community
    d) Any significant perceived risk to the health of consumers
    e) Significant consumer perception of changes in water quality
    f) Significant consumer concern about the quality of the water supplied
    g) Any combination of the above

3. Appendix 15.11 (page 54) outlines the membership and duties of the IMT. Clear roles should be assigned to IMT members. At the earliest opportunity, there needs to be agreement on public information for general release and how to handle on-going media contacts (see Appendix 4: Media Relations, page 28). Expert advice should be sought on whether it is appropriate to follow up by commissioning an epidemiological study. Advice will also be shared with experts retained by the water company, the HPA for chemicals and radiological contamination, and NHS Medical Physicists when appropriate.

4. If chemical contamination (or other agents not causing an outbreak) requires an IMT to meet to assess the public health impact, the LA and Public Health Wales shall ensure adequate resources to facilitate this. A chair shall be agreed and minutes taken. Rapid decisions may need to be agreed with the water company to minimise exposure and the checklist (Appendix 15.11.4, page 55) should be considered. All information gathered should be shared amongst the IMT members.

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[1] Within this Framework, an 'event' is any biological, chemical or radiological occurrence which may potentially impact public health.

[2] An IMT may work over phone or video links when appropriate, rather than hold meetings.

[3] For guidance on epidemiological evidence used to determine the likely association with drinking water, refer to Appendix 13.14.

5. Once the incident is clearly under control, an interim report should be prepared and shared with all the relevant bodies including Welsh Government, DWI, the affected LAs, as well as all IMT members (this is distinct from the reports which the water companies is required to submit to DWI). A final report may need to be delayed until any epidemiological studies can be completed. This could be followed by a peer-reviewed publication.

6. Where an IMT is convened, a record of proceedings will be made and circulated to an agreed distribution list. In the event of a significant emergency, the report will also be circulated to; the Welsh Government, the HB, all LAs involved, DWI and any other parties as deemed appropriate by the IMT.

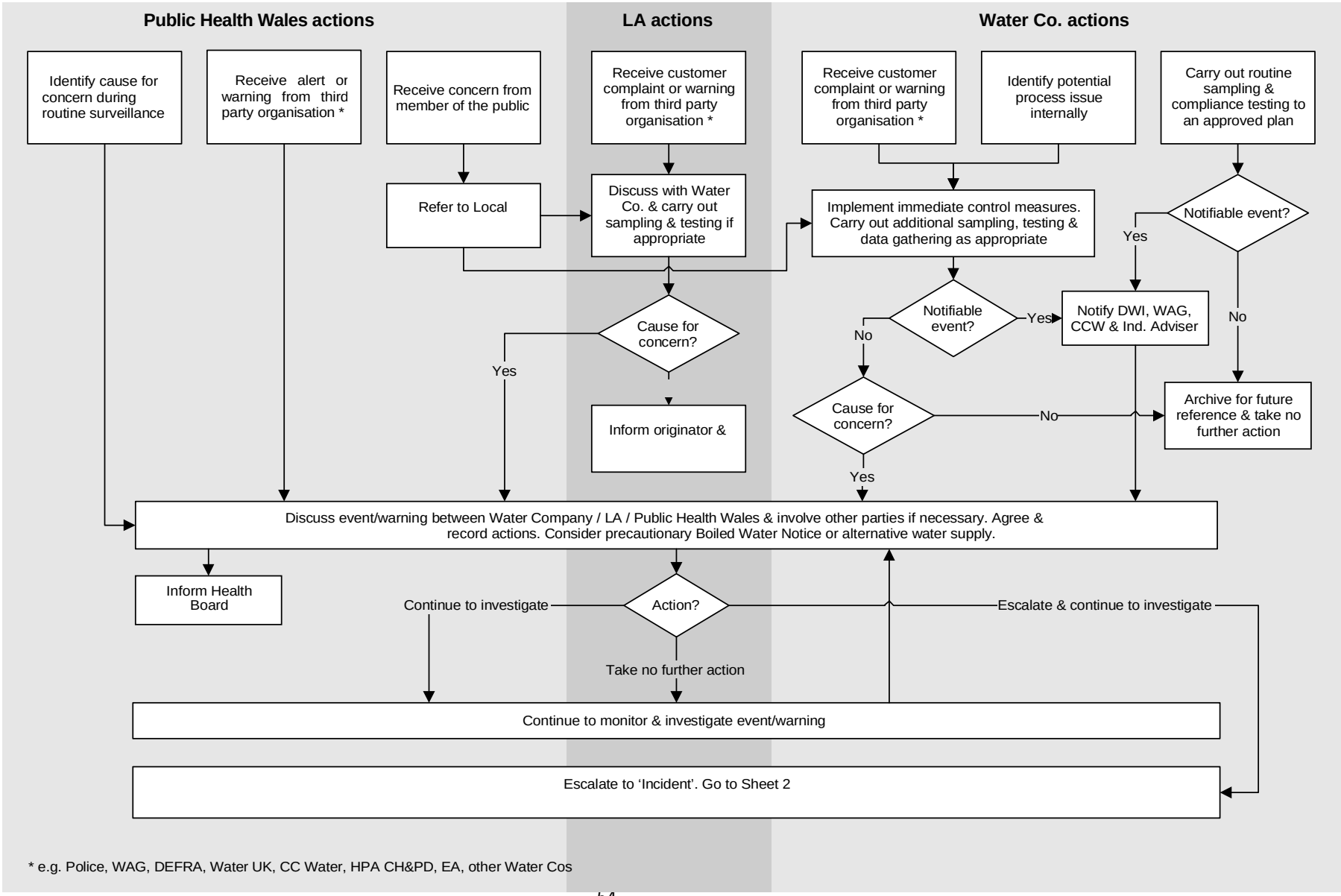
7. The IMT shall bear in mind the statutory requirement for the water company to report at 3 working days and 20 working days (and at other times as required) to the DWI. This report will contain details of the investigation, compilation of the results, conclusions, recommendations and lessons learnt. Minutes of all IMT and/or OCT meetings will be appended.

15.6 Outbreak Control

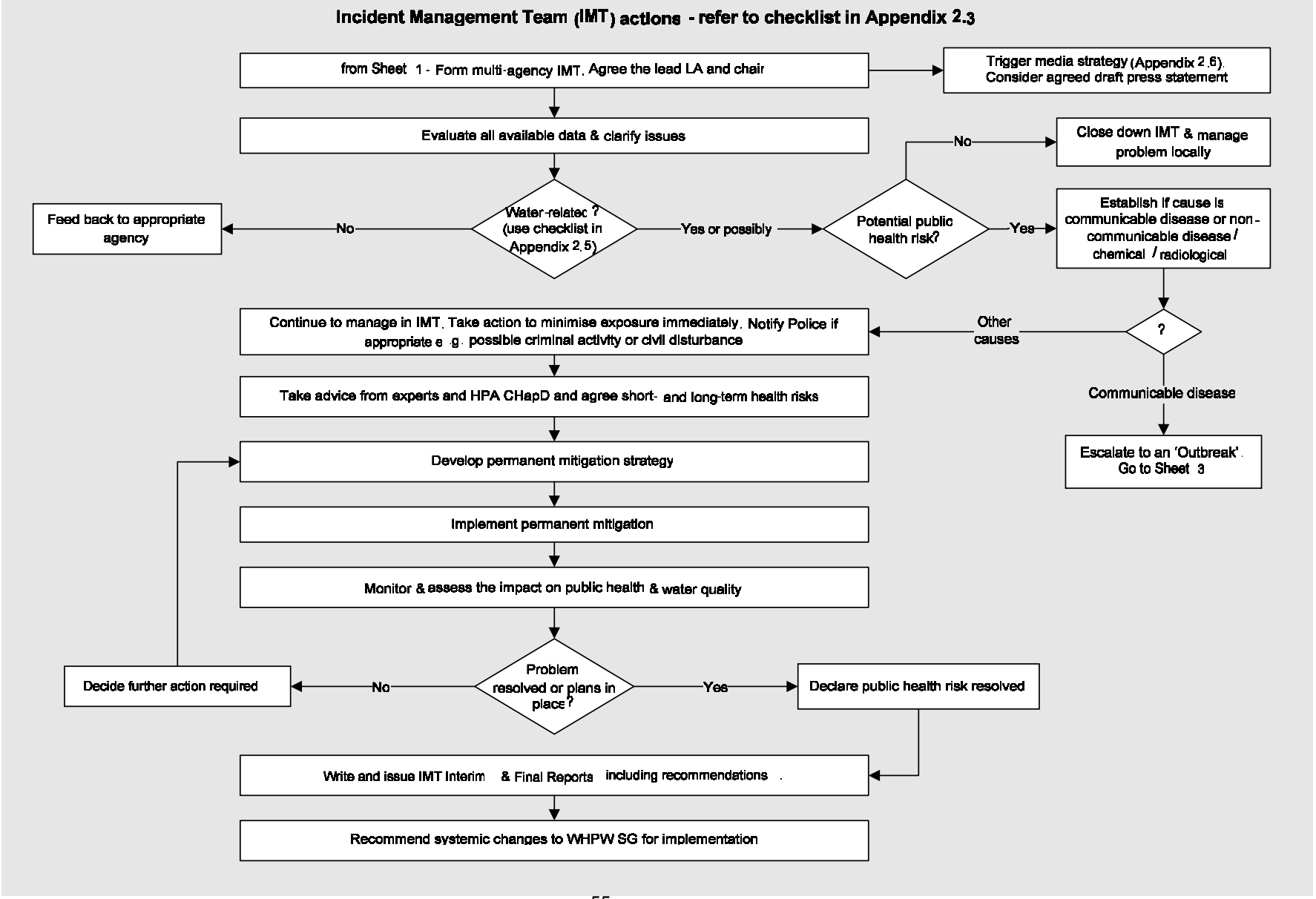
1. Where an outbreak is suspected or declared, the Generic Plan should be followed.

2. The OCT shall bear in mind the statutory requirement for the water company to report at 3 working days and 20 working days (and at other times as required) to the DWI. This report will contain details of the investigation, compilation of the results, conclusions, recommendations and lessons learnt. Minutes of all IMT and/or OCT meetings will be appended.

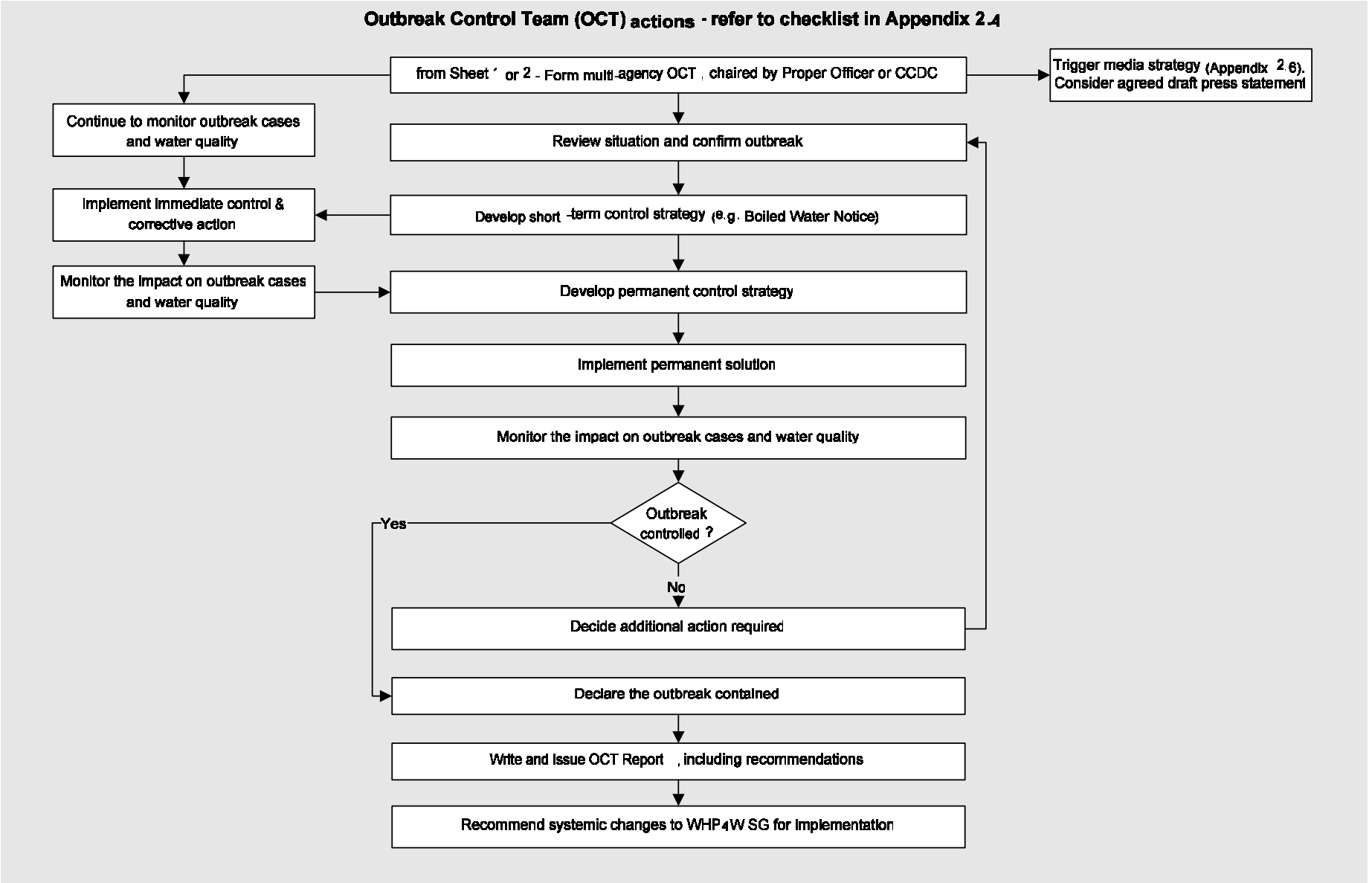
15.7. Detailed Process Maps: Sheet 1 – Identifying Events and Escalating



15.8. Detailed Process Maps: Sheet 2 – Managing an Incident or Escalating



15.9. Detailed Process Maps: Sheet 3 – Controlling an Outbreak



15.10 Role of Water Company in IMT/OCT

1. Water companies have statutory duty under the Water Industry Act 1991 to supply safe and wholesome water, as defined in the Water Quality Regulations, within their respective regions. When a breach of a Water Quality standard has occurred that might have a potential impact on public health, water companies are required to inform the relevant LAs and CCDCs and to agree, and undertake, the appropriate investigations and mitigation measures to control or prevent potential risk e.g. Boil Water Notices. In the event of a continuing risk to the safety of public water supplies and an escalation to 'Incident' or 'Outbreak' status, the water companies shall appoint one or more senior responsible officers to the IMT or OCT to fulfil specific operational and customer related requirements.

2. The water company representative(s) will have sufficient authority and knowledge to:

    a) Understand the cause, effects and extent of the issue and inform the IMT/OCT fully of any events before the incident or outbreak was declared.
    b) Make the appropriate operational decisions on behalf of the IMT or OCT and ensure that they are immediately and fully implemented by the water company.
    c) Provide the IMT or OCT with a water company perspective on the management of the incident.
    d) Be adequately briefed and ensure that the IMT or OCT are made aware of, and have access to, all relevant water quality and operational data.
    e) Facilitate the diversion and commitment of water company resources i.e. equipment and manpower to manage the incident.
    f) Inform customer communications and other stakeholder briefings and, if necessary, enlist the support of the media communications personnel within the Company. This will include agreeing 'lines to take' for customer call centres and sharing this with the IMT/OCT.
    g) Share any necessary information from their customer database.
    h) Ensure that all alliance partners and other experts, contractors, etc. assist the IMT/OCT and ensure that any relevant information is shared with all members.

15.11 Incident Management Team for the Public Health Aspects of a Water Incident

1. Purpose

1.1 The overall purpose of the IMT is to protect public health during an incident by identifying the source of contamination, implementing the necessary temporary and permanent measures to minimise exposure and prevent further spread or recurrence.

2. IMT Members

2.1 Core members for all incidents:

- LAs
- HBs and/or Primary Care Trusts
- Public Health Wales
- Water companies
- External Advisors (accessed through Water Company)

2.2 Co-opted members as necessary:

- Chemical Hazards and Poisons Division of HPA
- Environment Agency
- Medical Physicist
- FSA
- Emergency Planning Officers (Water Companies or LAs)
- Veterinary Laboratory Agency and/or Animal Health
- DWI

2.3 Dependent upon the scale of the incident, representatives may require the support of additional staff to accompany them. The IMT will usually be chaired by a health or LA representative and the Chair will be agreed at the first meeting. However, any member of the IMT can chair by the agreement of the members of the IMT. If the incident becomes an outbreak, an outbreak should be declared, the IMT dissolved and an OCT formed. The OCT will operate as laid out in the Wales Outbreak Plan at the front of this document.

3. Duties

3.1 The duties of the IMT are to:

a) Appoint a chair, aiming for continuity whenever possible
b) Take minutes which record their decisions (including deferred decisions) and actions, together with their rationale
c) Maintain a log of actions and decisions as appropriate
d) Establish an Incident Room if appropriate
e) Review evidence for the incident and investigate source and cause
f) Identify and assess the risk to public health and likely illness in the community
g) Establish the cause of the risk and determine if it is drinking water-related
h) Escalate to an ‘Outbreak’ if the cause is a communicable

disease

For other causes:

a) Agree and implement immediate protective action
b) Agree and implement longer-term actions to prevent recurrence
c) Identify the population at risk
d) Take advice from external experts
e) Draft statement for media (see Appendix 4) and information for consumers
f) Delegate all information releases to specific IMT members
g) Meet at appropriate intervals and record minutes
h) Issue a report on the outcome, including recommendations
i) IMT may need to escalate to an OCT for a communicable disease. This should be clearly recorded.

4. Checklist

4.1 The following is intended as a checklist of actions to be considered in order to deal effectively with an incident. The step-by-step approach does not imply that each action must follow the one preceding it. In practice, some steps must be carried out simultaneously and not all steps will be required on every occasion.

5. Assessment of situation

a) Describe the incident (location, what's occurred, magnitude, nature and toxicity of chemical contamination, immediate control measures planned and implemented)
b) Obtain expert toxicological advice
c) What other information is currently available from the different agencies (Health, LA, EA, VLA, SVS, water companies, HPA, etc.)?
d) What is the potential health impact for individuals or population on the information currently available?
e) Who are the population at risk (consumers supplied (households, schools, hospitals, etc.) industry, leisure?
f) Has the population been exposed already?
g) Is there on-going exposure?

6. Is there a potential health risk?

a) What else can be done immediately to minimise on-going exposure and effects on those exposed?

- Removal/treatment of contamination?
- Provision of clean drinking water for the consumer?
- Information and advice to public and media?
- Information and advice to health professionals?
- Agreement on further monitoring and analysis?
- All agencies on the IMT to consider implications impacting on their own particular remits?

7. On-going information requirements and considerations:

a) Is the current data set accurate and complete enough to assess hazard and risk? If more information is needed, resources to gather more samples and analysis should be agreed.
b) Are there any possible by-products which should be identified or eliminated?
c) Have we taken additional expert advice from external sources?
d) Are we taking the option with the least impact on health?
e) Are there any long term health effects that also need to be considered?
f) Do we need additional epidemiological advice on any analytical epidemiological study that may be helpful?
g) Should a follow up study, e.g. bio-monitoring, be recommended? If so, how should this be undertaken?
h) The LA should ensure that adequate resources are available to facilitate the health response and record clearly the events and decisions particularly relating to health effects and protection.

8. Communication

a) Consider the best means of communication with colleagues, patients and the public, including the need for an incident room and/or helplines.
b) Ensure appropriate information and advice is given to the public, especially those at high risk.
c) Ensure accuracy and timeliness.
d) Include all those who need to know.
e) Use the media constructively.
f) Liaise with other agencies as appropriate:

- Other LAs/Port health Authorities
- Other HBs
- CDSC (Wales)
- HPA
- General Practitioners
- Education and Social Services Departments
- Public Analyst
- Government Agencies, e.g. DEFRA, Environment Agency
- Welsh Government
- HPA CHaPD
- Divisional Veterinary Officer
- DWI
- Health & Safety Executive
- FSA
- CSSIW

g) Prepare a written report.
h) Disseminate information on any lessons learnt from managing the incident.

15.12 Control Measures to be Considered in Both Incidents and Outbreaks

1. Control the source: animal, human, environmental, treatment type or distribution system.

2. Control the mode of spread by providing alternative supplies (re-zoning, overland mains, bowsers, bottles) and/or issuing Boil Water Notices, also:

    a) Isolation or exclusion of cases and contacts
    b) Screening and monitoring or contacts
    c) Protection of contacts by immunisation or prophylaxis
    d) Examination, sampling and corrective actions at treatment, catchment or distribution points
    e) Diverting sources and/or disinfection of process/distribution
    f) Giving advice on protection measures especially to immuno-compromised groups

3. Monitor control measures by continued surveillance for disease.

4. Evaluate the management of the outbreak and make appropriate recommendations for the future.

5. Lift Boil Water Notice subject to agreed criteria being met.

6. Declare the outbreak contained.

15.13 Epidemiological Evidence Used to Determine Likely Association with Drinking Water

The following evidence that may contribute to defining an outbreak as waterborne independently of findings related to water treatment and supply:

1. Numbers exceeding expected background level for time and place or linked cases.

2. Descriptive evidence (person, place, time): A large proportion of cases clustered in water distribution area.

3. Strength of statistical association by an analytical epidemiological approach (e.g. case-control or cohort), especially with dose response (risk increased with amount of water consumed).

4. Consistency with natural history of pathogen.

5. Plausibility in terms of descriptive details, outbreak dynamics etc.

6. Analogy with other waterborne outbreaks (including high proportion of adult cases in suspected Cryptosporidium outbreaks).

7. Strength of likely association increased by recovery of pathogen from supply.

8. Lack of evidence for plausible alternative explanation.

9. Case numbers decrease following the introduction of appropriate control measures.

15.14 Relevant Legislation & Guidance

1. Public Health (Control of Disease) Act 1984
2. Health Protection (Local Authority Powers) Wales Regulations 2010
3. Health Protection (Part 2A Orders) (Wales) Regulations 2010
4. Health Protection (Notification) (Wales) Regulations 2010
5. Food Safety Act 1990
6. Water Industry Act 1991
7. Civil Contingencies Act 2004
8. Cryptosporidium in Water Supplies. Report of the Group of Experts, Chairman – Sir John Badenoch. Department of Environment/Department of Health. HSMO London 1990.
9. Cryptosporidium in Water Supplies. Second Report of the Group of Experts, Chairman – Sir John Badenoch. Department of Environment /Department of Health. HSMO London 1995.
10. Cryptosporidium in Water Supplies. Third Report of the Group of Experts to:Dept of the Environment, Transport and the Regions & Department of Health.Chairman – Professor Ian Bouchier. November 1998.
11. Dŵr Cymru Welsh Water Incident Response – Incidents Managed by Others(Section 4 of DCWW Incident Plan)
12. The Water Supply Regulations 2010
13. The Water Supply (Water Quality) Regulations 2010 (Wales)
14. The Water Supply (Water Quality) Regulations 2001 (Wales) SI No. 3911
15. The Water Supply (Water Quality) Regulations 2001 (Amendment) Regulations 2007
16. Water Supply (Water Fittings) Regulations 1999
17. The Water Industry Act 1991
18. The Private Water Supplies (Wales) Regulations 2010
19. Guidelines For Water Quality On Board Merchant Ships Including Passenger Vessels HPA 2003
20. World Health Organisation Guidelines for Drinking Water Quality

Appendix 16: LEGIONNAIRES' DISEASE SPECIFIC APPENDIX

Appendix 16.1 : Sampling at industrial premises in Legionnaires' disease outbreaks

Interim practical advice note for sampling at industrial premises in Legionnaires' disease outbreaks

Context

1. Detailed guidance is being drawn up in Wales to cover a number of aspects of Legionnaires' disease outbreaks. However recent experience identified confusion around urgent industrial premise sampling in outbreak situations. This informal practical advice note is an interim measure to assist those involved if an outbreak occurs in Wales before definitive guidance has been agreed. It only covers practical issues relating directly to urgent sampling and should not be used as a guide to other aspects of dealing with the outbreak.

Warning

2. Urgent control measures to control *Legionella* risk (eg: emergency inspection/shutdown/disinfection) should not be delayed to wait for sampling to be sorted.

3. Sampling for *Legionella* in industrial systems in outbreak situations may be of little benefit in detecting the bacterium. A negative result does not exclude the possibility that the premise sampled is the source. Consider whether sampling is of public health value to the OCT before proceeding.

4. At present PCR testing is not recommended by HSE as an indicator of control or for epidemiological investigations in outbreaks. PCR detects both living (viable) and dead bacteria; this makes it difficult to evaluate the real health risk.

Issues to consider:

Legal powers of entry and to undertake sampling

5. In outbreak situations the company may co-operate fully. However the powers in the Health Protection (Wales) Regulations 2010 under the Public Health (Control of Disease) Act 1984 can be used. The Request to Co-operate Letter under this legislation is useful in this situation.

6. Powers of entry under the Environmental Protection Act 1990 could be used to gain access to the premises. Section 79 of this Act allows LA's to deal with "any dust, smell or other effluvia arising on…premises and being prejudicial to health or nuisance", which includes pathogenic organisms. EHO's are allowed to enter premises and take samples, regardless of whether the premises are enforced by HSE or the LA under health and safety legislation.

7. The HSE advise that case law (R v Board of Trustees of Science Museum) has confirmed that evidence of actual Legionella (i.e. from sampling) is not required to support enforcement under the Health & Safety at Work etc Act 1974.

8. HSE legal advice has confirmed that there are no powers to sample for Legionella under health & safety legislation for public health purposes.

Who will sample

9. Each sampling exercise must be subject to an individual risk assessment before commencement so that samplers are not put at risk.
Samples in industrial premises should only be taken by appropriately trained and experienced individuals
Samplers could be:
a) Appropriately trained Local Authority Officers
b) Appropriately trained Local Authority Officers from a neighbouring authority
c) Reputable private contractors offering these services

10. In some circumstances, the Environment Agency may be able to assist by providing advice on securing samples to ensure evidential standards are met and providing courier services. This may be particularly useful on unusual/complex industrial sites regulated by the Agency with which other potential samplers may be unfamiliar. In these cases Environment Agency staff will not be entering and sampling using their own powers but accompanying the Local Authority under Local Authority public health legislation in the same way as private contractors can access the site and sample in these circumstances.

Progression through factory

11. The sampler should be accompanied by:
a) The Responsible Person from the company/site to ensure safety on site
b) A Regulatory officer from the Local Authority/HSE if the sampler is not a LA officer

If the Regulator is not available to urgently accompany the sampler, the Regulator should provide advice as required on any known relevant aspects of the process being sampled. Such advice is necessary to inform the risk assessment prior to the sampling visit and activity.

Chain of evidence

12. The protection of public health takes precedence over collecting evidence. However it would be wise to consider how to protect the chain of evidence when samples are taken, and take steps to maintain this.

Sampling when Officers identify *Legionella* control issues whilst inspecting a potential industrial source in an outbreak situation

13. During an outbreak, a number of industrial premises may be visited. Any of these may be identified as not having adequate *Legionella* controls and an enforcement notice may be issued. In this case, the inspecting Officer should report this urgently to the OCT so that if sampling is deemed necessary by the OCT, it can be arranged without delay. It would be wise for any OCT to consider arrangements to respond to this contingency, particularly out of hours, prior to it arising.

August 2012