



HEALTH PROTECTION AGENCY NORTH WEST

Joint Infectious Disease Outbreak Plan

October 2008

(Review Date: October 2011)

(Reviewed in Sept 2007 – there have been no major changes to the substance of the plan but the contacts list has been updated)

There are other national guidelines available.
This is recommended for use in the North West.

www.hpa.org.uk

PLUS ANY OTHER RELEVANT WEBSITES



Insert Local Authority logo

Insert PCT logo

XX PRIMARY CARE TRUST
XX HEALTH PROTECTION UNIT
XX COUNCIL

Current status: Final

October 2008 (revised from November 2004)

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1 Introduction

- 1.1 This document has been prepared in line with
- i. guidance issued jointly by the Department of Health and the Department of the Environment in November 1993 as HSG(93)56 which reminded health authorities and local authorities of the collaborative arrangements, which should be in place for the provision of an effective communicable disease control service and
 - ii. "Getting Ahead of the Curve", the Chief Medical Officer's report of 2000 which identified the need for improved collaboration and communication between the various agencies responsible for communicable disease control at local, regional and national level.
- 1.2 In April 2003, the Health Protection Agency was formed, combining the functions of Consultants in Communicable Disease Control (CsCDC), the Public Health Laboratory Service (PHLS), the Centre for Applied Microbiological Research (CAMR), the National Focus for Chemical Incidents (NFCI), the Chemical Incident Response Service (CIRS) and the National Radiological Protection Board (NRPB). This agency acts as a source of expertise and to provide key services, including advice on outbreak management at local, regional and national level. The NHS continues to undergo major re-organisation in recent years. Primary Care Trusts came into being in April 2002 and bear the responsibility for the public health of their populations, including all health protection issues. Primary Care Trusts are now gradually moving towards a separation of the commissioning and the community services provider function.
- 1.3 The guidance stresses the need for an up-to-date joint plan covering the structures and procedures necessary for managing infectious disease control both on a day-to-day basis and when an outbreak occurs.
- 1.4 This document constitutes a plan to manage an outbreak of infectious disease. It does not cover the surveillance of, nor the day-day management of infectious diseases. It has been prepared jointly by XX Primary Care Trust, XX Council and XX Health Protection Unit and in consultation with the Infection Control Team at XX Acute Trust.

- 1.5 The following representatives of the above agencies have signed and approved this document.

Agency	Name	Signature	Date
XX Health Protection Unit			
XX Council			
XX PCT			
XX Acute Trust Microbiology Services			

- 1.6 **Document details and status**

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- 1.7 **Acknowledgements**

This document has been widely circulated, and comments received from a large number of people. Thanks to all who read and commented on the draft version.

2 Aim and Scope of the Plan

- 2.1 The purpose of the outbreak plan is to provide a framework which will ensure that outbreaks of communicable disease and infection are effectively investigated, brought under control and where possible measures taken to prevent similar outbreaks in the future.
- 2.2 This plan is in place to ensure that a coordinated approach is taken. It identifies the roles and responsibilities of the key organisations and individuals and covers management and organisational aspects, communication, investigation and control procedures.
- 2.3 The plan covers all infectious diseases, defined as all illnesses caused by microbiological agents including bacteria, viruses, fungi and parasites. The majority of outbreaks will be caused by an enteric organism or have an environmental component. These outbreaks will require significant involvement from the Environmental Health Services. In the less common event of an outbreak without these components, the Environmental Health Services may not be involved and the roles normally undertaken by Environmental Health personnel will be allocated to other personnel.
- 2.4 Outbreaks and incidents of unusual illnesses might have any one of a number of causes in addition to infectious causes, including chemical, nutritional, radiological or even hysterical. Biological agents may be released deliberately. This document will provide a framework for the initial management of such incidents, although as soon as suspicion of such an incident is raised, reference should be made to other specific guidance (available at HPA website www.hpa.org.uk, click on 'Emergency Response').
- 2.5 Outbreaks may occur within the community or within institutions, or a combination. This plan covers, in the main, outbreaks in the general community. There are specific plans for other scenarios for which the relevant plans should be consulted:

Outbreaks confined to hospital	Hospital outbreak plan
Viral gastroenteritis in nursing and residential homes	Plan for management of an outbreak of diarrhoea and/or vomiting in a nursing or residential home setting
<i>Legionella pneumophila</i> outbreak	Delete if a local plan does not exist HPA North West legionella incident template plan and local plans developed therefrom
Influenza	Influenza Pandemic Plan <ul style="list-style-type: none">• Local plan may exist• Department of Health contingency plan and an array of national guidance

	http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/index.htm
Outbreak of unusual illness	<ul style="list-style-type: none"> • WHO guidance Initial investigation and management of outbreaks and incidents of unusual illness. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1201265888951
Deliberate release	Various guidance documents on HPA website

"Delete or add local plans as appropriate"

- 2.6 Most outbreaks are small to medium-sized and may not impact greatly on routine services. On occasions, outbreaks may be of such magnitude that there are very significant implications for routine services and the additional resources required. In these circumstances, the major incident plans of the Local Authority, the Primary Care Trust (PCT) and the hospital will be invoked.

3 Definitions of Incidents and Outbreaks

- 3.1 Any incident which may have the potential to develop into an outbreak will be monitored closely and discussed between the Consultant in Communicable Disease Control (CCDC; also known as Consultant in Health Protection) the PCT Infection Control Nurse (ICN) and/or Director of Public Health, Environmental Health Officers (EHO) and the Consultant Microbiologist/Virologist.
- 3.2 The difference between an incident and an outbreak is a matter of judgement. Whatever the terminology, either scenario might be handled in a similar way and either might demand significant resources. This plan will refer to outbreaks, but the plans detailed within are equally applicable to significant infectious disease incidents.
- 3.3 As a guide, the calling of an Incident Team or Outbreak Control Team (OCT) will be considered when one or more of these conditions apply:
- the disease poses an **immediate health hazard** to the local population
 - there is a **significant number** of cases
 - the disease is **important**, in terms of its severity and/or its capacity to spread
 - cases have occurred in a **high-risk establishment** e.g. schools, hotels, hospitals, nursing homes and residential homes, guesthouses and food premises.
- 3.4 Broadly, an outbreak can be defined as:
- an incident in which two or more people experiencing a similar illness are linked in time/place.
 - a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.
 - a single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio.
- 3.5 Two types of outbreaks are considered:
- acute outbreaks – which lead to a sudden increase in numbers of cases; often associated with a point source
 - persisting outbreaks – which develop over a number of days and weeks; often involving a disease in which person to person spread is common (with or without an initial point source)

a Definition of minor and major outbreaks

i Minor outbreak

A minor outbreak is one that can normally be investigated and controlled within the resources of the local HPU, the Local Authority Environmental Health Services and the appropriate microbiology laboratories. In a minor outbreak, an Outbreak Control Team (OCT) will not usually be convened but investigation and management of the outbreak will require close collaboration between local health professionals.

ii Major outbreak

A major outbreak is defined as one in which

- A large number of people, or multiple cohorts of people, are affected and may include residents from beyond the local HPU area
- The organism involved is unusually pathogenic (*e.g.* diphtheria, viral haemorrhagic fever *etc*)
- There is a potential for transmission to large numbers of people (*e.g.* widespread distribution of food product, public water supply or point source affecting large numbers).

b Major incident status

At such time that a major outbreak is affecting large numbers of the population, consuming increasing health care resources and stretching the local capacity to deal with clinical, professional and media demands, the OCT may declare a major public health emergency. On declaration of such an emergency the local PCT or HPU will alert the appropriate local NHS Trusts to come to major emergency status and bring local major incident plans into effect.

3.6 Declaring an outbreak

The ultimate decision about whether to declare an outbreak and its classification as major or minor will rest primarily with the CCDC but, depending on the circumstances, may involve other relevant people such as the Head of Environmental Health, Community Infection Control Nurse, Director of Public Health, Consultant Microbiologist/Virologist, Director of the North West Health Protection Agency Laboratory.

4 Roles and Responsibilities

4.1 Health Protection Agency

The Regional Management team will ensure that arrangements are always in place to support the appropriate management of outbreaks. The Regional Management Team will also ensure that when necessary additional measures are put in place to maintain business continuity and business recovery so that an effective level of delivery of health protection services is maintained during and immediately after a significant outbreak of infectious disease. The management team will discharge this responsibility through individual unit directors and corporately through operational and business meetings

4.1.1 Xxx Health Protection Unit

The CCDC or nurse consultant (hitherto referred to as HPU Consultant) will:

- make the decision to call an OCT
- act as chairperson
- ensure membership is appropriate
- coordinate the investigation of the outbreak
- be responsible for coordinating work on the control of the outbreak
- lead the epidemiological investigation and data analysis
- act as Proper Officer as appropriate
- ensure effective communications
- notify the Regional Epidemiologist
- inform the health protection services in neighbouring districts
- support the PCT infection control nurse to advise on infection control measures in the community
- provide advice to investigating officers and community staff assisting in the management of the outbreak
- participate in education and training to support this plan

4.1.2 Health Protection Agency Laboratory Service will:

- provide a full microbiology service (including virology and serology) for the investigation of major outbreaks
- issue an outbreak log number (I log number)
- provide support and advice for field investigation officers
- provide a representative to be a member of the OCT as appropriate

- participate as necessary in the inspection of premises and collection of samples.
- ensure that positive results are communicated promptly by telephone to the Outbreak Control Officer
- ensure that all results are reported promptly in writing to the Outbreak Control Officer and other relevant personnel
- refer specimens to, and liaise with, the relevant reference laboratories, as appropriate

4.1.3 Health Protection Agency North West/ Regional Epidemiologist:

- provide advice and support as required to the OCT
- inform and liaise with HPA Centre for Infections
- inform and liaise with the appropriate personnel in Government Office North West (GONW) and the Department of Health (DH)
- in certain circumstances may act as chair of the OCT e.g. when outbreaks affect more than one SHA area or involve complex/high profile incidents

4.2 **XX** PCT

During this current period of re-organisation there are likely to be differences between PCTs with respect to configuration of community service provision and commissioning.

4.2.1 Commissioning function

Director of Public Health will:

- have overall executive responsibility for reviewing the health of the population including the surveillance, prevention and control of communicable diseases and infections.
- represent the PCT on the Outbreak Control Team either in person or through an appropriate deputy.
- act as Proper Officer if this is in accordance with pre-existing local arrangements
- ensure, in liaison with the provider function of the PCT or Community Healthcare Trust, (insert appropriate wording to suit local arrangements) that appropriate resources are available to support the investigation and control of outbreaks, including human, financial and other resources e.g. the assistance of community staff, funding of vaccinations
- ensure 24-hour PCT emergency management availability
- ensure that hospitals are alerted and able to cope with a potential influx of patients
- ensure that The Strategic Health Authority Chief Executive is informed

- ensure PCT Chief Executive and Chairman are informed
- liaise with other PCTs as appropriate
- assist the HPU Consultant with media and other relations if required.

PCT infection control nurse will:

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- be a member of the OCT as appropriate
- provide advice and guidance to the OCT on matters of infection control
- provide advice to health staff and the general public on infection control issues
- provide infection control advice to investigating officers and community staff assisting in the management of the outbreak
- assist the HPU Consultant in the investigation and management of the outbreak as required
- liaise as appropriate with PCT-related professionals e.g. general practitioners, pharmacy leads, clinical governance leads etc.
- participate in education and training to support this plan
- be responsible for updating the joint infectious diseases outbreak plan annually, or more frequently if necessitated by organisational or other changes, in line with the regional outbreak plan template.

Chief Executive of the Primary Care Trust will:

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- ensure that adequate resources and staff are available to allow the investigation and control of the outbreak to proceed without hindrance.
- assist HPU Consultant with media and other relations if required.
- maintain a written plan for the response to major outbreaks of infection.

4.2.2 Service provider function

The Director of Infection Prevention and Control (or other appropriate person) will:

- represent the community service provider organisation on the Outbreak Control Team either in person or through an appropriate deputy.
- arrange for the availability of resources as required for the investigation and control of outbreaks, including human, financial and other resources e.g. the assistance of community staff, funding of vaccinations
- ensure 24-hour emergency management availability

- arrange for communication with relevant primary care staff and other healthcare staff in the district
- co-ordinate the primary and community care response

Community service provider organisation infection control nurse will:

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- be a member of the OCT as appropriate
- in liaison with the PCT infection control nurse, provide advice and guidance to the OCT on matters of infection control
- in liaison with the PCT infection control nurse, provide advice to community staff and the general public on infection control issues
- in liaison with the PCT infection control nurse, provide advice to investigating officers and community staff assisting in the management of the outbreak
- assist the HPU Consultant in the investigation and management of the outbreak as required
- liaise as appropriate with PCT-related professionals e.g. general practitioners, pharmacy leads, clinical governance leads etc.
- participate in education and training to support this plan

Chief Executive of the Community Service Provider Organisation will:

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- ensure that adequate resources and staff are available to allow the investigation and control of the outbreak to proceed without hindrance.
- assist HPU Consultant with media and other relations if required.
- maintain a written plan for the response to major outbreaks of infection in the community Trust.

4.3 XX Acute Health Services NHS Trust/ NHS Foundation Trust (delete as appropriate)

4.3.1 Consultant Microbiologist/Virologist will:

- present relevant information to the HPU Consultant and OCT
- ensure laboratory tests are undertaken appropriately and promptly
- ensure that positive results are communicated promptly by telephone to the Outbreak Control Officer
- ensure that all results are reported promptly in writing to the Outbreak Control Officer and other relevant personnel
- ensure that specimens are referred and transported promptly to appropriate specialist services (e.g. HPA laboratory services) as required

- provide advice and guidance on the microbiological aspects of the investigation and control of the outbreak.
- assist the HPU Consultant and clinical colleagues with treatment and prophylaxis protocols.
- ensure that appropriate infection control measures are being implemented throughout the hospital.
- maintain hospital infection control policies and outbreak control plans

4.3.2 Chief Executive of NHS Acute Trust will:

- ensure that clinical services are available for the diagnosis and treatment of cases and contacts
- ensure that the hospitals have adopted suitable admissions policies including the need to stop non-emergency admissions and arrangements for patient isolation as appropriate
- assess the need for ward closures and emptying to allow for increased numbers of admissions and potential staff illness
- ensure that appropriate infection control measures are being implemented in the hospital
- co-operate with the requests of the OCT
- encourage medical, nursing and other staff to assist the OCT in the management of the outbreak.
- ensure that all necessary resources are available to the OCT as appropriate
- maintain a written plan for the response to outbreaks of infection in the Acute Trust.

4.4 XX Council

4.4.1 The Local Authority (for outbreaks which have or may have an environmental component) be responsible for:

- making a control room available if needed.
- ensuring an incident log of all the actions taken by the Authority during the outbreak is maintained.
- providing adequate resources, including administrative and investigative staff including, when necessary, outside normal office hours.
- liaising with other departments of the Local Authority and/or neighbouring Local Authorities as appropriate.
- informing and consulting with relevant bodies/agencies, (e.g. Food Standards Agency, Health & Safety Executive).

- where necessary, in conjunction with the nominated Proper Officer(s) for the Local Authority, arranging for the exclusion from work of food handlers.
- co-ordinating media enquiries and arranging press briefings in line with the arrangements agreed by the OCT (and in line with the Emergency Plan for Major Incidents).
- arranging adequate refreshments for staff working in connection with the outbreak.
- arranging for assistance from voluntary organisations if required (in line with the Local Authority's Emergency Plan for Major Incident).
- keeping elected members and senior management informed of the outbreak as appropriate.
- any other actions as necessary and agreed with the Outbreak Control Team.

4.4.2 Outbreak Coordinating Officer (for outbreaks which have or may have an environmental component) will:

- co-ordinate the Local Authority's investigation and response (not to be confused with the Chair of the Outbreak Control Team)
- usually, but not necessarily, be a senior EHO
- be a member of the Outbreak Control Team
- present to the OCT relevant information relating to the outbreak in a timely fashion
- supervise administrative and field staff
- in conjunction with the HPU Consultant produce an appropriate incident-specific investigation form (because of the wide range of organisms covered by this plan, it is not feasible to append a template investigation form)
- arrange for the necessary information to be gathered from all suspect cases, contacts and other relevant parties e.g. controls.
- arrange for the collection of specimens and their submission to the laboratory
- arrange, as necessary, for environmental investigations
- arrange for appropriately authorised officers to gather evidence in accordance with Police And Criminal Evidence legislation and other relevant legislation, to allow the Local Authority to decide whether legal proceedings are appropriate (guidance on chain of evidence is at Appendix 6).
- ensure the necessary inspections of premises is undertaken
- ensure that all appropriate follow-up action as agreed by the CT is taken when necessary

- make the necessary arrangements for enforcement actions e.g. exclusions, closures, service of notices etc.
- ensure that recording charts are kept up to date
- ensure that all investigating officers are aware of the Ilog number
- arrange daily morning briefing of all staff involved in the outbreak
- provide an up to date emergency contact list of appropriate Local Authority staff
- act as a contact officer with appropriate outside bodies/agencies (e.g. Food Standards Agency, Health & Safety Executive, other Local Authorities)
- inform appropriate bodies and officers of the Council

Please note: the term outbreak coordinating officer is simply a generic term used in this plan, to refer to the individual who takes responsibility for the tasks outlined above. The role may be known by another term in different localities.

4.4.3 Investigating Officers (this will usually be Environmental Health staff for outbreaks which have or may have an environmental component)

- investigate each case and appropriate contacts and controls; complete questionnaires as fully and accurately as possible and give all necessary advice and guidance to those being investigated
- return completed investigation forms promptly to the Outbreak Coordinating Officer.
- ensure suitable provision is made for collection of specimens
- advise the Outbreak Coordinating Officer (normally at the daily briefing) where specimens require collection in order that the Outbreak Coordinating Officer may nominate persons to ensure collection is made.
- collect food and environmental samples as requested by the OCT
- ensure that all specimens are clearly labelled with the correct I Log number to facilitate easy and accurate collation of outbreak data

In outbreaks which do not have an environmental component the OCT will identify appropriate personnel to undertake the responsibilities outlined above.

4.5 The press officer

The designated lead press officer may be from any of the key organisations and will:

- provide advice to the OCT on media relations.
- help to prepare press releases and statements.
- ensure such material is circulated appropriately.
- organise press conferences and media briefings as appropriate.
- be the initial point of contact for all media enquiries.
- liaise with the press officers of all the key organisations.

5 Outbreak Management

5.1 Recognition of an outbreak

Each partner organisation has its own procedures for surveillance, detection and control. Outbreak of infection may sometimes be extremely obvious. This will occur if a specific group is involved. However, if patients are cared for by different general practitioners or admitted to several hospitals, awareness of the extent and severity of an outbreak may be slow to emerge.

Outbreaks of infection may be identified from the following sources:

- statutory notifications and routine surveillance
- laboratory services
- informal reports from GPs and hospital clinicians
- residential establishments
- members of the public *e.g.* complaints are frequently received by Environmental Health. Sometimes these reports can come via the media
- neighbouring PCTs and local authorities
- the Regional Epidemiology Unit
- HPA CDSC

5.2 Initial response and preliminary investigation

As soon as there is a suspicion that an outbreak has occurred the HPU Consultant, the Environmental Health Officer (if relevant), PCT Infection Control Nurse and other relevant personnel will hold informal discussions.

The key objectives in the initial phase are to determine the following:

- Whether a problem exists
- The nature and extent of the outbreak
- What immediate steps need to be taken to
 - Identify those who are ill
 - Ensure patients receive appropriate care
 - Identify those at risk
 - Control the source
 - Contain the infection
- Whether the episode is of sufficient significance to require special arrangements for investigation and management

5.3 Outbreak not confirmed

There may be insufficient evidence to confirm an outbreak although suspicion may remain. It is then necessary to collect further evidence before the occurrence of an outbreak can be excluded.

5.4 Action in the event of a minor outbreak

A minor outbreak will normally be managed by the HPU Consultant, the PCT ICN and the lead EHO with other staff of the Environmental Health Department. There will be close liaison and meetings as required.

Individual roles and responsibilities will be agreed at the outset. The HPU Consultant will normally take the lead. Provision for appropriate resources including personnel will be decided.

Appropriate advice will be sought as necessary.

5.5 Action in the event of a major outbreak

The decision to implement the major outbreak plan will normally be taken by the **XX** Health Protection Unit after consultation with the PCT and the Local Authority. The HPU Consultant will declare and initiate the action for a major outbreak and will convene a meeting of the OCT (see section 6).

The location of the incident control room will be determined by the circumstances at the time. The following have been identified as potential incident control rooms:

Insert as appropriate

The equipment/facilities which may be required are listed at Appendix 1.

5.6 Systematic investigation

A systematic approach to the investigation and control of an outbreak is required. A schematic overview is shown at Appendix 2, a checklist at Appendix 3 and definitions at Appendix 4.

The purpose of systematic investigation is to provide timely and reliable information on which to base sound decisions about the management of the outbreak.

5.7 Epidemiological investigation

See Appendix 5.

Epidemiological investigation is the responsibility of the HPU Consultant.

5.8 Microbiological investigation

Involves the appropriate microbiological analysis of samples from human cases, contacts, food, water, the environment and animals to identify the causative organism and its likely origin.

Human microbiological investigation is the responsibility of the Acute/Foundation Trust Consultant Microbiologist/Virologist and the Health Protection Agency Laboratory Service.

5.9 Environmental and organisational investigation

Is undertaken to highlight possible vehicles of infection and modes of transmission including examination of food handling practices, review of premises and personal hygiene, scrutiny of procedural documentation and critical records and tracing all risk foods back to source (as appropriate).

Environmental investigation is the responsibility of the Local Authority Environmental Health Department.

5.10 Veterinary investigation

If appropriate.

Veterinary investigation is the responsibility of Animal Health.

5.11 Samples and legal issues

All personnel involved in the taking or handling of any samples must be mindful of chain of evidence issues if criminal prosecutions may result from the investigation (Appendix 6).

5.12 Control measures

The basic principles of communicable disease outbreak control are:

- (i) Control the source (may be animal, human or environmental)
- (ii) Control the mode of spread
- (iii) Protect persons at risk
- (iv) Continue surveillance of control measures

A systematic approach to the investigation and the rigorous application of scientific methods allow control measures to be implemented with greater confidence of success. Control measures may be directed at the source or the vehicle or both. Measures will depend on the mode of spread and the particular circumstances of the outbreak.

Control may also include offering protection to people at risk (e.g. giving immunoglobulin to those exposed to infection during an outbreak of hepatitis A). Continued monitoring, both of the control measures themselves and to identify any further cases of illness associated with the outbreak, is essential to ensure that the measures are working.

5.13 General responsibilities

It is the responsibility of the OCT to:

- ensure adequate control measures are identified, implemented, and monitored to ensure their effectiveness and to ensure that no potential continuing sources of infection exist
- make recommendations to the PCT on chemo / immuno—prophylaxis as necessary
- be responsible for general medical advice to the public.

It is the responsibility of the HPU Consultant to:

- ensure that the OCT receive adequate information in order to institute preventive actions
- make recommendations on isolation, exclusion and segregation of infected persons as necessary (acting with the lead EHO to perform such duties according to public health law)

It is the responsibility of the EHO to:

- manage the disinfection, removal or treatment of known or suspected environmental sources of infection

It is the responsibility of the Hospital Infection Control doctor or nurse to:

- take measures to control the spread of infection on hospital/Trust premises.

5.14 Record keeping

Detailed recording of all aspects of the outbreak and its management must be undertaken. Legal action may ensue and this should always be borne in mind.

Detailed minutes will be taken at every meeting. The minutes will document all decisions taken and actions agreed and by whom they should be taken. The minutes will remain confidential.

A nominated person will be responsible for documentation of all the events and information related to the outbreak plan. All correspondence and minutes of meetings should be filed together in chronological order.

Individual members of the OCT should keep personal logs of their activities and include details of information received, conversations held and meetings attended.

All documentation, including computer-generated information relating to the outbreak must be retained and regular back-ups of electronically stored information made.

An initial report will be completed after the preliminary inquiry if possible within 48 hrs and a final report at the end of the investigation, which must be suitable for publication.

5.15 Information to the media and general public

The OCT will appoint a media spokesperson and will, with the support of the press officer, prepare interim and final briefing statements to be used by that person. Any statements will be circulated to all team members and to all relevant organisations as agreed by the OCT.

During an incident the Team will decide:

- the information to be made available to the press and public – there are advantages in providing a daily update for the press at an agreed time and for the production of media briefing notes;
- the timing and methods in which such information should be released. Special arrangements may need to be made for those who may not hear or understand the advice given;
- whether to establish a telephone information service for the public.

In reaching decisions on these issues, the OCT should be alert to the importance of providing early and clear information on the nature and scale of the problem and on the action recommended, if any, and of updating this information regularly.

A press officer will be identified who will act as the initial point of contact for all media enquiries.

Information will be reinforced throughout the outbreak. When the outbreak has been controlled those at risk initially must be informed.

5.16 Confidentiality and communication

Individual clinical/food histories should be treated as medical records and managed with the same degree of confidentiality, according to 'Caldicott' principles.

All members and co-opted members of the OCT should be fully appraised of the requirement for confidentiality.

Personal medical information should generally not be divulged without permission.

Information given or obtained for one purpose should not be used for a different purpose without the consent of the provider of the information.

The fact that the name of an ill person is already known to others and the media is no reason to breach confidentiality. General information on a need to know basis, which will not identify a person, can be provided to others.

The OCT may disclose information about a person in certain circumstances to prevent serious risk to public health or the health of other individuals. Each disclosure is considered on its merit after consultation with relevant people.

All data, including computer-held data, are covered by the Data Protection Act 1998. Information on manual records may be subject to the Access to Health Records Act 1990.

5.17 End of the outbreak

The OCT will decide when the outbreak is over and will make a statement that there is no longer a risk to public health.

A debriefing meeting of the OCT should be convened to consider the lessons learned and any further preventive action required.

A standard summary form should be completed and sent to HPA Centre for Infections, usually by the HPU Consultant.

A full report will be prepared and agreed by the OCT. The report should be suitable for publication and will be circulated as appropriate. The final outbreak report should be submitted to the appropriate Local Authority Committee as the formal route into the public domain. It may in some cases be necessary to delay or limit the publication of the report pending legal action.

6 Outbreak Control Team (OCT)

6.1 The role of the OCT

The role of the OCT is to agree and coordinate the activities of the agencies involved in the investigation and control of the outbreak in order that the aetiology, vehicle and source of the outbreak are identified and control measures implemented as soon as possible and if required legal advice sought.

6.2 The authority of the OCT

The OCT works with the delegated authority of either the PCT or the Local Authority. This should be clearly stated and recorded at the first meeting.

6.3 Establishment of the Team

The decision to convene the OCT will usually be taken by the HPU Consultant.

Each core member of the OCT shall have equal status to any other.

During the course of an investigation or incident the OCT shall have the power to co-opt such other members as it feels appropriate.

6.4 Membership of the OCT

6.4.1 The core members of the OCT will, depending on the circumstances, usually include:

- HPU Consultant, XX Health Protection Unit
- Senior Environmental Health Officer
- Infection Control Nurse, XX PCT
- Director of Public Health (or nominated deputy), XX PCT
- Director of Infection Prevention and Control, Community Service Provider Organisation
- Infection Control Nurse, Community Service Provider Organisation
- Consultant Microbiologist/Virologist, XX Acute Trust
- Consultant Microbiologist/Virologist, Health Protection Agency laboratory service

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Depending on the size and nature of the outbreak, other members may be co-opted as necessary from a wide range of agencies, but need not all be accorded full member status.

6.4.2 The status of individual OCT members should be decided at the first meeting *e.g.* full member, observer etc.

6.4.3 Members are required to declare any possible conflicts of interest as individuals or on behalf of their organisations. Any declarations of a conflict of interest should be recorded and a decision made by the chair on that individual's status *e.g.* whether they are to remain on the OCT, whether they attend for specific sections of the meetings etc.

6.5 Arrangements for the OCT

Full secretarial services to support the Team will usually be provided by the host authority at the location decided for the meeting.

Each meeting will have an agenda, usually determined by the HPU Consultant (see Appendix 7 for a suggested agenda).

6.6 Cross-boundary outbreaks

When outbreaks cross administrative boundaries the Senior EHO (or appropriate designated alternative) will inform the relevant Local Authorities and the HPU Consultant will inform the relevant Health Protection Unit(s). The neighbouring Health Protection Unit will then inform the relevant PCTs.

The HPU Consultant and an EHO from the area where the outbreak originated will usually take the lead roles, although the relevant officers from other affected districts will be involved in meetings and decision taking. The lead authorities should be identified at the first joint meeting.

If possible there should be a single OCT.

Each authority will make available at the request of the joint OCT, the necessary resources to effectively investigate and control the outbreak. It is inevitable in a cross boundary outbreak that relevant information may need to be released to a neighbouring authority/agency. Information will be released on a "need to know" basis. All authorities and agencies will ensure confidentiality of information obtained during cross boundary outbreaks.

A common dataset and database should be established as soon as possible.

6.7 Terms of reference

The OCT must agree its terms of reference at the first meeting. Suggested terms of reference are listed below.

- i. to confirm the existence of an outbreak;
- ii. to establish case definitions;
- iii. to establish the extent of the outbreak through active case finding;
- iv. to identify an appropriate outbreak Coordinating Officer dependent on nature of outbreak;
- v. to coordinate all arrangements for the investigation of the source and cause of the outbreak;
- vi. to coordinate the control measures to be employed;
- vii. to ensure that all necessary steps are being taken for the continuing clinical care of patients during the outbreak;
- viii. to ensure, if the outbreak is likely to lead to a significant increase in hospital admissions, that hospital managers are made aware of the need to assess requirements for additional supplies and staff;
- ix. to establish effective and consistent communications – internally, between organisations and with the public; including with the press. Appoint an appropriate media spokesperson.
- x. to assess the need for additional resources including administrative support;
- xi. to ensure the OCT has the appropriate membership and to co-opt additional members as appropriate
- xii. to agree and assign individual responsibilities to the members of the OCT
- xiii. to consider the need for outside help and expertise;
- xiv. to provide clear instructions and/or information for staff;
- xv. to provide information for general practitioners, members of the public, PCT members, and elected members of XX Council ;
- xvi. to ensure communication with the Strategic Health Authority, Regional Epidemiologist, HPA Cfl, Department of Health, Government Office North West and others where appropriate e.g. FSA, DEFRA;
- xvii. to ensure prompt, consistent, accurate and adequate information is available to the media;
- xviii. to meet as frequently as necessary in the circumstances of the particular outbreak and maintain an agreed detailed written record of all meetings;
- xix. to define the end of the outbreak and to state the lessons learned;
- xx. to prepare for the consideration of the relevant local and health authorities, a preliminary report, ideally within 48 hours, interim reports if necessary and a final report.

7 Training and Review of Plans

- 7.1 This plan should be tested at regular intervals (ideally on an annual basis) and the appropriate training be arranged for all those likely to be involved in outbreak investigation and control.
- 7.2 It is the responsibility of the HPA NW policy group to update the regional outbreak plan template. It is the responsibility of the PCT Infection Control Nurse in conjunction with the appropriate HPU Consultant to ensure the local plan is updated annually or more frequently as dictated by organisational or other changes. Ideally changes should be in line with the regional template. Any proposed changes or amendments to the plan will be formally notified in writing to the key personnel immediately.

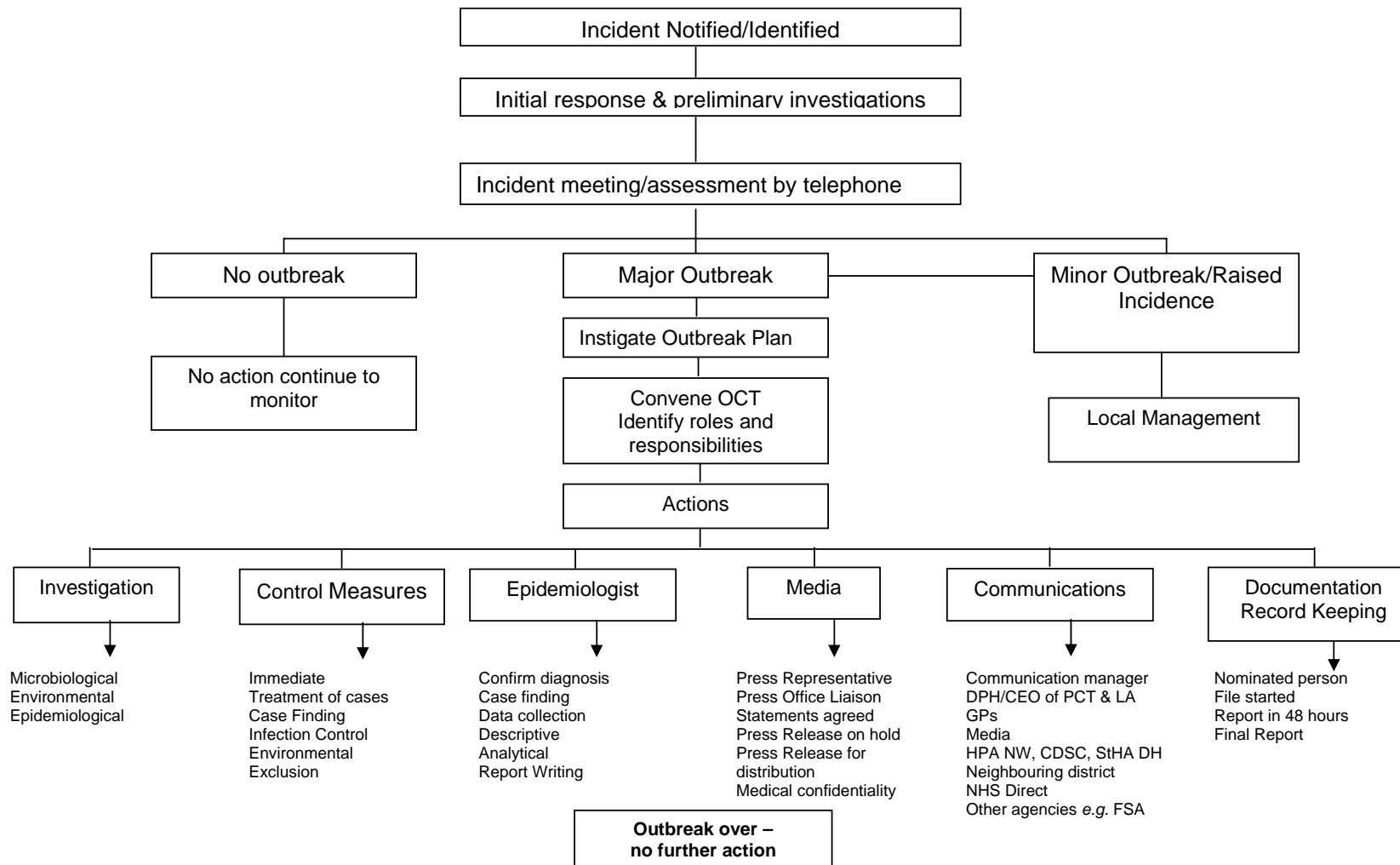
Appendix 1

Incident Room Suggested Checklist

Stationery	Pens - black, blue green red Felt tip pens Pencils Scissors Sellotape Staples and staple remover Tippex Hole punch Date stamp and pad Paper clips, drawing/map pins, filing tags Erasers Calculators Envelopes
Paper	A4/A3 sectional pad A4/A3 graph paper A4 refill pad Telephone message pad Removable self-stick notes
Files	A4 box files A4 ring binder files A4 lever arch files A4 correspondence files A4 transparent document files A4 document wallets Magazine box files (open) Computer printout files
Maps	A to Z Street maps - various UK atlas
Other	Telephone directories Flip charts and holder Camera Card index boxes and cards Notice board or white board with marker pens Hospital Year Books PHLS directories Municipal Year Book Proper Officer directories
Equipment	Telephone Fax PC E-mail Printer Photocopier Terminal

Arrangements for suitable refreshments for members of the OCT.

Appendix 2 – Flow Chart for the Management of an Outbreak



Appendix 3

The Investigation and Control of an Outbreak – Check List

[Source: Management of Outbreaks of Foodborne Illness: Department of Health, December 1994]

This step-by-step approach to the investigation of an outbreak is not meant to imply that each action must follow the one preceding it or that all steps are needed on every occasion. In practice some steps will be carried out simultaneously and others, for example, communication and collation of data, will be required throughout the whole process.

Preliminary phase

- Consider whether or not the cases have the same illness and establish a tentative diagnosis;
- Determine if there is a real outbreak;
- Collect specimens and consider informing local GPs;
- Conduct in-depth interviews with initial cases;
- Identify factors common to all or most cases;
- Conduct site investigation at implicated premises;
- Consider formal requests for information;
- Form preliminary hypothesis;
- Consider if there is a continuing public health risk;
- Initiate immediate control measures;
- Decide whether to convene a formal outbreak control group;
- Make decision about the need for further investigation;
- Inform FSA if food-related;
- Consider need to formally seek legal advice.

Communication

- Consider best routes of communication with colleagues, patients and the public;
- Ensure accuracy and timeliness;
- Include all those who need to know;
- Use the media constructively;
- Prepare written report for local use and for other relevant agencies;

Descriptive Epidemiology

- Draw up lists of those at risk;
- Identify persons posing a risk of further spread;
- Establish a case definition;
- Identify as many cases as possible;
- Collect data from affected persons on standardised questionnaire;

Analysis and interpretation

- Calculate attack rates;
- Confirm factors common to all or most cases;
- Categorise cases by “time, place or person” associations;
- Construct epidemic curve;
- Review all existing data;
- Review hypotheses;
- Collect further clinical and food specimens for laboratory tests;
- Carry out analytical epidemiological study;
- Ascertain source and mode of spread.

Control measures

- Control the source: animal, human or environmental;
- Control the mode of spread;
- Protect persons at risk;
- Continue surveillance of control measures;
- Declare the outbreak over (usually) when the number of new cases has returned to background levels.

Further studies

- Conduct further analytical case/control or cohort studies;
- Conduct further microbiological studies

Conclusion of OCT

- Produce final report on outbreak.

Appendix 4

Definitions

Airborne transmission	This is due to the formation of droplet nuclei by evaporation; the particles are small and can be widely dispersed.
Carrier	People who intermittently or continuously harbour infective organisms without suffering the clinical manifestations of the disease. People who excrete the organisms only occasionally are referred as intermittent carriers. Convalescent carriers are those who remain infective if this condition persists over months or years. Typhoid carriers may excrete the organism for years because <i>Salmonella typhi</i> infects the gallbladder. Some infections are carried by people who give no history of illness caused by the agent. This healthy carrier state occurs in diphtheria and meningococcal infection.
Case	A person in the population or study group identified as having the particular disease, health disorder, or condition under investigation. A variety of criteria may be used to identify cases e.g. individuals physicians' diagnosis, registries and notifications, clinical notes, population screening and reporting of defects.
Case Definition	<p>The public health action required depends on the case definition. A case can be defined as</p> <ul style="list-style-type: none">• <i>Confirmed</i> e.g. clinical diagnosis of the condition confirmed microbiologically as caused by an identified organism• <i>Probable</i> e.g. clinical diagnosis of a condition without microbiological confirmation in which consultation took place with the clinician managing the case, considers that it is most likely caused by the condition under investigation• <i>Possible</i> e.g. as probable case, but the consultation with the clinician managing the case, considers that it is unlikely caused by the condition under investigation.
Case control study	A study, which starts with identification of persons with the disease of interest and a suitable control group without the disease. The relation of an attribute to the disease is examined by comparing the diseased and not diseased with regard to how frequently the attribute is present in each group.

Cohort study	The method of epidemiological study in which subsets of a defined population can be identified who have been exposed or not exposed to a factor, which influence the probability of the occurrence of the disease.
Communicable disease	Synonymous with 'infectious diseases' and sometimes referred to as 'contagious disease or 'transmissible diseases'. Communicable diseases are caused by a living organism and transmitted by person to person or animal or bird to man either directly or indirectly.
Contact	A person who has the opportunity to acquire infection by virtue of having come into contact with an infected individual or animal, or contaminated environment.
Droplet transmission	Infection caused by a projection of small droplets from the nose or mouth due to sneezing, coughing, talking or exhaling. The range of spread is usually limited to a few feet.
Endemic	An endemic disease is one, which is constantly present in a given geographical area; although it may temporary increase its incidence to become an epidemic.
Epidemic	An epidemic is an increase in the frequency of occurrence of a disease in a population above its baseline level for a specified period of time.
Exclusion	Means advice to refrain from or prohibition of working. In most circumstances it will be the responsibility of the food business manager to ensure this advice is heeded. In some situations it may be appropriate for exclusion advice to be reinforced by a formal exclusion notice given in writing by Warwickshire Environmental Health Services, signed by the HPU Consultant under Section 20 of the Public Health (Control of Disease) 1984.
Food Handler	There is no legal definition of a food handler but usually a food handler is understood to be any person who handles or prepares food whether open/unwrapped or packaged. The primary concern is the avoidance of microbiological contamination of food by infected persons whether by direct contact with open food or by indirect contact with surfaces in production and processing areas.
Food poisoning	Any disease of an infectious or toxic nature caused by, or thought to be caused by, the consumption of food or water.

- Incubation period The time which elapses between the person becoming infected and the appearance of the first symptoms. Its length is mainly determined by the nature of the infecting organism but it is also influenced to some extent by the dose of the organism, the route of entry into the body and the susceptibility of the host.
- Outbreak An incident in which two or more persons have the same disease, similar symptoms or excrete the same pathogens and in which there is a time, place and/or person association between these persons. An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number. A foodborne or waterborne outbreak results from ingestion, by those affected, by food or water from the same contaminated source or which has become contaminated in the same way.

Appendix 5

Epidemiological Investigation –

Steps to be taken in an epidemiological investigation

Establishing that a problem exists and confirming the diagnosis	<p>A report of an outbreak of infection may be mistaken. It may result from increased clinical or laboratory detection of cases, changes in reporting patterns, changes in the size of the 'at risk' population or false positive laboratory tests.</p> <p>The HPU Consultant should liaise directly with the Consultant Microbiologist/Virologist to assess the interpretation of test results, the need for confirmatory test etc.</p>
Establishing a case definition	<p>Cases can be diagnosed either clinically or by laboratory investigations. At an early stage it is important to produce and adhere to a clear case definition (using disease, time and place). This is particularly important with previously unrecognised diseases in which proper definitions are needed before epidemiological studies can proceed.</p>
Immediate control measures	<ul style="list-style-type: none">• Control measures involve either controlling the source of infection, interrupting transmission or protecting those at risk.• Ensure cases receive appropriate medical care• Advise on appropriate precautions for cases and contacts including: investigation, screening and follow-up; isolation; hygiene; criteria for exclusion from the return to work• Antibiotic prophylaxis; and immunisation.• Advise on organisational issues including catering practices, disinfection and waste disposal. Serve enforcement and/or food seizure notices if appropriate.
Case finding	<p>In an episode of infection, the cases that are first noticed may only be a small proportion of the total population affected and may not be representative of that population. Efforts must be made to search for additional cases. This allows:</p> <ul style="list-style-type: none">• the extent of the incident to be quantified,• a more accurate picture of the range of illness that people have experienced,• individual cases to be treated and control measures to be taken• identification of subjects for further descriptive and analytical epidemiology.

- Searching for additional cases
- statutory notifications of infectious disease
 - requests for laboratory tests and reports of positive results
 - people attending their GPs, the local accident and emergency department, hospital inpatients and outpatients
 - reports from the occupational health departments of large local businesses
 - reports from schools of absenteeism and illness
 - household enquiries
 - appeals through TV, radio and local newspapers
 - screening tests applied to communities and population sub-groups

- Case definition
- A simple definition of a “case” for the purpose of the outbreak should be formulated.
 - The initial case definition should be designed to include all those reasonably part of the outbreak.
 - It needs to be defined geographical, clinical and temporal parameters and whether temporary residents are included.
 - Cases can be subdivided into “confirmed (on appropriate microbiological criteria) and unconfirmed (probable or possible).

Collection of data

A set of data is collected from each of the cases in a standard form. This includes name, age, sex, address, telephone number, occupation, name of GP, recent travel, immunisation history, date of illness and clinical description of illness.

Data should also be collected about exposure to possible sources of the infection. In the case of a foodborne infection this would include a recent food history. In the case of infection spread by person-to-person contact the case would be questioned about contact with other affected persons. In the case of an infection spread by the airborne route, cases would be questioned about places they had visited.

It is preferable to collect these data by administering a detailed semi-structured questionnaire in a face-to-face interview. This allows the interviewer to ask probing questions, which may sometimes uncover previously unsuspected associations between cases. Telephone interviews or self-completion questionnaires are less helpful at this stage of an investigation. It may be necessary to re-interview early cases to ask about possible exposures that are reported by later cases.

Descriptive epidemiology	<p>Cases are described by the three epidemiological parameters of time, place and person.</p> <p><i>Person:</i> includes clinical features, age, sex, occupation, social-class, ethnic group, food history, travel, leisure activity.</p> <p><i>Place:</i> includes home address, work address, recent travel <i>etc.</i></p> <p><i>Time:</i> involves plotting the epidemic curve, a frequency distribution of date or time of onset.</p> <p>The incubation period should be related to events that may have occurred in the environment of the cases and which may indicate possible sources of infection.</p>
Generating a hypothesis	<p>A detailed epidemiological description of typical cases may well provide the investigators with a hypothesis regarding the source of infection or the route of transmission. A description of atypical cases may also be helpful.</p>
Testing the hypothesis	<p>Finding that consumption of a particular food, visiting a particular place or being involved in a certain activity is occurring frequently among cases is only a first step. These risk factors may also be common among those who have not been ill. Confirmation of an association between a risk factor and disease may require further microbiological or environmental investigations or an analytical epidemiological study. This can be either a cohort study or a case control study.</p>
Ending the Outbreak	<p>The OCT has to decide when an outbreak is over and when a statement can be made that there are no longer a risk to the public health.</p> <p>A debriefing meeting should be convened to consider lessons learned and any further preventive action required.</p> <p>A standard summary form should be completed.</p>

Appendix 6

Chain of evidence issues and practical implementation

Introduction

This chain of evidence guidance note is intended to provide the forms necessary to document possible medico-legal cases and should be used in conjunction with local guidelines and SOP's. This document contains suggested forms for the collection, transport, laboratory tests and storage of samples and specimens.

Medico-legal cases have become increasingly important. There have been several incidences where cases have been dismissed due to failings in documentation, in particular failure to establish a 'chain of evidence'.

Chain of evidence

The 'chain of evidence' (or chain of custody) is a legal concept, which requires that the history and origin of any exhibit presented as evidence in a Court of Law must be clearly shown to have followed an unbroken chain from its source to the court. This chain must be intact at every stage to demonstrate that the sample or samples have not been interfered with and that the correct sample was tested and the results relate to the proper specimen. All persons handling the sample and the places and conditions of storage must be identified with times, dates and signatures where appropriate. Once the samples have reached the laboratory, the onus transfers to the microbiology laboratory to ensure that there is a specimen record, which accompanies the sample from its reception to the issue of a final report.

Any specimen sampled could potentially be involved in a court case, although these may be retrospective. Problems arise when the need to start a formal chain is not appreciated. A sample initially intended for clinical or epidemiological purposes may later be of important evidential value. Unless the chain of evidence has been initiated by the person taking the sample, the result will be inadmissible in court. For legionella incidents, a chain may involve Environmental Health Officers, nurses, physicians, pathologists, mortuary technicians, police officers, couriers, porters, laboratory staff, microbiologists and forensic scientists.

If a person is called as a witness, expert or otherwise, in a Court of Law he or she is permitted to refer to notes, lab books *etc* as an aide-memoir to his or her evidence. A Chain of Evidence Record as a booklet will negate the need/requirement to have the various documentation collated in order to present the "story" of; the sample being taken; its transit and receipt by the laboratory; the various tests undertaken with details of operators, batch numbers expiry dates of reagents and results in addition to all records of storage and re-testing. All these details will be entered and retrievable from ONE source, the Chain of Evidence Record booklet. The outcome being that ONE piece of documentation will hold ALL details, ONE document will have to be studied to provide the facts in any legal process and that ONE document need be taken and referred-to in court.

Collection and transport

The Chain of Evidence record (CER) is a formal record of the specimen's progress from point of collection of the sample to the issue of the final report. The initiator of the specimen (e.g. EHO, nurse, physician) should complete the first part of a Chain of Evidence record (one record for each specimen), seal the sample in a tamper-proof container, label it fully and hand it to the next person in the chain. The Chain of Evidence record should include a fully documented (time, date, place and signatures) chain of persons handling the sample and in addition records the conditions of the specimen's storage.

The sample should be fully labelled and include:

- the name of the person initiating the chain
- description of the sample
- sample site
- the date
- the time (24 hour clock)
- signature of the person initiating the chain
- patient hospital number allowing the sample to be anonymous (if appropriate)

If the results of laboratory investigations are to be used as forensic evidence the Chain of Evidence record must be shown to be intact.

To demonstrate the validity of the chain ALL persons handling the sample should enter the following details on the CER:

- place of storage
- conditions of storage
- date
- time (24 hour clock)
- designation of custodian
- signatures of custodian.

If location of collection and the investigating laboratory are at two different locations the receiving laboratory should be informed that a medico-legal specimen is being sent to the lab. All couriers who handle the specimen(s) must be part of the chain of evidence and sign the record that accompanies the specimen.

NO breakdown or failure of the chain should occur. ALL details MUST be entered into the Chain of Evidence record at EVERY stage of its examination and storage and at every stage of retrieval from storage and re-examination of the specimen.

Laboratory investigations

At every stage of the process in the laboratory a record must be kept of who received the specimen, who processed it and how (with a record of the SOP followed), batch numbers of all reagents and kits used and that any equipment has been calibrated, regularly serviced and maintained and a record kept. If the specimen would normally be rejected a signed disclaimer stating 'this sample was processed in good faith by the laboratory' should be appended as a repeat specimen may not be available. The number of staff handling the specimen should be kept to a minimum. If confirmatory tests are indicated enough of these should be done, and of a different type, to prove isolate identity.

Reporting

All telephone conversations relating to the specimen or isolate should be recorded. The final report should not contain any ambiguities or comment that could be interpreted in more than one way and the final report, together with all request forms, chain of evidence records and other paper work relating to the case should be kept in a locked filing cabinet indefinitely.

The Royal College of Pathologists sets out guidelines for retention of routine patient records and pathology samples¹. With regard to medical-legal cases it also states that hand-written notes are preferable to electronically stored information.

Referral of specimen or organism(s) to another laboratory (e.g. reference laboratory)

If the isolate(s) need to be referred to a reference laboratory for further specialist testing e.g. phage-typing or PFGE this should be fully documented and the reference laboratory informed as the chain of evidence must still be in place. The reference laboratory should be an accredited laboratory.

Final storage

Isolates and specimens should be stored at -70°C indefinitely, preferably in a lockable freezer with restricted access.

These procedures represent good practice by the laboratory and tie in with ISO standard 17025:2000 together with CPA standards E3 (specimen collection and handling), E5 (specimen reception), E6 (referral to other laboratories) and F3 (assuring the quality of examinations).

1 The Royal College of Pathologists. *The retention and storage of pathological records and archives (2nd edition)*. London: The Royal College of Pathologists, 1999

GUIDELINES FOR COMPLETING THE CHAIN OF EVIDENCE RECORD

Completion of this chain of evidence record brings together all the information relating to the collection, transport, laboratory testing and reporting.

All sections must be completed or struck through if not, however if the patients name is omitted for reasons of patient anonymity then the hospital or patient identifier number **MUST** be used.

All forms should be kept together. Form 2 Laboratory examination of specimens with medico-legal implications may be reproduced if further tests are needed in which case it should be renumbered 'Form 2.1, 2.2 *etc*'

Separate forms are included for:

- Taking and transport of specimens with medico-legal implications (FORM 1)
- Laboratory examination of specimens with medico-legal implications (FORM 2)
- Storage of specimens with medico-legal implications (FORM 3)

**SPECIMEN COLLECTION WITH POTENTIAL MEDICO-LEGAL IMPLICATIONS
FORM 1**

Department.....

Hospital.....

*BLOCK CAPITALS **MUST BE USED EXCEPT FOR THE SIGNATURE***

*ALL PATIENT AND SPECIMEN DETAILS **MUST BE ENTERED** BY PERSON TAKING THE SPECIMEN*

*A SEPARATE RECORD **MUST BE USED** FOR EACH SPECIMEN TAKEN*

*FORMS 1, 2 AND 3 **MUST BE KEPT TOGETHER***

Person taking the specimen	
Patient's name (may be omitted if sample is to be anonymous but MUST include Patient's hospital or clinic number)	
Patient's date of birth	
Patient's hospital or clinic number	
Ward or clinic name or number	
Specimen site	
Date specimen taken	
Time specimen taken	
Name of person taking specimen	
Position title and grade of person taking specimen i.e. Doctor grade or Nurse grade	
Signature of person taking specimen	
Clinical details	
What was done with the specimen once taken	
If you as the person taking the specimen handed it to another person please sign in this box →	
If you as the person taking the specimen delivered it to the lab yourself please sign in this box →	
As the recipient of the specimen YOU MUST ENSURE Details on specimen match	
Date specimen received in lab	
Time specimen received in lab	
Name of person accepting specimen	
Position title of person accepting specimen i.e. BMS, MLA or MTO AND grade	
Signature of person accepting specimen	
Transport details of specimen i.e. received at room temperature, on ice etc	
Time lab number assigned	
Name of person assigning lab number	
Position title of person assigning lab number i.e. BMS, MLA or MTO AND grade	

**LABORATORY EXAMINATION OF SPECIMENS WITH MEDICO-LEGAL IMPLICATIONS
SPECIMEN TESTING FORM 2**

Patient and Specimen details	
Patient's name	
Patient's hospital or clinic number	
Specimen lab. number	

SOP No.	Procedure	Reagent/kit		Operator			Tested		Result
		Lot no.	Expiry	Name	Grade	Signature	Date	Time	
	Final Result								Sent to reference laboratory Y/N
									Date sent
								Reference lab. No.	
								Result	
								Final storage location of specimen or isolate	

STORAGE OF SPECIMENS WITH MEDICO-LEGAL IMPLICATIONS FORM 3

Patient and Specimen details	
Patient's name	
Patient's hospital or clinic number	
Specimen lab. number	

	Specimen		Specimen handled		Operator / checker		
	In or out of storage	Temperature held at	Time	Date	Name	Grade	Signature
Operator							
Checker							
Operator							
Checker							
Operator							
Checker							
Operator							
Checker							
Operator							
Checker							

Appendix 7

Suggested Agenda for an Outbreak Control Team Meeting

1. Introduction
2. Attendance and Roles
 - Identify all attendees and nominate specific functional team roles as appropriate.
3. Review evidence to date
 - general situation statement
 - incident update including contacts, illness in the community, results of monitoring, protective measures, further investigation
 - patient report
 - epidemiological report
 - environmental report
 - microbiological report
 - other relevant reports
4. Management of outbreak
 - Control measures
 - Care of patients
 - Investigation
 - Case definition
 - Epidemiological
 - Microbiological
 - Environmental
5. Communication
 - to statutory bodies and organisations about the existence of the OCT and about any actions.
 - to patients and public of any control measures or protective advice decisions.
 - to GPs
 - preparation of initial press release and consideration of help lines.
 - consider establishing a subgroup.
6. Public concerns
 - Likely questions and anticipated concern with prepared responses
7. Surveillance
8. Consultation
 - Establish link with external experts
9. Obtain telephone numbers of all key personnel within and outside normal working hours.
10. Agree actions required and timetable for action. Identify individuals responsible for delivering actions as agreed.
11. Date and time of next meeting.

Appendix 8

Major Incident Telephone Helpline

The decision to set up a help line will be taken by the OCT. Organisation and planning should be delegated to a subgroup, which includes:

- a public health physician
- Telecommunications expertise.
- Access to the type of staff likely to be needed on the line.
- Someone with the managerial power to make and implement financial decisions.
- A middle manager to which organisational tasks can be delegated.

The purpose of the help line must be explicitly defined and is likely to include:

- Provision of general information to members of the public who are anxious.
- Identification of individuals at risk/contacts/cases.

Consideration should be given to using a Regional or National help line (e.g. NHS Direct). The most appropriate in an outbreak are likely to be Health wise or the Meningitis Trust. Health wise may be particularly useful in screening calls and therefore reducing the number of lines and workers required locally, thought consequently, these must all be more specialised.

Good briefing notes and data collection forms for the help line workers are essential, to provide consistent advice and to ensure completeness of any information collected. The COT would normally be responsible for their production and should cover:

- Background to the incident
- Responses to expected questions
- Procedures for following up individuals identified as at risk, contacts or cases, with a failsafe dataflow system to keep track of such individuals
- Procedures for dealing with unexpected queries
- Guidelines on confidentiality/dealing with enquiries from the press
- Details of other resources available
- Procedures for dealing with threatening or obscene calls

The following data should be collected for monitoring the help line:

- Date and time of call
- Sex, age, postcode of caller
- Category of caller e.g. general enquiry/potential case/contact
- Name, address and phone number

The media can be used to publicise the help line once a press statement has been released. It is important to notify other switchboards that may be contacted by callers e.g. neighbouring hospitals, health centres etc.

The needs of specific groups e.g. ethnic minorities and the hearing impaired should also be considered.

Staffing

Ideally, sources of an appropriate number of potential help line workers should be identified in advance, as part of the emergency planning process. They should have both appropriate knowledge of the subject and sufficient communications skills to deal with callers effectively and sympathetically. *e.g.* NHS Direct.

All should receive a careful group briefing before the lines opens, on background information, use of the equipment and completion of any forms.

Four-hour shifts are standard practice, though some workers may feel able to do two shifts. A rota covering at least the first week should be arranged at the outset. A shift supervisor is needed for each shift to deal with administration and cover staff breaks.

Operation

The hours of operation will depend on the circumstances: 8am to 9 pm is usually adequate, though continuing till midnight may be appropriate.

An answering machine with a recorded message giving the opening hours would be available overnight.

The Control of Outbreak Team must keep the help line staff fully aware of changes in the situation and a whiteboard in the help line room can be used to display new information. In particular, action may be required to deal with anxiety raised by misleading press coverage. Debriefing allows information gathered during the shift to be shared and may clarify issues of concern.

Separate numbers may be published *e.g.* one for cases and one for general public.

After the help line

The decision to close the help line will depend on the number of incoming calls and the cause of the outbreak.

A formal debriefing session for all staff involved is valuable.

A report should be prepared for the PCT, LA, HPA and appropriate national bodies.

Sources

Stark C. Christine P. Marr, C. How to do it: run an emergency help line. *BMJ* 1994;309 : 44-5.

AIDS-HIV infected health care worker: practical guidance on notifying patients. DH 1993.

Appendix 9

Contact Numbers

HEALTH PROTECTION AGENCY	
Health Protection Agency North West Out of hours: (answering machine with on-call Consultant's details)	Tel: 0151 482 5688 Fax: 0151 482 5689 Tel: 0151 482 5688
Cheshire and Merseyside Health Protection Unit Cheshire (inc Wirral) Merseyside (Liverpool, Sefton, St Helens & Knowsley) Out of hours: Mersey Regional Ambulance HQ (ask for HPA Consultant on call)	Tel: 01244 366766 Fax: 01244 366782 Tel: 0151 290 8360 Fax: 0151 290 8366 Tel: 0151 264 6922
Cumbria and Lancashire Health Protection Unit (incl Preston, Accrington and Ormskirk) Out of hours (ask to speak to the on-call consultant): Preston Royal Hospital OR Blackpool Victoria Hospital	Tel: 01257 246450 Fax: 01257 246451 Tel: 01772 716565 Tel: 01253 300000
Greater Manchester Health Protection Unit Out of hours: Tameside General Hospital switchboard (ask for the Greater Manchester Health Protection Unit on-call rota) Regional HPA Press Officer	Tel: 0161 786 6710 Fax: 0161 707 9686 Tel: 0161 331 6000 Tel: 0151 482 5688 Mobile: 07764 906508 Home: 01704 877024 Pager: 08700 555500 (ask for NWR130)
Communicable Disease Surveillance Centre (CDSC)	Tel: 0208 200 6868
CHEMICAL HAZARD & POISONS DIVISION	Main Office No: 0121 352 5240 Fax No: 0121 352 5262 Hotline No: 0870 606 4444
Andrew Kibble (Head of Unit) – Andrew.kibble@hpa.org	Office No: 0121 352 5250 Mob: 07776 234596 Pager: 07623 973771
Dr Toby Smith (Environmental Scientist) – toby.smith@hpa.org.uk	Office No: 0121 352 5260 Mob: 07799 335792 Pager: 07623 953965
James Isaac (Environmental Scientist) – james.isaac@hpa.org.uk	Office No: 0121 352 5295 Mob: 0777 1631730 Pager: 07623 903449
Lorraine Stewart (Environmental Scientist) – lorraine.stewart@hpa.org.uk	Office No: 0121 352 5247 Mob: 07946 747902
Patrick Saunders (Environmental Scientist) – Patrick.Saunders@hpa.org.uk	Office No: 0121 352 5257 Mob: 07831 693427 Pager: 0762 3973777
Chris Jewell (Environmental Scientist) – chris.jewell@hpa.org.uk	Office No: 0121 352 5287 Mob: 07747 476522 Pager: 07623973766
Dr Ivan Browne (Specialist Trainee) – ivan.brown@hpa.org.uk	Office No: 0121 352 5199 Mob: 0773 2923488
Carol Richards (Senior Administrator) - carol.Richards@hpa.org.uk	Office No: 0121 352 5240 Mob: 07788 798430
Acute Incidents	
West Midlands/North West – Incident Contact Line	Office Hours: 0121 0121 352 5266
ChaPD 24 Hour National Hotline Rota	Out of Hours: 0844 892 0555

CENTRE FOR RADIATION, CHEMICAL AND ENVIRONMENTAL HAZARDS	
HPA Centre for Radiation Chemical and Environmental Hazards (CRCE) reception. (PLEASE DO NOT GIVE THIS NUMBER TO ANYONE OUTSIDE OF THE HPA)	Office Hours: 01253 – 831818 (Mon-Thurs 08:00-16:50, Fri 08:00 – 16:10) Outside of Office Hours: 01253 831818 Emergency on-call duty officer at CEPR – 01980 6132100 (24 Hr Number)
HPA COLLABORATING LABS	
National (Colindale)	Tel: 0208 200 4400
Carlisle	Tel: 01228 814641
On call microbiologist	Tel: 01228 523444
Chester	Tel: 01244 366770
HPA NW Laboratory Service, MRI	Tel: 0161 276 8788/8854
Out of hours	Tel: 0161 276 1234
Liverpool	Tel: 0151 529 4900
Preston	Tel: 01772 522100
Liverpool School of Tropical Medicine	Tel: 0151 708 9393

ENVIRONMENTAL HEALTH DEPARTMENTS		
Cheshire & Merseyside	Office Hours	Out-of-Hours
Chester CC	01244 402310	01244 324324
Congleton MBC	01270 769480	01270 883999
Crewe MBC	01270 537404	01270 537777
Ellesmere Port & Neston MBC	0151 356 6789/6654	0151 355 0202
Halton MBC	0151 424 2061	0151 424 4857
Knowsley MBC	0151 443 4737	1 st line: 0769 972 8920 2 nd line: 0769 972 8922
Liverpool CC	0151 225 4028	0151 233 3000
Macclesfield MBC	01625 500500	01625 511495
Sefton MBC	0845 140 0845	0151 922 6107
St. Helens MBC	01744 456347	01744 23044/01744 456728
Vale Royal MBC	01606 862862	01606 862862
Warrington BC	01925 442575	01925 444400
Wirral MBC	0151 666 4989	0151 647 7810
Cumbria & Lancashire	Office Hours	Out-of-Hours
Allerdale Borough Council	01900 326333	01900 871080
Barrow Borough Council	01229 894260	01229 833311
Blackburn with Darwen Borough Council	01254 585393	01282 416387/0773 6029082
Blackpool Borough Council - Emergency	01253 478444/ 01253 478456	01253 477600
Burnley Borough Council	01282 664535	01254 384940
Carlisle City Council	01228 817325	–
Chorley Borough Council	01257 515720	01257 515142
Copeland Borough Council	01946 598347	0774 008 9034/0776 959 7909
Eden District Council	01768 864671	01768 867468
Fylde Borough Council	01253 658658	01253 712137
Hyndburn Borough Council	01254 388111	0800 587 5273
Lancaster City Council	01524 582701	01524 67099
Pendle (Borough of)	01282 661199	01282 661999
Preston City Council	01772 906163	01772 253421
Ribble Valley Borough Council	01200 425111	01200 444448
Rossendale Borough Council	01706 217777	01706 853121
South Lakeland District Council	01539 733333	Kendal: 0762 695 7236 Lakes Area: 0762 697 9114

		Ulverston Area: 0762 697 9022
South Ribble Borough Council	01772 421491	01772 625499
West Lancashire District Council	01695 577177	01695 577177
Wyre Borough Council	01253 891000	01253 895116
Greater Manchester	Office Hours	Out-of-Hours
Bolton MBC	01204 336500	01204 336900 (No Environmental Health out of hours number)
Bury MBC	0161 253 6639	0161 253 6639
High Peak MBC	0845 129 7777	01663 752099/01298 813395
Manchester CC	0161 234 5000	0765 912 5657 (Pager)
Oldham MBC	0161 770 4580 (Control Room)	0161 628 2000 (Ex-Directory)
Rochdale MBC	0845 121 2971	0845 121 2975
Salford CC	0161 794 4711 (Switch)	0161 794 8888/0161 728 2200 (Major Incident)
Stockport MBC	0161 474 4344	0161 474 5554
Tameside MBC	0161 342 8355	0161 342 3999/ 2222 (Major Incident)
Trafford MBC	0161 912 4174	0161 912 4191
Wigan & Leigh MBC	01942 404040 (Control Room)	01942 404040 (Ask for Environmental Health Officer)

MAJOR INCIDENT NOTIFICATION NUMBERS		
Organisation	Normal Working hours	Out-of-Hours
NHS North West	0161 223 4732	0161 223 4732
North West Ambulance Service	0161 223 4732	0161 223 4732
Lead PCT CEO On Call rota	0161 223 4732	0161 223 4732
Colin Kelsey – GM Asst Director Emergency Preparedness	01204 462139 Mob 07918 721455	N/A
ACUTE TRUSTS (See details on Page 6)		
Mental Health NHS Trusts (See details on Page 8) Greater Manchester		
EXTERNAL PARTNER AGENCIES		
Greater Manchester Health Protection Unit	0161 786 6710	0161 331 6000 (ask for HPU on-call)
Greater Manchester Police	0161 856 1671	0161 856 1671
Greater Manchester Fire & Rescue	0161 736 5866	0161 736 5866
Bolton Metropolitan Borough Council	01204 336 900	01204 336900
Bury Metropolitan Borough Council	01204 521568	01204 521568
Manchester City Council	0161 223 9999	0161 223 9999
Oldham Metropolitan Borough Council	0161 770 4580	0161 770 4580
Rochdale Metropolitan Borough Council	01706 925436/924757	0845 121 2975
Salford City Council	0161 728 2200	0161 728 2200
Stockport Metropolitan Borough Council	0161 474 5554	0161 474 5554
Tameside Metropolitan Borough Council	0161 342 3999	0161 342 3999
Trafford Metropolitan Borough Council	0161 912 2020	0161 212 2020
Wigan Metropolitan Borough Council	01942 404040	01942 404040
Derbyshire County Council	01629 585394	01629 585123 (ask for the Duty Emergency Planning Officer).

EMERGENCY PLANNING		
Greater Manchester	Office Hours	Out-of-Hours
Bolton MBC	01204 336993	01204 336900
Bury MBC	0161 253 6639	0161 253 6639
High Peak MBC	0845 129 7777	01663 752099/01298 813395
Manchester CC	0161 234 5000	0161 223 9999 (Ex- Directory)
Oldham MBC	0161 770 4580 (Control Room)	0161 628 2000 (Ex-Directory)
Rochdale MBC	0845 121 2971	0845 121 2975
Salford CC	0161 794 4711 (Switch)	0161 794 8888/0161 728 2200 (Major Incident)
Stockport MBC	0161 474 5599	0161 474 5554
Tameside MBC	0161 342 8355	0161 342 3999/ 2222 (Major Incident)
Trafford MBC	0161 912 4191	0161 912 4191
Wigan & Leigh MBC	01942 404040 (Control Room)	01942 404040

UNITED UTILITIES EMERGENCY PLANNING		
Greater Manchester	Office Hours	Out-of-Hours
Niall Clarke (niall.clarke@uuplc.co.uk) Risk & Response Manager	01925 464564 Fax: 01925 463528	07785 778250
Paul Roberts (Paul.Roberts@uuplc.co.uk) Risk Control Manager	01925 463303 Fax 01925 463528	0790 9537959
Irene Jenkinson (Irene.jenkinson@uuplc.co.uk) Risk Control Analyst	01925 464730 Fax: 01925 463528	0771 388 7303
Gail Pattullo (gail.pattullo@uuplc.co.uk) Risk Control Analyst	01925 464712 Fax: 01925 463528	0771 388 7300

LOCAL AUTHORITIES (CHIEF EXEC/SWITCHBOARD)	
Cheshire & Merseyside	
Chester CC	01244 324324
Congleton MBC	01270 763231
Crewe and Nantwich MBC	01270 537777
Ellesmere Port & Neston MBC	0151 356 6789
Halton MBC	0151 424 2061
Knowsley MBC	0151 443 2804/2823/2433
Liverpool CC	0151 233 3000
Macclesfield MBC	01625 500500
Sefton MBC	0151 922 2057 (Chief Exec office)
St. Helens MBC	01744 456101
Vale Royal MBC	01606 867804
Warrington BC	01925 444400
Wirral MBC	0151 606 2000
Cumbria & Lancashire	
Allerdale Borough Council	01900 326333
Barrow Borough Council	01229 894900
Blackburn with Darwen Borough Council	01254 585585
Blackpool Borough Council - <i>Emergency</i>	01253 478444
Burnley Borough Council	01282 425011

LOCAL AUTHORITIES (CHIEF EXEC/SWITCHBOARD)	
Carlisle City Council	01228 817000
Chorley Borough Council	01257 515151
Copeland Borough Council	01946 852585
Eden District Council	01768 864671
Fylde Borough Council	01253 658658
Hyndburn Borough Council	01254 388111
Lancaster City Council	01524 582000
Pendle (Borough of)	01282 661129
Preston City Council	01772 906000
Ribble Valley Borough Council	01200 414401
Rossendale Borough Council	01706 217777
South Lakeland District Council	01539 733333
South Ribble Borough Council	01772 421491
West Lancashire District Council	01695 577177
Wyre Borough Council	01253 891000
Greater Manchester	
Bolton MBC	01204 333333
Bury MBC	0161 253 5000
High Peak MBC	0845 129 7777
Manchester CC	0161 234 5000
Oldham MBC	0161 770 3000
Rochdale MBC	01706 647474
Salford CC	0161 794 4711
Stockport MBC	0161 480 4949
Tameside MBC	0161 342 8355
Trafford MBC	0161 912 1212
Wigan & Leigh MBC	01942 244991

PRIMARY CARE TRUSTS - INFECTION CONTROL NURSES and DIRECTORS OF PUBLIC HEALTH		
Cheshire & Merseyside	Community Infection Control Nurse	Director of Public Health
Bebington & West Wirral PCT	0151 678 7272	0151 643 5416
Birkenhead and Wallasey PCT	0151 651 3946	0151 651 0011
Central Cheshire PCT	01606 564001	01270 415300
Central Liverpool PCT	0151 300 8076/0151 300 8090	0151 285 2345
Cheshire West PCT	01244 364858	01244 650300
Eastern Cheshire PCT	01625 661769	01625 508300
Ellesmere Port & Neston PCT	01244 364858	0151 373 4900
Halton PCT	01928 593690	01928 593663
Knowsley PCT	0151 292 3519	0151 443 4914
North Liverpool PCT	0151 300 8076 / 0151 300 8090	0151 293 1900
South Liverpool PCT	0151 300 8076 / 0151 300 8090	0151 234 1000
South Sefton PCT	0151 478 1239	0151 478 1249
Southport and Formby PCT	01704 553543	01704 387026
St Helens PCT	01744 620377	01744 457298
Warrington PCT	01925 664000	01925 843600
Cumbria & Lancashire	Community Infection Control Nurse	Director of Public Health
Blackburn with Darwen PCT	01254 263611	01254 267061
Blackpool PCT	01253 651030	01253 651026
Burnley, Pendle & Rossendale PCT	01282 607014	01282 610250
Carlisle & District PCT	01228 814393	01228 603608
Chorley & South Ribble	01772 644479	01772 644459

PRIMARY CARE TRUSTS - INFECTION CONTROL NURSES and DIRECTORS OF PUBLIC HEALTH		
Eden Valley PCT	01228 814393	01228 603542
Fylde PCT	01253 306483	01253 306456
Hyndburn & Ribble Valley PCT	01254 263555	01254 380400
Morecambe Bay PCT	01539 583769	01539 797820
Preston PCT	01772 645625	01772 645587
West Cumbria PCT	01228 814393	01900 324220
West Lancashire PCT	01695 598155	01695 598180
Wyre PCT	01253 303247	01253 306311
Greater Manchester	Community Infection Control Nurse	Director of Public Health
Ashton, Wigan & Leigh PCT	01942 481730	01942 481729
Bolton PCT	01204 462356	01204 907725
Bury PCT	0161 272 4058	0161 272 4062
Manchester PCT	0161 946 8242	0161 219 9428
Heywood, Middleton & Rochdale PCT	01706 652818	01706 652876
Oldham PCT	0161 484 3839	0161 622 6606
Salford PCT	0161 212 4958	0161 212 4819
Stockport PCT	0161 426 5488	0161 426 5031
Tameside & Glossop PCT	0161 308 3171	0161 304 5342
Trafford PCT	0161 873 6024	0161 873 9588
Ashton, Wigan & Leigh PCT	01942 772711	01942 244000
PRIMARY CARE TRUSTS – Emergency Contact Numbers – For Out of Hours ask for Directors Rota		
Greater Manchester	Office Hours	Out of Hours
Bolton PCT	01204 462000	01204 390390
Bury PCT	07966079733	07966079733
Manchester PCT (Health Control hold up-to-date on call rotas for M/cr PCT's)		
North Locality	07973 138303	0161 223 4732
Central Locality	07973 138303	0161 223 4732
South Locality	07973 138303	0161 223 4732
Heywood, Middleton & Rochdale PCT	01706 652876	0161 223 4732
Oldham PCT	0161 956 0007 (ask for Oldham PCT Director on call to be paged)	0161 956 0007 (ask for Oldham PCT Director on call to be paged)
Salford PCT	0161 212 4800/4811	First instance page 07659 581787/Page 07659 584525
Stockport PCT	07798 877322 (24 Hrs)	07798 877322 (24 Hrs)
Tameside & Glossop PCT	0161 304 5300	0161 331 6000
Trafford PCT	First ring 0161 873 9500 and ask for manager on call if no response ring 07813 319345 (24 Hrs)	First ring 0161 748 4022 and ask for PCT manager on call if no response ring 07813 319345 (24 Hrs)
ACUTE TRUSTS		
Cheshire & Merseyside		
Aintree Hospital (University Hospital Aintree, also known as Fazakerley Hospital), Liverpool	Liverpool	0151 525 5980
Alder Hey Hospital (Royal Liverpool Children's NHS Trust), Liverpool	Liverpool	0151 228 4811
Arrowe Park Hospital, Wirral	Wirral	0151 678 5111
Ashworth Hospital, Liverpool	Liverpool	0151 473 0303
Broadgreen Hospital, Liverpool (Royal Liverpool & Broadgreen Hospital)	Liverpool	0151 282 6000
Cardiothoracic Centre, Liverpool	Liverpool	0151 228 1616
Clatterbridge Centre for Oncology, Wirral	Wirral	0151 334 1155
Clatterbridge Hospital, Wirral	Wirral	0151 334 4000
Congleton War Memorial Minor Injuries Unit, Congleton	Congleton	01260 272227

ACUTE TRUSTS		
Countess of Chester Hospital, Chester	Chester	01244 365000
Ellesmere Port Hospital, Wirral	Ellesmere Port	01244 362986
Fazakerley Hospital, Liverpool (University Hospital Aintree, also known as Aintree Hospital)	Liverpool	0151 525 5980
Halton General Hospital, Runcorn	Runcorn	01928 714567
Hollins Park Hospital, Warrington	Warrington	01925 664000
Knutsford & District Community Hospital, Cheshire	Knutsford	01565 632112
Leighton Hospital, Crewe	Crewe	01270 255141
Liverpool Women's Hospital, Liverpool	Liverpool	0151 708 9988
Macclesfield District General Hospital, Macclesfield	Macclesfield	01625 421000
Regional Infectious Diseases Unit, Royal Liverpool Hospital, Liverpool	Liverpool	0151 706 2432/2436 0151 706 2000
Royal Liverpool Hospital, Liverpool (Royal Liverpool & Broadgreen University Hospital)	Liverpool	0151 706 2000
Smithdown Road Paediatric Minor Injuries Unit, Liverpool	Liverpool	0151 733 4644
Southport Hospital, Southport, Merseyside	Southport	01704 547471
St Catherine's Hospital, Wirral	Wirral	0151 678 7272
Victoria Central Hospital, Wallasey, Merseyside	Wallasey	0151 678 7272
Victoria Infirmary, Northwich, Cheshire	Northwich	01606 564000
Walton Hospital, Liverpool	Liverpool	0151 525 3611
Warrington Hospital, Warrington	Warrington	01925 635911
Whiston Hospital, St Helens & Knowsley	Liverpool	0151 426 1600
Cumbria & Lancashire		
Blackburn Royal Infirmary	Blackburn	01254 263555
Burnley General Hospital	Burnley	01282 425071
Cumberland Infirmary	Carlisle	01228 523444
Furness General Hospital	Barrow in Furness	01229 870870
Ormskirk & District General Hospital	Ormskirk	01695 577111
Royal Lancaster Infirmary	Lancaster	01524 65944
Royal Preston Hospital	Preston	01772 716565
Victoria Hospital	Blackpool	01253 300000
West Cumberland Hospital	Whitehaven	01946 693181
Greater Manchester		
Birch Hill Hospital	Rochdale	01706 377777
Booth Hall	Manchester	0161 795 7000
Central Manchester Trust Hospitals (MRI, St Mary's, Eye Hospital)	Manchester	0161 276 1234
Fairfield Hospital	Bury	0161 956 0007
North Manchester General Hospital	Manchester	0161 956 0007
Royal Albert Edward Infirmary	Wigan	01942 244000
Royal Bolton Hospital	Bolton	01204 390390
Royal Manchester Children's Hospital	Manchester	0161 794 4696
Royal Oldham Hospital	Oldham	0161 956 0007
Salford Royal	Salford	0161206 7373
Stepping Hill Hospital	Stockport	0161 483 1010
Tameside General Hospital	Tameside & Glossop	0161 331 6000
Trafford General Hospital	Trafford	0161 748 4022
Wythenshawe Hospital	Manchester	0161 998 6141
NHS WALK-IN CENTRES		
Greater Manchester		
Lever Chambers, 27 Ashburner Street, Bolton, BL1 1SQ	Bolton	01204 872725
18 Parsons Lane, Bury, BL9 0JZ	Bury	0161 763 2460
Fairfax Road, Prestwich, M25 1BT	Bury	0161 773 7832
Leigh Infirmary, The Avenue, Leigh, Lancs, WN7 1HS	Leigh	01942 264000
Burnage Health Centre, 347 Burnage Lane, Manchester, M19 1EW	Manchester	0161 443 0600

Manchester Royal Infirmary, Oxford Road, Manchester, M13 9WL	Manchester	0161 276 1234
Terminal 1, Manchester Airport	Manchester	0161 489 2109
1 st Floor Gateway House, Station Approach, Piccadilly South, Manchester, M1 2GH	Manchester	0161 233 2525
Wythenshawe Health Care Centre, Stancliffe Road, Manchester, M22 4PJ	Manchester	0161 946 9400
Withington Hospital, Nell Lane, Manchester, M20 2LR	Manchester	0161 217 3015
Lindley House, 1 John Street, Oldham, OL8 1DF	Oldham	0161 785 7500
90 Whitehall Street, Rochdale, OL12 0ND	Rochdale	0161 217 3015

NHS General		
Greater Manchester		
NHS Direct North West Second Floor Sefton House Northgate Close Middlebrook Horwich BL6 6PQ	General Telephone No: 01204 478700 Fax: 01204 478785 Contact for Health Alert: Office Hours – General Manager, Operations – Joanne Birkett (01204 478709 or 07880 500875	Out of Hours: Operational Supervisor – 01204 - 478750
NHS North West Communications On-call To contact the SHA Communications On-Call Manager (It is the role of the SHA Director on-call to activate communications support as appropriate	07824 463578	07824 463578
NHS North West	0161 223 4732 (Office Hours)	0161 223 4732 (Out of Hours)

Mental Health NHS Trusts Greater Manchester		
	Normal Working Hours	Out of Hours
Bolton, Salford & Trafford Mental Health NHS Trust	0161 772 3622	0161 773 9121
Manchester Mental Health & Social Care Trust	0161 882 1359	07966 658813
Pennine Care Mental Health Trust	0161 604 3000 (ask for the CEO's office)	0161 331 6000

OUT OF HOURS GENERAL PRACTICE SERVICES
Refer to GP lists in the back of the folder.

EMERGENCY SERVICES		
Cheshire & Merseyside		
Police	Cheshire Merseyside	Tel: 01244 612270 (duty insp) Tel: 0151 777 4999
Fire	Cheshire Merseyside	Tel: 01606 868953 Tel: 0151 296 5263 (control) Tel: 0151 296 4000 (switch)

Ambulance	Merseyside & Cheshire	Tel: 0151 260 5220 (control)
Cumbria & Lancashire		
Police	Cumbria	Tel: 01768 891999 (main) Tel: 01768 213814 (duty insp)
	Lancashire	Tel: 01772 614444 (main) Tel: 01772 410001 (duty insp)
Fire	Cumbria Lancashire	Tel: 01900 822503 Tel: 01772 866820
Ambulance	Cumbria Lancashire	Tel: 01228 596016 (control) Tel: 01772 865965 (main) Tel: 01772 773093 (duty mgr)
Greater Manchester		
Police	Greater Manchester	Tel: 0161 856 1671
Fire	Greater Manchester	Tel: 0161 736 5866
North West Ambulance Service		Tel: 0161 223 4732
Ambulance	Greater Manchester Ambulance Service Out of Hours and Weekend	Tel: 0161 438 4168 (24 hour control – ask to speak to Control Manager)

PUBLIC NUMBERS	
UNITED UTILITIES:	
Water	Tel: 0845 746 2200
Electricity (no supply) in United Utilities area	Tel: 0800 195 4141
Sewer / waste water problems (24 hrs)	Tel: 0845 602 0406
TRANSCO: National Grid	
Gas – Emergencies	Tel: 0800 111 999

UNITED UTILITIES DIRECT NUMBERS	
<i>These are direct numbers used by their operatives in the field and should not be used for anything less than dire/life threatening emergencies.</i>	
<i>Not for public information/circulation.</i>	
Ops Centre Urgent – Cheshire & Mersey (West Desk) Emergency Only	Tel: 01925 714812 (direct) Tel: 01925 714813
Ops Centre Urgent – Cumbria & Lancashire (North Desk) Emergency Only	Tel: 01925 714810 (direct) Tel: 01925 714809
Ops Centre Urgent – Greater Manchester (East Desk) Emergency Only	Tel: 01925 714807 (direct) Tel: 01925 714806

UNITED UTILITIES EMERGENCY CONTACT NUMBERS		
Water & Wastewater 24 hours This number is to be used by Cat 1 responders to seek information on water and wastewater services to assist in response to incidents also to engage in multi agency response to an incident. Ex directory contact numbers (not for general public use)	Ask for Duty Manager - 07713887302	Tel: 01925 714806 (East) Tel: 01925 714809 (North) Tel: 01925 714813 (West) Tel: 01925 714983 (Fax)
Electricity Safety incidents (damaged cables, fallen poles, risk of injury etc) 24 hours – life & death issues	This number is not to be used to notify UU of dangerous or potentially dangerous electrical apparatus.	Tel: 0161 236 6320 (ex directory)

Fire & Rescue Service	Fire & Rescue Services – For use only in case of life & death situations General water supply queries including hydrant abuse	01925 714714 08457 462200
Electricity Incidents (power loss)	For Major Incidents only – This number is to be used by Cat 1 responders to seek information on electricity services to assist response to major incidents	Duty Manager: 0161 236 3601
Electricity general public and business numbers 24 hours For customer calls about loss of electricity supply only. All other queries should be directed to customer's supplier	(Cumbria/Lancashire, Greater Manchester and parts of Cheshire)	0800 195 4141
Electricity 24 hours general power outages	Cumbria/Lancashire/Greater Manchester and parts of Cheshire	Tel: 0800 1954141 Fax: 01925 463528

Contact umbers for general public & general enquiries from Cat 1 & 2 responders

24 hours	For customer calls (domestic and business) about water and wastewater services , including foul flooding. [Regional]	0845 746 2200
24 hours	For customer calls about loss of electricity supply only.	0800 195 4141

Emergency Planning Liaison

Risk Management Team

Room AG057 The ORC, Haweswater House, Lingley Mere, Warrington, WA5 3LP.

Name/Designation	Work	Mobile
Niall Clarke (niall.clarke@uuplc.co.uk) Risk & Response Manager	01925 464564 Fax 01925 463528	07785 778250
Paul Roberts (paul.roberts@uuplc.co.uk) Risk Control Manager	01925 463303 Fax 01925 463528	0790 9537959

Irene Jenkinson irene.jenkinson@uuplc.co.uk Risk Control Analyst	01925 464730 Fax 01925 463528	0771 388 7303
Gail Pattullo gail.pattullo@uuplc.co.uk Risk Control Analyst	01925 464712 Fax 01925 463528	0771 388 7300

GREATER MANCHESTER HEALTH CONTROL	Tel: 0161 223 4732
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STRATEGIC HEALTH AUTHORITIES	
North West Strategic Health Authority	Tel: 0161 223 4732 (Manchester Health Control)

GOVERNMENT OFFICE NORTH WEST	
Government Office North West	Tel: 0161 952 4000
Emergency Response Contact Arrangements	Fax: 0161 952 4099
Out of Hours	Tel: 0161 952 4095
Regional Resilience Team Contact Information	Fax: 0161 952 4006
Kathy Settle Regional Resilience Director	Pager: 0765 955 1103
Julie Dawber Regional Resilience Team Leader	Tel: 0161 952 4146 Mobile: 07771 978920
Graham Scott Regional Resilience Manager	Tel: 0161 952 4226 Mobile: 07818 015860
General Enquiry Point	Tel: 0161 952 4345 Mobile: 07771 815226
	Tel: 0161 952 4135 Fax: 0161 952 4090
	Email: rrt.gonw@go-regions.gsi.gov.uk
	Address: Government Office for the North West, City Tower, Piccadilly Plaza, Manchester M1 4BE
Strategic Health Control Desk (24 Hours)	0161 223 4732 (If no response within 1 minute ring: 0161 866 2505)
(In the event of an emergency rendering Strategic Health Control out of Action a back-up copy of the rota is held at the Royal Liverpool Hospital Switchboard)	
Regional Director of Public Health Office – NHS North West	0161 237 2725
Royal Liverpool Hospital Switchboard	0151 706 2000
GOVERNMENT AGENCIES	
Environment Agency (General Public)e.g. pollution incidents Dedicated Emergency Line	Tel: 0800 80 70 60 Tel: 0845 8503518 Fax: 0800 587 6032 Email: Incident.Communication.Service@environment-agency.gov.uk
DEFRA Animal Health Office Out-of-hours	Tel: 01772 861 144 Ring above number for pager number for duty officer Fax: 01772 861798
Department of Health, London (Duty Officer) Out of hours	Tel: 0207 972 5000 Tel: 0207 210 5371
Food Standards Agency Switchboard Emergency only/out of hours	Tel: 0207 276 8000 Tel: 0207 276 8960
NHS Direct Public number Management	Tel: 0845 46 47 Tel: 01204 599502
NHS Direct (Cumbria, Lancashire & Mersey)	Tel: 01772 773 130 (control)
NHS Direct (Greater Manchester, Cheshire & Wirral)	Tel: 01204 599 502 (control)
Health & Safety Executive	
Carlisle (Cumbria)	Tel: 01228 634100
Preston (Lancashire)	Tel: 0161 952 8200
Manchester (Cheshire, Mersey & Greater Manchester) Out-of-hours	Tel: 0161 952 8200 Tel: 0151 922 9235
HELPLINES NUMBERS	
National Meningitis Trust	Tel: 0845 6000 800
Meningitis research Foundation	Tel: 0808 800 3344
DDSHL Sexual Health Line	Tel: 0800 567 123

"UNKNOWN" OR DELIBERATE RELEASE AGENTS		
Agent	Department	
Unknown	Respiratory & Systemic Infections Laboratory, SRMD Colindale	0208 200 4400
Botulism	Food Safety Microbiology Laboratory, SRMD Colindale	0208 200 4400
Plague	Laboratory of Enteric Pathogens, SRMD Colindale or Special Pathogens Laboratory, HPA Porton Down	0208 200 4400 or 01980 612100
Anthrax	Special Pathogens Laboratory, HPA Porton Down	01980 612100
Tularaemia		
VHF		
Melioidosis	Laboratory of Healthcare Associate Infection, SRMD Colindale	0208 200 4400
Smallpox	Enteric and Respiratory Virus Laboratory, SRMD Colindale or Special Pathogens Laboratory, HPA Porton Down	0208 200 4400 or 01980 612100
Smallpox SMART Team rota	Rota held at Royal Preston Hospital	01772 716565

Appendix 10

Abbreviations

CCDC	Consultant in Communicable Disease Control
CAMR	Centre for Applied Microbiological Research
CDSC	Communicable Disease Surveillance Centre
Cfi	HPA Centre for Infections, Colindale
CHP	Consultant in Health Protection
CIRS	Chemical Incident Response Service
DH	Department of Health
DPH	Director of Public Health
EHO	Environmental Health Officer
GONW	Government Office North West
HPA	Health Protection Agency
HPU	Health Protection Unit
ICN	Infection Control Nurse
NFCI	National Focus for Chemical Incidents
NRPB	National Radiological Protection Board
OCT	Outbreak Control Team
PCT	Primary Care Trust