



# The Communicable Disease Outbreak Plan for Wales

(The 'Wales Outbreak Plan')

**Final Revised Version**

**Version 1: 26 July 2022**

## Preface

This model plan (“The Wales Outbreak Plan”) should be used as the framework for managing all communicable disease outbreaks with public health implications across Wales. Separate plans exist for managing the public health risks from [environmental incidents](#) and [healthcare premises](#) outbreaks.

In particular, the Wales Outbreak Plan outlines a way of working that follows the principles enshrined in the Well-being of Future Generations (Wales) Act 2015.

This Act requires public bodies such as Local Authorities, Local Health Boards, Natural Resources Wales (NRW), Public Health Wales (PHW) and the Welsh Government to act in accordance with the principles therein. These seek to ensure the needs of the present are met without compromising the ability of future generations to meet their own needs by using the following ways of working:

- looking to the long term so not compromising the ability of future generations to meet their own needs;
- taking an integrated approach;
- involving a diversity of the population in the decisions affecting them;
- working with others in a collaborative way to find shared sustainable solutions; and
- acting to prevent problems from occurring or getting worse.

The Welsh Government expects public bodies in Wales to follow these five ways of working when preventing and managing communicable disease outbreaks.

The “Wales Outbreak Plan” is divided into seven parts. Parts 1 and 2 contain details pertinent to all outbreaks. Parts 3-7 contain the technical operational detail needed for managing specific issues. In the case of cross-border outbreaks, all those led by Wales will be managed in accordance with this plan.

For outbreaks occurring in hospitals, a separate plan for “*Outbreak Management in Hospital Settings*” should be followed. However, if a hospital outbreak has any potentially serious public health implications outside the hospital setting, then this plan (The Wales Outbreak Plan) takes precedence in control of the outbreak.

Within the former “Water Framework”, there was a section on managing water incidents which was separate to managing water borne outbreaks but used the same generic principles. This section has been retained in Part 4: Water Specific Issues.

For outbreaks occurring in prisons, the multi-agency contingency plan for the management of communicable diseases or other health protection incidents in prisons in Wales should normally be followed. The prison plan contains the same principles as the Wales Outbreak plan but includes more specific details in the prison setting. This plan is provided in Part 6.

## When to use this plan

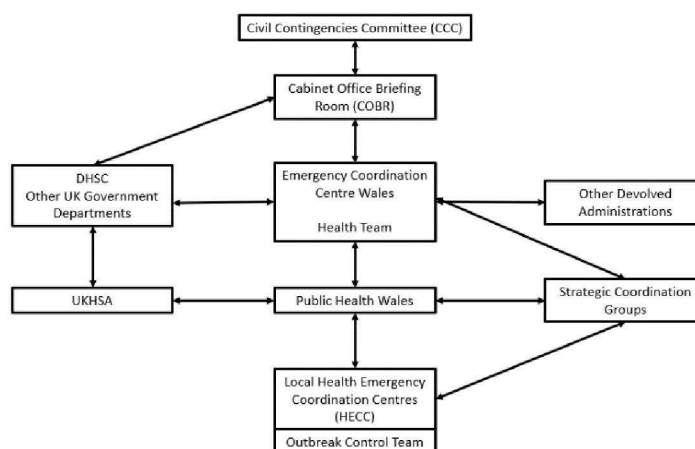
This plan should be used to manage outbreaks when an outbreak has been formally declared in Wales, in such circumstances partners meet as an Outbreak Control Team. However, the principles, role descriptors and tasks within this plan can also be applied when managing situations described as incidents or clusters for instance. Where guidance, standard operational procedures or similar documents relevant to the health protection response in Wales refer to applying the principles of this plan it shall be taken to mean that an outbreak should be formally declared. It shall be taken to mean that the roles, aims and objectives, and structures can be applied as appropriate, however communication and engagement with partner agencies should be considered key objective in all circumstances.

Where there is a cross border outbreak affecting people living in one or more of the other UK countries or cases are part of an international outbreak, the participating Outbreak Control Team's arrangements may differ. For example, if the response is led by a Team from another country, it may be chaired by a representative of an agency outside Wales, but the principles of this plan should still apply and the Welsh response should be guided by the requirement to protect the public's health.

There will be rare occasions where an outbreak may necessitate the activation of civil contingency arrangements. This is likely to be where the nature and scale of the communicable disease overwhelms services, or where it creates wider strategic issues or risks that may have a serious impact on the public.

In such a scenario, the **Wales Resilience Emergency Civil Contingency structures** will be employed or invoked. [Part 7](#) of this plan outlines in detail the assessment process with the relevant **Local Resilience Forum**, the activation of a **Strategic Co-ordinating Group** if required and the co-ordination and communication with **Welsh Government** in these circumstances.

If the **Wales Framework for Managing Major Infectious Disease Emergencies** is activated, the diagram below outlines the co-ordination arrangements and where Outbreak Control Teams (and thus the arrangements in the Communicable Disease Outbreak Plan for Wales) sit. In exceptional circumstances there are also specific UK arrangements for bioterrorism or other particular infectious disease threats which take precedence over these plans.



Adapted from: Welsh Government: Wales Framework for Managing Major Infectious Disease Emergencies. October 2014

## **Acknowledgement**

This outbreak plan has been revised with contributions from representatives from the following groups and agencies: Caerphilly Council, Wrexham Council, Newport Council, Neath Port Talbot Council, the Communicable Disease Expert Panel, Directors of Public Protection, Heads of Environmental Health, Cardiff and Vale University Health Board, Swansea Bay University Health Board, Public Health Wales, Food Standards Agency Wales, North Wales LRF, the Welsh Government.

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**ABBREVIATIONS**

APHA	Animal and Plant Health Agency
CCDC / CHP	Consultant in Communicable Disease Control/Consultant in Health Protection
CDSC	Communicable Disease Surveillance Centre
CEO	Chief Executive
CMO(W)	Chief Medical Officer of Wales
CRCE	Centre for Radiation, Chemical and Environmental Hazards
CIW	Care Inspectorate Wales
DCWW	Dŵr Cymru Welsh Water
DEFRA	Department for Environment, Food and Rural Affairs
DOB	Date of Birth
DPP	Director of Public Protection (see 3.1)
DWI	Drinking Water Inspectorate
ECCW	Emergency Coordinating Centre Wales (Welsh Government)
EDPH	Executive Director of Public Health (see 3.4)
EHO	Environmental Health Officer
EHRB	Environmental Health Registration Board
FSA	Food Standards Agency
GP	General Practitioner
HARP	Healthcare Associated Infection & Antimicrobial Resistance Programme
HB	Health Board
HCAI	Healthcare Associated Infection
HMPPS	Her Majesty's Prison and Probation Service
HPT	Health Protection Team
HSE	Health and Safety Executive
IMT	Incident Management Team
LA	Local Authority (including Port Health Authority)
LRF	Local Resilience Forum
MoJ	Ministry of Justice
NHS	National Health Service
NOMS	National Offenders Management Service
OCT	Outbreak Control Team
OCMO	Office of Chief Medical Officer Welsh Government
PCR	Polymerase Chain Reaction
PHW	Public Health Wales
PII	Period of Increased Incidence
PO	Proper Officer
PPE	Personal Protective Equipment
RASFF	Rapid Alert System for Food and Feed
SCG	Strategic Coordination Group
STAC	Scientific and Technical Advice Cell
UKHSA	UK Health Security Agency
WG	Welsh Government
WHC	Wales Health Council
WHO	World Health Organisation
WHP	Wales Health Partnership



## PART 1: OUTBREAK PLAN

### 1.1 INTRODUCTION

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

- 1.1.1 The Welsh Government expects public bodies to adopt the five ways of working set out in the Well-being of Future Generations (Wales) Act 2015 (“the WFG Act”). As these ways of working include policy integration and collaboration with partners, this guidance seeks to convey the importance of joined up working to achieve sustainable outcomes.
- 1.1.2 In addition, the Food Standards Agency Framework Agreement on Official Feed and Food Controls by Local Authorities, requires Local Authorities to have plans in place to deal with foodborne outbreaks. This document supports these statutory requirements.
- 1.1.3 The plan is comprised of 7 Parts. Parts 1 and 2 are the generic plan for how all outbreaks formally declared in Wales will be handled. Parts 3-7 are the incident/disease specific sections providing additional technical detail for certain specified circumstances.
- 1.1.4 Responsibility for managing outbreaks is shared by all the organisations who are members of the Outbreak Control Team (OCT). Specifically, the responsibility for decisions made by the OCT is collectively owned by all organisations represented on the OCT. Individual organisations are then responsible for achieving the aims assigned to them as agreed at OCT meetings. The OCT (usually the Chair) can escalate any unresolved issues to the CEO of the Health Board.
- 1.1.5 The OCT is a collaborative arrangement between organisations operating to the rules of engagement set out in this plan. This plan does not confer on any organisation any additional accountability for the oversight of the actions of other organisations and does not affect any pre-existing oversight arrangements.<sup>1</sup> Although this plan refers to individual post holders each organisation is accountable for their own response and actions and should have their own governance arrangements in place to ensure this.
- 1.1.6 An outbreak is usually declared jointly by the Director of Public Protection (DPP), the Consultant in Communicable Disease Control/Consultant in Health Protection (CCDC/CHP) and the Health Board Clinical Lead for Microbiology, in conjunction with the Health Board Executive Director of Public Health (EDPH), after these individuals have jointly considered the information available. However, any one of these can declare an outbreak if required.
- 1.1.7 In practice, an urgent meeting is usually held first with these individuals (or their representatives) as a minimum in attendance to consider the facts and decide if an outbreak needs to be declared. From the point at which an outbreak is declared, the meeting becomes a formal OCT meeting and attendees become formal members of an OCT.

- 1.1.8 The Core members of all OCTs are the DPP of the relevant LA, the CCDC/CHP, the Health Board Clinical Lead for Microbiology, the Executive Director of Public Health for the Health Board (HB) and the Lead Officer for Communicable Disease of the LA. Examples of additional, co-opted, members for some outbreaks are listed in 2.1.2.
- 1.1.9 Core OCT Members are responsible for ensuring that all relevant organisations are co-opted on to the OCT (see 2.1: Outbreak Control Team). Others can make a request to join the OCT if there is a case to do so but the final decision on membership resides with the core members.
- 1.1.10 Core Member responsibility also includes having the authority/delegated authority from their organisation to provide sufficient resources necessary to bring the outbreak to a successful conclusion. All organisations represented on an OCT must recognise their responsibilities and ensure their representatives are adequately supported at all times.
- 1.1.11 **If the DPP, CCDC/CHP, EDPH, Health Board Clinical Lead for Microbiology, or Lead Officers delegate core membership responsibilities and/or OCT attendance to their representative, they remain ultimately accountable for the decisions made by their representative on their behalf.<sup>2</sup>**
- 1.1.12 This plan is intended to be a framework for the organisations represented by these individuals to discharge their duties in relation to the management and control of communicable disease outbreaks. More detailed advice that is pathogen or setting specific may be provided in policy documents, operational guidance or similar documents.

## **1.2 MANAGEMENT AND ORGANISATION ARRANGEMENTS FOR HANDLING OUTBREAKS**

- 1.2.1 The primary objective in the management of an outbreak is to protect public health by identifying the source and/or main determinants of the outbreak and implementing necessary measures to prevent further spread or recurrence of the infection. The protection of public health takes priority over all other considerations and this must be understood by all members of the OCT.
- 1.2.2 The secondary objective is to improve surveillance, refine outbreak management, add to the evidence collection, and learn lessons to improve communicable disease control for the future.
- 1.2.3 It is important that the OCT is allowed the time to collect and interpret the intelligence and agree appropriate actions without undue interference. The successful management of outbreaks is dependent upon good and timely communication, collaboration and action between the LA, the HBs and Public Health Wales and all interested parties.
- 1.2.4 On occasion, there are cross boundary interests and close liaison and collaboration between LAs is essential in such situations. The LA where an affected individual is resident will lead the investigation process of the individual case and apply control measures relevant to that individual. Control measures relating to a premises, or a thing will be applied by the LA within which it is situated, unless legislation dictates otherwise.<sup>3</sup>

## 1.3 DETERMINATION OF AN OUTBREAK

### *Detection and Assessment*

- 1.3.1 An urgent incident meeting may be held first with the individuals in 1.1.6 in attendance to consider the facts and decide if an outbreak needs to be declared. From the point at which an outbreak is declared in an incident meeting, the meeting becomes a formal OCT meeting and attendees become formal members of an OCT.
- 1.3.2 If the OCT (or the prior processes outlined in 1.3.1) identifies or suspects a potential scenario that may necessitate escalation to the relevant Local Resilience Forum (LRF), [part 7](#) of this plan **must** be implemented and initial contact should be made with the relevant LRF Coordinator to discuss the circumstances of the outbreak.
- 1.3.3 In reality, there are many minor outbreaks and clusters of disease that occur in Wales every year that are managed satisfactorily without the formal declaration of an outbreak and the convening of an OCT<sup>4</sup>. When a decision has been made not to formally declare an outbreak, the reasons for this decision should be documented. It is the duty of the three parties above to keep the situation under review to determine if the incident is resolving or if a formal declaration of an outbreak and an OCT should be made. In such circumstances agencies may meet as an Incident Management Team (IMT), using the principles contained within this document to engage, communicate and manage the situation under consideration.

### *Declaration*

- 1.3.4 The decision to declare an outbreak and to subsequently convene an OCT as necessary may be made jointly through the process outlined in paragraph 1.1.6. Should any party not agree there is an outbreak, there is a duty on them to attend the OCT meeting and formally explain their opinion and discuss this further.
- 1.3.5 The formal declaration of an outbreak as soon as possible will normally be considered if an outbreak is characterised by one or more of the following:
- a) a significant immediate and / or continuing communicable disease health hazard;
  - b) one or more cases of serious infectious disease;
  - c) large numbers of cases or numbers greater than expected of infections for which there is a wider public health implication;
  - d) involvement of more than one LA where a joint response needs coordination.
- 1.3.6 Core membership of the OCT will be in accordance with [part 2.1](#) (OCT)

### *Outbreak Control Team*

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

- 1.3.8 It shall be the duty of the Chair to manage the OCT in an accountable and professional manner.
- 1.3.9 Responsibility for handling the outbreak **must** be given to the OCT by the members' organisations, and representatives **must** be of sufficient seniority and have the delegated authority to make and implement decisions on behalf of their organisation and to ensure that adequate resources are available to undertake outbreak management.

#### *Communication*

- 1.3.10 It is essential that effective communication is established between all members of the OCT and maintained throughout the outbreak in accordance with [part 2.5](#) (Tasks of the Outbreak Control Team) and [part 2.6](#) (Public Communications). The Chair will ensure that minutes will be taken at all meetings of the OCT and circulated as soon as possible to participating organisations. These draft minutes will normally be agreed as final at the next OCT meeting. The minute taker is accountable to the Chair for this function.
- 1.3.11 The CCDC/CHP must inform the office of the Chief Medical Officer (CMO(W)) of the Welsh Government of any outbreak, usually outlining in brief the public health risk and actions being taken to mitigate the risk.
- 1.3.12 The widespread adoption of MS Teams and similar packages to enable remote attendance at meetings means 'virtual' meetings will be common. However, face to face meetings should be utilised when particularly difficult decisions are being considered, OCT members feel it will support collaboration or the sensitive nature of discussions mean being co-located is desirable.
- 1.3.13 Use of communication through the media may be a valuable part of the control strategy of the outbreak. The OCT should consider the risks and benefits of proactive versus reactive media engagement in any outbreak. Consideration of this should be given very early in the proceedings to ensure the attendance of a communications officer at the OCT meetings.
- 1.3.14 A member of the OCT should be nominated to liaise with the manager of any premise/organisation involved in the outbreak to explain how an OCT works and the potential consequences of declaring an outbreak, (which include the potential impact of communication with the media and other stakeholders).

#### *Conclusion*

- 1.3.15 The OCT should consider how best to communicate with cases about:
- the declaration of the end of the outbreak;
  - the release of the OCT report outlining actions agreed and taken during the outbreak;
  - and the outcomes.

[Part 2.11](#) contains advice on such communication.

- 1.3.16 At the conclusion of the outbreak the OCT will prepare a written report. The report should be anonymised as far as possible. The full approved OCT report should be available within twelve months of the conclusion of the outbreak if there are no legal constraints. This final report must be submitted, (including the evaluation of the response) to the Welsh Government for consideration by the Outbreak and Incidents Subgroup. However, if urgent recommendations are identified during the outbreak, then the chair of the OCT (with support of OCT members) should formally write to the relevant organisation or Chair of the Health Protection Advisory Group of Welsh Government about these within three months of the conclusion of the outbreak.

### *Evaluation*

- 1.3.17 After the conclusion of the outbreak, the OCT should undertake an evaluation of the outbreak. The evaluation should be based on the template in [part 2.12](#) and be included in the OCT report. The timing of the evaluation can be flexible; OCTs may find it helpful to have time to reflect on the outbreak prior to carrying out the evaluation. At this stage, the OCT should consider any urgent recommendations which may need to be flagged up prior to the full OCT report.

## **1.4 OUTBREAK REPORT**

- 1.4.1 Where an OCT is convened, a record of proceedings will be made and circulated to a distribution list agreed by OCT members, which will include all Core and Co-opted member organisations. The report will in addition, be circulated to the Welsh Government, the FSA (where food is the implicated vehicle), Drinking Water Inspectorate (DWI) (where drinking water is the implicated vehicle) and any other parties as deemed appropriate by the OCT.
- 1.4.2 This report will contain details of the investigation, compilation of the results, conclusions and the evaluation.
- 1.4.3 The suggested format is contained in [part 2.10](#) (Format for Outbreak Reports).
- 1.4.4 The OCT report is owned jointly by all the organisations represented on the OCT. The OCT should agree when and how the report is to be first released, paying due consideration to impending legal proceedings and freedom of information issues.

## **1.5 REVIEW**

- 1.5.1 This Plan will be reviewed formally every 3 years, or sooner if it has been identified that changes are required.
- 1.5.2 The review will include a consultation between the relevant parties and any other organisations or individuals as appropriate regarding organisational arrangements for the management of an outbreak.

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

## PART 2: OUTBREAK PLAN ORGANISATION

### 2.1 MEMBERSHIP OF THE OUTBREAK CONTROL TEAM (OCT)

The OCT comprises of three categories of members: **Core Members**, who are involved in all outbreaks, **Co-opted Members**, who are co-opted as necessary when the outbreak requires their expertise or lies within their sphere of operations, and additional **Professional Support Members** who support the functions of the OCT.

#### 2.1.1. Core Members (All Outbreaks)

- Director of Public Protection (or their nominated officer of sufficient seniority – see [part 3.1](#))
- Consultant in Communicable Disease Control or Consultant in Health Protection
- Health Board Clinical Lead for Microbiology
- Executive Director of Public Health of the Health Board (or their nominated officer of sufficient seniority)
- Lead Officer for Communicable Disease of relevant LAs

#### 2.1.2. Co-opted Members (the following list is provided as a prompt, but is not exhaustive)

##### Health Board

- Hospital Pharmacist
- Immunisation Co-ordinator
- Infection Prevention and Control Specialist

##### Local Authority

- LA specialist enforcement officers (e.g: Pollution Team EHO (in water incidents))
- Any other LA Officer deemed appropriate (e.g: Director of Education)

##### Public Health Wales

- Consultant Epidemiologist
- Director of Infection, Public Health Wales

##### Regulators

- Animal and Plant Health Agency
- Care Inspectorate Wales (CIW)
- Drinking Water Inspectorate
- Food Standards Agency (Wales)
- Health and Safety Executive
- Healthcare Inspectorate Wales
- Maritime Coastguard Agency
- Natural Resources Wales
- Primary Authority Representative

##### Others

- Head(s) of Communications or accountable senior communications officer from Core Member Organisation(s) and Welsh Government
- Occupational Physician
- Public Analyst



- Relevant LRF Co-ordinator (if wider civil contingency issues possible- [see part 7](#))
- Relevant Water Company
- Representatives from other Outbreak Control Teams/LAs
- Others as appropriate

### 2.1.3. Additional Professional Support Members to OCT

- Communications Officer(s)
- Epidemiologists or Data Analysts / Health Protection Nurse or Practitioner
- Outbreak dependent Resource Team provided by:
  - a) Local Authority
  - b) Public Health Wales;
  - c) Microbiology Laboratory; and
  - d) Health Board.

## 2.2 ROLES AND RESPONSIBILITIES OF OCT MEMBERS

### 2.2.1 Core Members

- Are required to be OCT members for all outbreaks
- Where it is felt that a core member will have little to no involvement if the situation being managed following their involvement in ensuring the OCT is properly convened they may, only where they agree, cease to attend meeting and be updated through receiving the SitReps mentioned below
- Have specified roles and responsibilities under this plan as laid out in [part 3](#)
- Will achieve consensus on decisions about the management and control of the outbreak and are jointly accountable for decisions made by the OCT
- Are responsible for ensuring the OCT functions correctly and in accordance with this plan
- Ensure that co-opted members appropriate to the outbreak are invited to join the OCT and are given the opportunity contribute fully on matters within the sphere of their expertise or field of operations
- Agree who (usually the Chair) and to whom multi-agency updates (SitReps) are provided to following meetings where matters of interest are discussed (rather than being in a monitoring phase)
- Agree who (usually the Chair) will make a report to the CEO of the relevant Health Board(s) where there are unresolved issues regarding measures that have not been implemented or where there is serious disagreement within the OCT

### 2.2.2 Co-opted Members

- Are co-opted by Core Members as necessary when the outbreak requires their expertise or lies within their sphere of operations
- Regulators such as CIW, HSE, Food Standards Agency and Drinking Water Inspectorate will be co-opted where matters within their jurisdiction are being considered and their powers or responsibilities may contribute to management and control of the outbreak
- Will achieve consensus on decisions about the management and control of the outbreak and are jointly accountable with Core and other Co-opted members for these decisions
- Are required to follow the rules of engagement and principles laid out in this plan

### 2.2.3 Professional Support Members

- Provide support to the OCT in their area of professional expertise to manage the outbreak
- Undertake tasks as directed by the OCT

## 2.3 DUTIES OF THE OCT

### 2.3.1 These may include:

- Appointing a Chair (bearing in the mind the advantages of continuity).
- Ensuring that in the absence of a team member a competent deputy is made available.
- Taking minutes to record decisions and actions.
- Reviewing evidence and confirm that there is an outbreak or a significant incident which requires public health intervention.
- Agreeing the case definition, case finding strategies and identification of carriers as appropriate.
- Identifying the population at risk.
- Identifying the nature, vehicle and source of infection by using microbiological, epidemiological and environmental health expertise.
- Investigating the outbreak, implementing control measures and monitoring their effectiveness, using laboratory, epidemiological and environmental health expertise.
- Ensuring adequate human and other resources are available for the management of the outbreak.
- Escalating any concerns about resource and other issues to the appropriate agencies
- Ensuring appropriate arrangements are in place for out of hours contact with all members.
- Preventing further cases elsewhere by communicating findings to national agencies.
- Developing communications strategy to keep Welsh Government, relevant local organisations, the general public and the media appropriately informed.
- Providing support, advice, and guidance to all individuals and organisations directly involved.
- Considering the potential staff training opportunities of the outbreak (attendance at the OCT is at the discretion of the Chair).
- Identifying and utilising any opportunities for the acquisition of knowledge about communicable disease control.
- Declaring the conclusion of the outbreak and preparing a final report with recommendations and evaluating the outbreak response.

## 2.4 RULES OF ENGAGEMENT OF THE OCT

- 2.4.1 At the first meeting of the OCT, **all** members (whether core or co-opted) will agree to work to this plan. No organisation will attend in an observer capacity (except by invitation of the Chair). **The primary duty of each member of the OCT is to contribute fully to the control of the outbreak and the protection of public health.** All other duties will be secondary.

- 2.4.2 Each member will recognise the roles and duties of other members, particularly where an outbreak crosses LA boundaries or involves a hospital(s).
- 2.4.3 Members of the OCT must declare any known interest in any organisation or premises that is the subject of the outbreak investigation. This is likely to occur if the premises are owned by the HB, Public Health Wales, or LA. Anyone who declares such an interest should not chair the OCT. Where an interest is declared, the Chair of the OCT should consider the potential conflict of interest and make the final decision as to participation in the OCT. A person having an interest in the premises and if permitted to participate in the OCT, shall refrain from voting on a policy or action by the OCT. Alternatively, the Chair of the OCT may require the nomination of an additional person from that organisation to the OCT or ask for that individual to be replaced on the OCT.
- 2.4.4 Any OCT member, whether core or co-opted, **must** disclose all relevant information about any organisation or premises they regulate which is the subject of the outbreak investigation.
- 2.4.5 In the early stages of an investigation, it is not always apparent whether any criminal offence has been committed. However, the OCT is reminded that the police or other relevant enforcing agency may initiate an investigation where there is an indication of a criminal offence. The relevant enforcing agency investigation may overlap with the work of the OCT and may need to be considered in the wider context of managing the outbreak.
- 2.4.6 OCT members should be aware that in these circumstances, the relevant enforcing agency has primacy so will lead the overall investigation and may use some of the evidence already gathered as part of the OCT response. They may want to lead on interviewing some of those affected by or involved in the outbreak, such as cases, Food Business Operators and/or staff.
- 2.4.7 Information gathered as part of an outbreak investigation may also be used as evidence in a criminal prosecution. OCT members should be aware that all notes and records are potentially disclosable to the defence team if the case proceeds to a court of law. This may lead to medical confidentiality conflicts for NHS staff with regard to patient identifiable information. Members of the OCT may also be asked to provide witness statements.
- 2.4.8 It is important that the points highlighted in paragraphs 2.4.5 to 2.4.7 do not hamper **either** essential outbreak management and control **or** the parallel investigation. Urgent legal advice may be necessary to resolve any issues that arise.
- 2.4.9 If measures required to bring an outbreak under control are not available or cannot be accessed, the OCT should escalate this to the Office of the Chief Medical Officer, Welsh Government (OCMO).

## 2.5 TASKS OF THE OCT

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

### 2.5.1 Preliminary Phase

- Consider whether or not cases have the same illness and establish a tentative diagnosis.
- Establish case definition (clinical and/or microbiological).
- Determine if the epidemiology suggests there is a real outbreak.
- Agree method of case finding and establishment of a single comprehensive case list.
- Collect relevant clinical and/or environmental specimens for laboratory analysis.
- Conduct in-depth interviews of index cases. Conduct appropriate environmental investigation including inspection of involved or implicated premises and other relevant environments including land, water, air, plant or equipment.
- Identify population at risk, and if appropriate, an individual from that population who will support the outbreak management;
- Identify possible factors that pose a risk a risk of further spread, including people, water, location, premises, equipment and food, and initiate immediate control measures.
- Form preliminary hypotheses on the cause of the outbreak.
- Consider whether detailed analytical studies would further contribute to understanding of the outbreak.
- Assess the availability of adequate resources to deal with the outbreak.
- Alert hospital pharmacists and/or Immunisation Co-ordinators urgently about any outbreaks where mass immunisation sessions are a possibility, co-opting them onto the OCT if necessary.
- Ensure that the Director of Infection, Public Health Wales is promptly and formally briefed even if the outbreak is being supported directly by local microbiology services.

### 2.5.2 Initial Outbreak Investigation and Control

- Identify and investigate the routes of transmission which may include food distribution chain/water supply network etc.
- Identify as many cases as possible, including through enhanced case ascertainment.
- Describe cases by 'time, place and person'.
- Construct epidemic curve.
- Collect clinical and/or epidemiological and/or environmental data from affected and unaffected persons using a standardised questionnaire.

### 2.5.3 Collation of Information

- Calculate attack rates.
- Confirm factors common to all or most cases.
- Categorise cases by 'time, place or person' associations.
- Test and review hypotheses through analytical epidemiological studies.
- Collect further clinical, environmental or any other relevant specimens for laboratory analysis if required.
- Agree potential/most likely source and mode of spread.

### 2.5.4 Control Measures

- Control the source: animal, human or environmental.

- Control the mode of spread by appropriate OCT members taking the following actions:
  - Screening and/or monitoring of cases and contacts, Isolation, and exclusion,
  - Protecting contacts by immunisation or prophylaxis
  - Giving infection control and other advice to cases and contacts
  - Examining, sampling and detaining and where necessary seizing, removing and disposing of foodstuffs
  - Giving advice in respect of closure and/or disinfection of premises
  - Giving advice on prohibition of defective processes, procedures or practices
  - Implementing water treatment or distribution mitigation measures
  - Taking appropriate enforcement/regulatory action to control the source and/or prevent/control onward transmission.
  - Or any other measure that needs to be taken depending on the risk
- Monitor control measures by continued surveillance for disease.
- Agree the parameters for declaring the outbreak over.
- Declare the outbreak over when the above has been satisfied.

### 2.5.5 Communication

- Agree who needs to know about this outbreak
- Provide multi-agency updates (SitReps) following OCT meetings – the frequency and timing will depend on the nature of discussions and the frequency of meetings.
- Consider the most appropriate means of communication with identified individuals/bodies, which may include internal & external colleagues, stakeholders, patients/cases and carers, and the public, including the need for an incident room and/or helplines. With professional communications advice, consider the range of communications channels available, including print media, broadcast and social media).
- Draw up a list of organisations that press statements should be circulated to when released.
- Ensure appropriate information and advice is given to the public, if required
- Ensure accuracy, consistency and timeliness.
- Use the media constructively.
- Consider the issues around information governance and data protection.
- Liaise with all relevant agencies including:
  - Other LAs/Port Health
  - Other Health Boards
  - Public Health Wales
  - General Practitioners
  - Education and Social Services Departments
  - Public Analyst
  - Government Agencies e.g. APHA, Natural Resources Wales
  - Welsh Government
  - Chief Veterinary Officer
  - UKHSA/Public Health Scotland/ Public Health Agency (PHA) of Northern Ireland
  - Water Companies
  - Health and Safety Executive
  - FSA
  - Local Resilience Forums

- CIW/HIW
- DWI
- Community Health Councils
- Consumer Council for Water
- Prepare a written report.
- Disseminate information on any lessons learnt from managing the outbreak.

## 2.6 PUBLIC COMMUNICATIONS

- 2.6.1 The OCT will endeavour to keep the public and media as fully informed as necessary without prejudicing the investigation and without compromising any statutory responsibilities or legal requirements and without releasing the identity of any patient/case.
- 2.6.2 At the first meeting of the OCT, a communications approach should be agreed including arrangements for dealing with the media. This should include a nominated spokesperson(s) and a process for arranging press conferences and releasing press statements and other public messages.
- 2.6.3 In reality, information may be circulating in the public domain prior to the declaration of an outbreak or before an OCT has met. It may be necessary for the communications team in any of the core members' organisations to release a holding social media post or statement promptly in response to such enquiries or circulating media stories. The communications team will make every effort to liaise with other relevant agencies before releasing this, but release of holding material in these circumstances should not be delayed to wait for a response.
- 2.6.4 The communications team must promptly inform communication teams in other relevant agencies that such an action has been necessary and provide the material released. These communications teams must inform the relevant people in their organisation (potential core members as specified in this plan) that such an action has been necessary. See 2.6.5 for approved examples of holding social media posts.
- 2.6.5 The purpose of such social media posts is to provide reassurance that the organisation has awareness of the issue (and is collaborating with other relevant organisations if this is in progress). It is not to provide any specific details on the incident. That duty lies with the OCT. Therefore, any holding posts released in these circumstances:
- Must **not** include any details about geography not already circulating in the public domain
  - Must **not** name any alleged source premises (except an educational premises if named already)
  - Must **not** be in response to any deaths without being agreed by the relevant people in their organisation (potential core members as specified in this plan).

Examples of suggested social media messages are:

*"We're aware of reports of cases of [specify symptoms eg: diarrhoea and vomiting/ rashes] in the [name of school or area, but only if this is already being named in social media already] and are investigating. More information to follow."*

*"We've received reports of suspected [name of illness eg: measles] in the [name of school or area if already identified on social media]. We are investigating with our colleagues @xxxxx and @xxxxx. More information to follow."*

Posts along similar lines will be covered under these arrangements.

- 2.6.6 Early and proactive engagement with the media and public is recommended wherever possible. However, it is recognised that there are some outbreaks in which early or proactive media engagement may have significant disadvantages or cause issues. For example, where there are parallel police investigations or police primacy, or the outbreak is amongst a group often stigmatised in media reporting or is best communicated with by different channels.
- 2.6.7 In these cases the OCT should formally discuss and document the rationale for not proactively involving the media in the OCT minutes and review it at every OCT meeting. Proactive public engagement may include a range of communication methods including social media. This may be instead of, or in addition to, press releases.
- 2.6.8 Press statements should be agreed by the OCT, or a small subgroup previously agreed by the OCT. The process for sign off should be agreed at the OCT meeting.
- 2.6.9 Press statements on behalf of the OCT will normally only be released by the Communications Officer of the organisation nominated to do so by the OCT.
- 2.6.10 **No other member of the OCT or the participating agencies will release information to the press or arrange press conferences without the agreement of the OCT.**
- 2.6.11 With the agreement of the OCT, press spokespersons will be appointed for specific purposes.
- 2.6.12 Notwithstanding the above, in the case of food poisoning outbreaks, all media statements should be prepared having regard to the provisions contained in the current Food Law Code of Practice.
- 2.6.13 Early communication will be made with Welsh Government Communications and copies of press statements will be sent to the Welsh Government and other organisations as specified by the OCT.
- 2.6.14 Consideration should be given as to whether it would be appropriate to purchase local print/social media space to provide clear public health messages in the event of a large outbreak with significant implications to the public generally.

## 2.7 CROSS BOUNDARY OUTBREAKS

- 2.7.1 Regardless of where the cases reside, the OCT will take responsibility for the investigation, management, and control of the outbreak. All involved LAs and HBs will participate fully in the OCT process.
- 2.7.2 Any initial meeting to discuss the facts will normally be chaired by the CCDC/CHP or DPP for the most appropriate LA on the information available at the time. If an outbreak is declared, the appointed Chair will usually undertake that role for the remainder of the outbreak until it is declared over unless agreed otherwise.
- 2.7.3 There will be a duty on the chair of the OCT to invite officers or professionals from local authorities, Health Boards, and relevant agencies to be part of the OCT where appropriate.
- 2.7.4 Other involved agencies other than those of the core membership will be invited to participate at an appropriate level as Co-opted members and to provide resources at a proportionate level.
- 2.7.5 The organisation of cross boundary arrangements between LAs will be in accordance with 1.2.4 (page 11) in the main plan.
- 2.7.6 Where an outbreak crosses the border and affects people living in one or more of the other UK countries or cases are part of an international outbreak, the overall Outbreak Control Team arrangements may differ. For example, the UK response may be chaired by a representative of an agency outside Wales, but the principles of this plan should still apply. The Welsh response should be guided by the requirement to protect the public's health and a local OCT may also need to be convened to manage the risk in Wales.

## 2.8 HEALTHCARE PREMISES OUTBREAKS WITH POTENTIAL PUBLIC HEALTH IMPLICATIONS<sup>5</sup>

- 2.8.1 In HBs, ultimate responsibility for infection prevention and control lies with the Chief Executive and is normally delegated to an Executive Director. The operational responsibility for infection prevention and control is then delegated to the Lead Infection Control Specialist (for example Infection Control Doctor, Consultant Microbiologist or lead Infection Control Nurse). The delivery of infection control support is through the Infection Control Team, led by the Lead Infection Control Specialist. The Infection Control Team is responsible for investigating incidents and outbreaks, reporting to the executive lead for infection prevention and control and ultimately the Chief Executive.
- 2.8.2 Most hospital outbreaks have minimal or no external public health implications and will be dealt with using the separate hospital outbreak plan. However, if an infectious disease outbreak within a hospital has any potentially serious public health implications, it will be managed using this plan (The Wales Outbreak Plan).
- 2.8.3 The Lead Infection Control Specialist will make an initial assessment of the extent and importance of any infectious disease incident and will report to the CCDC/CHP



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

- 2.8.4 If it is agreed that there are potentially serious public health implications arising from the incident and an outbreak is declared, this plan will be followed, supplemented by the hospital outbreak plan as required. Due regard should be had as to the statutory obligations of the LA in respect of certain diseases of public health importance.
- 2.8.5 It is expected that all hospital outbreak policies will stipulate that the local CCDC/CHP should be informed whenever a hospital OCT is convened regardless of the circumstances. The CCDC/CHP will assess whether there are any potential public health implications associated with any hospital outbreak. If any are identified, action should proceed as laid out in paragraph 2.8.3 and 2.8.4 above.
- 2.8.6 Whilst it is difficult to be prescriptive as to what constitutes a potentially serious public health threat, the following are suggestive features:
- the outbreak has significant implications for the community;
  - involves many cases of notifiable disease;
  - involves even small numbers of a disease which constitutes a serious public health hazard;
  - involves food or water borne transmission of infection.
- 2.8.7 If the use of this plan cannot be agreed, the issue should be referred to the Chief Executive of the HB involved.
- 2.8.8 Whenever this plan is activated, the lead organisation for media and public communications will be agreed at the OCT meeting. All media and public communications will be agreed jointly between the organisations involved and will follow the principles laid out in [part 2.6](#).

## **2.9 OUT OF HOURS SERVICE AND EMERGENCY ARRANGEMENTS**

- 2.9.1 All core members must make suitable and sufficient arrangements for providing an effective service to deal with incidents and outbreaks at all times outside normal office hours. These will include:
- In the evening and night times after normal office hours have finished
  - At weekends
  - During bank holidays
  - During extended periods of office closures, e.g. Christmas, Easter
- 2.9.2 The arrangements must include references to communications, resources and equipment, and enforcement activity administration.
- 2.9.3 All core members will ensure that effective contact arrangements and communication systems are in place and take responsibility for updating out of hours contact details/arrangements whenever necessary.

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

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

## 2.10 FORMAT FOR OUTBREAK REPORTS

2.10.1 All reports and other documents produced by the OCT must comply with the requirements of the [General Data Protection Regulation \(EU\) 2016/679](#) and the Data Protection Act 2018. For that purpose reports and other documents will anonymise any sensitive personal information and references to patients and businesses will be numerical and alphabetical, respectively.

2.10.2 There should be valid reasons for deviating from this standard format and these should be documented in the report.

### 1) Executive Summary

2) **Introduction/Background:** Brief narrative of circumstances of outbreak

### 3) Investigation:

- a) Case Definition
- b) Epidemiological
- c) Microbiological
- d) Environmental
- e) Chemical (if required)

### 4) Results:

- a) Epidemiological
- b) Microbiological
- c) Environmental
- d) Chemical (if required)

### 5) Control Measures

### 6) Conclusions/Recommendations:

- a) A statement on the causes of the outbreak,
- b) A statement on potential failures of or gaps in policies, procedures or legislation
- c) Referrals to other agencies for their actions
- d) Comments on the conduct of the investigation, evaluation and lessons learnt
- e) Comments on any training needs identified by the investigation and performance against agreed standards
- f) All recommendations should be SMART

### 7) Appendices:

- a) OCT evaluation of the outbreak (should be included see [part 2.12](#))

- b) Results of statistical analyses
- c) Epidemiological Report

## 2.11 COMMUNICATION FOR RELEASE OF OUTBREAK REPORTS

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

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

2.11.3 The plan should include consideration of communication with:

- Cases
- Public and media
- NHS partners
- Other public agencies
- Politicians
- Board members
- Business or setting associated with the outbreak

2.11.4 The media options around release include:

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

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

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

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

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

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

2.11.8 EHOs and Health Protection Teams members should consider acquiring e-mail addresses routinely for cases on interview wherever possible.

2.11.9 As a general principle, avoid Mondays for report release and check key spokespeople available for day of release. Mondays are best avoided because it may be difficult to contact cases over a weekend, or for cases to discuss issues or ask questions over a weekend if the OCT report is provided in advance.

## **2.12 TEMPLATE FOR OUTBREAK/SIGNIFICANT INCIDENT EVALUATION INTRODUCTION**

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

- To consider the conclusions and recommendations of the OCT report and their implementation
- To seek a response from relevant agencies to whom these recommendations are directed and to consider this response.
- To identify and address the procedural and other issues contributing to the outbreak.
- To consider ways to enhance and improve the response.
- To consider future challenges in achieving improvements; and
- To draw out learning points for future outbreak response.

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

### **Outbreak Evaluation Template<sup>6</sup>**

The OCT evaluation should cover the following headings:

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

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

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

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

## **PART 3: SPECIFIC ROLES AND RESPONSIBILITIES OF CORE AND CO-OPTED MEMBERS AND ORGANISATIONS**

### **3.1 DIRECTOR OF PUBLIC PROTECTION (DPP)**

For the purposes of this plan, the DPP is defined as “the relevant Director with strategic oversight and responsibility for the Public Protection functions of the Council and the ability to commit the Council’s resources in support of the investigation of the outbreak, its management and control”.

- Together with the CCDC/CHP and Health Board Clinical Lead for Microbiology to jointly consider the facts, declare an outbreak in conjunction with the EDPH and convene the OCT.
- To provide facilities and resources for the OCT including administrative support for team meetings, if appropriate.
- Where necessary, to organise an outbreak control centre or helpline.
- Where appropriate, to make available staff to assist in the investigation of the outbreak as required by the OCT.
- To provide resources for specialist information or action on environmental health aspects of any disease control.
- To provide resources for the prompt inspection of premises considered to be implicated in any outbreak and to receive reports thereon.
- To consider the use of statutory powers as appropriate.
- To liaise with other local authorities as necessary and secure appropriate mutual aid should additional resources be required.
- To inform the Chair/Leader of the Council and Chief Executive of the Authority of the outbreak and action taken in response.
- To liaise with FSA, Primary Authority, NRW or other statutory bodies as appropriate.
- To liaise with other DPPs and the Welsh Government if the outbreak is wider than of local and/or other significance.
- To liaise with other bodies including government departments such as DEFRA, and government agencies such as the FSA, Natural Resources Wales, Drinking Water Inspectorate, Health & Safety Executive, Animal and Plant Health Agency and other bodies, such as Dwr Cymru, as appropriate.
- Where appropriate, to provide resources to carry out environmental investigations and where necessary to exercise powers of entry, closure or prosecution.
- Where appropriate, to provide resources for the transport of clinical and/or environmental specimens to recognised laboratories for examination.
- Where appropriate, to provide resources to investigate the availability of cleansing and/or other treatment of premises, articles, equipment, land, and animals, seeking specialist advice as appropriate.
- To provide local information including that on vulnerable groups, businesses and institutions where appropriate.
- To contribute to the preparation of the final report with other members of the OCT and to facilitate its distribution and publication as appropriate.

### 3.2 CONSULTANT IN COMMUNICABLE DISEASE CONTROL/CONSULTANT IN HEALTH PROTECTION

- Together with the DPP and HB Clinical Lead for Microbiology jointly consider the facts, to declare an outbreak in conjunction with the EDPH and convene the OCT.
- To inform the Office of the Chief Medical Officer, Welsh Government (OCMO), the HB's EDPH, Public Health Wales' National Director, Health Protection and Screening Services and colleagues of the outbreak in accordance with escalation processes.
- To act as the Proper Officer of the local authority.
- To initiate case finding as appropriate.
- Where appropriate, to call on and deploy the resources of Public Health Wales to support the OCT. This shall include:
  - facilities and resources for the OCT including administrative support for team meetings.
  - organise an outbreak control centre or helpline.
  - provide staff to assist in the investigation of the outbreak as required by the OCT.
  - secure sufficient epidemiological, analytical and other specialist professional advice/assistance available.
  - act to coordinate the available resources of Public Health Wales on behalf of the OCT.
- To provide or source expert advice on communicable disease control/health protection / epidemiology to the OCT on the management of the outbreak including:
  - interpretation of clinical data, methodology of investigation and control measures to minimise spread and prevent recurrence.
  - assess and collate epidemiological information and to arrange epidemiological studies.
  - request/require medical examination of cases and contacts and the taking of clinical specimens either directly or in collaboration with the relevant Health Board and/or local authority.
  - request/require immunisation and/or prophylaxis for cases, contacts and others at risk in collaboration with the relevant Health Board.
- To communicate with partner agencies as appropriate, including: OCMO Welsh Government, local authorities, Health Boards, UKHSA, Animal and Plant Health Agency, FSA and water companies.
- Formally notify the Welsh Government when an outbreak has been declared, providing updates following every OCT meeting and provide formal notification that outbreak has been declared over.
- To consult and liaise with CDSC and with other CCDC/CHP's regarding the support that is available to the OCT and to ensure they remain informed of developments.
- To contribute to the preparation of the final report with other members of the OCT and to facilitate its distribution and publication as appropriate.

### 3.3 HEALTH BOARD CLINICAL LEAD FOR MICROBIOLOGY

- Together with the CCDC/CHP and the DPP jointly consider the facts, to declare an outbreak in conjunction with the EDPH and convene the OCT.
- To provide expert microbiological advice to the OCT on patient management, interpretation of clinical data, methodology of investigation, collection of specimens and control measures required to minimise spread and prevent recurrence.
- To liaise promptly with the Director of Infection, Public Health Wales to ensure appropriate specialist advice and support is made available from services within Wales and UKHSA if appropriate.
- To provide an outbreak number or advice on labelling outbreak microbiology samples on request from the DPP or the CCDC/CHP and communicate this to the OCT.
- To arrange prompt examination/analysis and reporting of clinical and/or environmental samples, as required.
- To advise from a microbiological perspective on the inspection of premises and other implicated settings as appropriate and collection of appropriate samples, as required.
- Where necessary, to provide certificates of examination/analysis in respect of samples submitted for examination.
- Where appropriate, to arrange for any further testing or typing of organisms identified or isolated.
- To liaise with other public health, hospital and reference laboratories as necessary.
- The local Microbiology Laboratory will normally:
  - provide suitable specimen containers and request forms if appropriate;
  - provide or facilitate laboratory testing facilities;
  - arrange for any special investigations required to be carried out by reference laboratories;
  - be responsible for arranging transport of specimens/isolates to reference laboratories; and
  - provide both rapid and written confirmation of relevant results to the OCT. An agreed process should include both positive and negative results on suspected cases and contacts for the organism under investigation.
- To prepare the final report with other members of the OCT and to distribute and publish as appropriate.

### 3.4 EXECUTIVE DIRECTOR OF PUBLIC HEALTH OF THE HEALTH BOARD

**[Out of Hours, this role should be temporarily covered by the HB Executive Director on Call until EDPH available]**

- To consult with the CCDC/CHP, the DPP and the HB Clinical Lead for Microbiology on their initial assessment.
- In conjunction with these individuals, to jointly declare an outbreak.
- Support the Health Board to fulfil its statutory responsibilities that are applicable to outbreak management and Control.
- To ensure that a senior representative of the HB is always available to respond in the event of an outbreak.
- To attend (or nominate a sufficiently senior member of staff to attend) OCT meetings.



- Where appropriate, to call on and deploy resources controlled/contracted by the HB at short notice to investigate and control communicable disease outbreaks, including skilled staff and resources (e.g. for urgent immunisation sessions/clinical examinations /chemoprophylaxis) as necessary.
- To provide/facilitate access to patients suffering from infection, their health records, clinical colleagues, and information held on databases if necessary for outbreak investigation and control.
- To disseminate information to the public or health professionals locally as agreed by the OCT.
- To liaise with other HB EDPHs if required and notify the HB Chair and CEO.
- To contribute to the preparation of the final report with other members of the OCT and to facilitate its distribution and publication as appropriate.

### **3.5 LEAD OFFICER FOR COMMUNICABLE DISEASE OF THE LOCAL AUTHORITY**

- Attend any preliminary incident meeting, provide appropriate information and advice, collaborate with other agencies and report to the DPP.
- To provide specialist information or action on environmental health aspects of communicable disease control.
- To initiate case finding as appropriate.
- To arrange for the prompt inspection of premises considered to be implicated in any outbreak and to receive reports thereon.
- At an early stage in the investigation to arrange to inform the FSA of any outbreak where food is implicated providing suitable and sufficient initial information.
- To ensure the FSA is informed of suspected or emerging foodborne incidents as required by the Food Law Code of Practice (Wales).
- Where appropriate, to carry out environmental investigations and where necessary, to consider use of statutory powers including exercising powers of entry, closure or prosecution.
- To provide expert advice on the use of health protection legislation and an awareness of how other areas of legislation may be applied to meet the aims of the OCT
- To liaise with other bodies including Welsh Government, government departments such as DEFRA, and government agencies such as the FSA, Natural Resources Wales, Drinking Water Inspectorate, Health & Safety Executive, APHA and other bodies, such as Dwr Cymru, as appropriate.
- Where appropriate, to arrange for the transport of clinical and/or environmental specimens to recognised laboratories for examination.
- Where appropriate, to investigate the availability of cleansing and/or other treatment of premises, articles, equipment, land and animals, seeking specialist advice as appropriate.
- To provide local information including that on vulnerable groups, businesses and institutions where appropriate.
- To contribute to the preparation of the final report with other members of the OCT.

### 3.6 ROLES OF LOCAL AUTHORITIES, HEALTH BOARDS, PUBLIC HEALTH WALES AND OTHER AGENCIES

#### Key organisations and their main roles and/or functions in Outbreak Control\*

Organisation	Main Role(s) and/or Functions
Welsh Government	Seeks assurance for the Minister through the CMO(W) and Director General of Health and Social Services that the response and management of clusters and outbreaks in Wales is in line with the requirement of the Wales Outbreak Control Plan and all agencies identified in the plan fulfil their role and statutory duties as indicated within this plan and are accountable for the actions taken.
Local Authorities	Responsible for the control of health hazards (including notifiable infections, food poisoning etc), health and safety matters and incidents relating to drinking water in their areas. The Local Authority appoints a Proper Officer to undertake certain functions on their behalf.
Health Boards	Responsible for the health of people in their areas and for commissioning health services. ( <i>exact quote from public inquiry report</i> )
Public Health Wales	Statutory duty to provide services, support, and expertise, (including microbiological testing) for the surveillance, prevention, and control of communicable diseases to help LAs and HBs fulfil their statutory duties.  CCDC/CHPs are also authorised proper officers for the LAs under the Public Health (Control of Disease) Act 1984.
Food Standards Agency Wales	Responsible for protecting public health in relation to the food chain and consumers' wider interests in food and providing support to local authorities and other Government departments.  FSA are notified of foodborne outbreaks which meet the definition of an incident set out in the FSA code of practice for LA's. The role of the FSA is to assist in the investigation of foodborne outbreaks through provision of advice and/or scientific risk assessments to ensure that any remedial action takes account of food safety issues.  FSA lead on national food and feed chain investigations (including withdrawal and recall of food) and are the national contact point for communication between national food safety authorities (including the EU) where implicated foods have originated from or been distributed outside of the UK.
UK Health Security Agency	Provides specialist and reference microbiology services and national expertise to support outbreaks in Wales when required.

Water Companies	Statutory duty under the Water Industry Act 1991 to supply safe and wholesome water, as defined in the Water Quality Regulations, within their respective regions. When a breach of a water quality standard has occurred that might have a potential impact on public health, water companies are required to inform the relevant Local Authorities and CCDC/CHPs and to agree, and undertake, the appropriate investigations and mitigation measures to control or prevent potential risk.
Health & Safety Executive	The HSE is an enforcing authority responsible for the health and safety at work in Great Britain. HSE regulates health and safety across a range of sectors and industries including major hazard sites. The Health and Safety (Enforcing Authority) Regulations 1998 allocate workplace activities to either HSE or LAs for enforcing health and safety legislation.
Care Inspectorate Wales	Responsible for registering and inspecting regulated services in Wales.  This includes: care homes for adults and children, including those providing nursing care, domiciliary support services, child care and play services for children up to 12 years old and residential family centres.
Drinking Water Inspectorate	Acts for and on behalf of the Secretary of State and Welsh Ministers to ensure that water companies in England and Wales meet their statutory obligations under the relevant Water Supply (Water Quality) Regulations, with regards to drinking water quality.
All Public Bodies	Duty to collaborate under: <ul style="list-style-type: none"> <li>• Civil Contingencies Act 2004 (all except *) are</li> <li>• Category One Responders under this Act</li> <li>• Well-being of Future Generations (Wales) Act 2015 (for public bodies in Wales)</li> </ul>

Adapted and developed further from: The Public Inquiry into the September 2005 Outbreak of *E. coli* O157 in South Wales: Chair Professor Hugh Pennington March 2009

### 3.7 THE LEAD OFFICER FUNCTION

#### 3.7.1 Lead Officer in Communicable Disease

- The development of the Lead Officer for Communicable Disease concept has two functions, namely:
  - The appointment of officer(s) within LAs who has specific expertise and responsibilities in the Communicable Disease function; and
  - To work with others as a cohort of specialists in the Communicable Disease function to be used on various locations in Wales to assist in the investigation, control and management of outbreaks of Communicable Disease.
- The initiative is supported by all LAs in Wales and given approval by the DPP in Wales and included in the CMO(W)'s Communicable Disease Strategy, published in July 2001.

- This is part of the continuing development of the communicable disease function in LAs and in particular the implementation of the Communicable Disease Outbreak Plan and is considered to be an important aspect of a LA 's role in providing effective and sufficient resources to enable it to respond to significant outbreaks and incidents of communicable diseases.
- The CMO(W)'s Communicable Disease Strategy has recommended the adoption of the principle of a "Lead Officer" and the Welsh Government has provided a level of funding, through Public Health Wales, to facilitate the training of Lead Officers in all LAs in Wales.

### 3.7.2 Lead Officer (local authority)

Each LA in Wales will appoint at least one named "Lead Officer" for communicable disease. This officer will be an existing employee of a LA working in the communicable disease/food safety or health and safety team within the public protection department.

### 3.7.3 Qualifications

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

### 3.7.4 Role

- To provide expert advice and information on all aspects of the communicable disease function within the LA
- To advise on specific aspects of investigation of serious or significant incidents of communicable disease
- To provide advice and support to the Chair of the OCT during significant outbreaks of Communicable Disease
- To provide expert advice on the use of health protection legislation
- To lead the investigative processes for such outbreaks on behalf of the LA.
- To assess the effectiveness and progress of such investigations.
- To be available for secondment to another LA following a request from that authority. This secondment is to assist that authority in the performance of tasks outlined in this document.
- To support other Lead Officers in relation to other communicable disease issues.
- It is anticipated that this officer will be a named person in the Communicable Disease Outbreak Plan but will not assume the responsibility of chairing the OCT convened to manage and control the outbreak. This function has already been dealt with in the Plan.

### *Further aspects to consider*

#### 3.7.5 Level of appointed person

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

#### 3.7.6 Type of specialism required

It is anticipated that the Lead Officer will be or have had experience in the Communicable Disease function.

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

#### 3.7.7 Arrangements for Collaborative Working

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

The collaborative working may take several forms, namely:

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

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

## **PART 4: WATER SPECIFIC ISSUES**

### **Health Related Incidents in Wales Potentially Caused by Contaminated Drinking**

#### **Water**

#### **4.1 INTRODUCTION**

4.1.1 This Annex sets out a consistent approach to managing communicable and environmental health related incidents potentially caused by contaminated drinking water. It has been adapted from the Drinking Water Annexes in the Communicable Disease Outbreak Plan for Wales ('The Wales Outbreak Plan (September 2012)) and the Environmental Incident Framework ('Managing public health risks from environmental incidents: Guidance for Wales' (March 2014)).

4.1.2 Identical copies of this Annex are provided in these plans and the relevant plan should be followed in the event of communicable disease outbreaks or environmental incidents involving drinking water supplies.

#### **4.2 PURPOSE**

4.2.1 This Annex sets out a multi-agency process for potential health-related incidents which involve both public and private drinking water supplies. It is designed to guide those involved, encourage collaboration between agencies and clarify process and roles and responsibility. By covering both communicable and environmental incidents, it will ensure a consistent response to drinking water events and facilitate a rapid and effective response to emergency situations.

4.2.2 The Annex does not override national and local resilience plans or the statutory duties of individual organisations. It does not describe the detailed internal procedures of the water companies and the reporting requirements to the Drinking Water Inspectorate.

#### **4.3 INCIDENT MANAGEMENT**

4.3.1 Responsibility for managing the public health aspects of event, incidents and outbreaks involving water is shared by Local Authorities, Health Boards and Public Health Wales, with the full assistance of the relevant Water Company and their service providers, plus other experts or relevant consultants. In Herefordshire (as part of England), Public Health England takes the responsibility of the Health Boards and Public Health Wales.

4.3.2 For the purposes of this Annex, a water quality event is defined as any biological, chemical, or radiological occurrence which by its nature is required to be notified under the Water Supply (Water Quality) Regulations (Wales) 2018 or the Private Water Supplies (Wales) (Amendment) Regulations 2017<sup>7</sup>

4.3.3 When an event has the potential to have a significant<sup>8</sup> impact on public health, it can be escalated to an incident and an Incident Management Team (IMT) formed (see [Flowchart 1](#)).

- 4.3.4 Any party can notify other parties of an incident with potential public health implications and initiate an IMT (see [Flowchart 2](#)). The criteria for calling an IMT are given in [Box 1](#).
- 4.3.5 If the incident becomes an outbreak, an outbreak should be declared, the IMT dissolved and an OCT formed (see [Flowchart 1](#)). The OCT will operate as laid out in the Wales Outbreak Plan.
- 4.3.6 The primary objective of the IMT or OCT is to protect public health by identifying the source of the contamination and implementing the necessary control measures to minimise or reduce exposure and prevent further spread, recurrence or exposure.
- 4.3.7 Both the Outbreak Plan and the Environmental Incident Management Guidance outline the membership and duties of the IMT/OCT.

**Core Members:**

- Local Authorities
- Local Health Board(s)
- Public Health Wales (supported by Public Health England CRCE Wales for environmental incidents)
- Water companies
- External Advisors (accessed through Water Company)

**Co-opted Members:**

- Natural Resources Wales
- Medical Physicist
- Food Standards Agency
- Emergency Planning Officers (Water Companies or LAs)
- Animal Health and Veterinary Laboratories Agency
- Drinking Water Inspectorate

- 4.3.8 The IMT will usually be chaired by a health or the local authority representative and the Chair will be agreed at the first meeting. However, any member of the IMT can chair by the agreement of the members of the IMT. All meetings of the IMT should be minuted and actions and decisions logged.
- 4.3.9 The core actions of a drinking water IMT are summarised in [Flowchart 3](#) and include:
- Undertake a risk assessment to identify the contaminant(s), the source and extent of contamination (see [Checklist](#)).
  - Identify gaps and information needed to update the risk assessment.
  - Evaluate and characterise the risk to public health and likely illness in the community, including defining the population at risk and identifying any high risk / susceptible individuals such as immunocompromised groups, home dialysis patients, health-care settings.
  - Declare an 'Outbreak' (in line with the principles in [part 1.3](#) of the main plan) if there is evidence of communicable disease following the contamination incident.
  - Agree and initiate immediate and long-term control measures to reduce exposure. Examples of control measures are given in [Box 2](#). Immediate control

measures may have been taken by the water company before the IMT is formed and these should be reviewed by the IMT.

- Communicate to the public and medical professionals including publication of media statements.
- Consider undertaking an epidemiological study to describe symptoms/cases (see [Box 3](#)):
  - i. Screening and monitoring of exposed population.
  - ii. Provision of medical care such as prophylaxis etc.
- Monitor control measures by continued surveillance for disease/symptoms.
- Live Warning Notices subject to agreed criteria being met.
- Evaluate the management of the incident and make appropriate recommendations for the future.
- Declare the incident over.
- Produce report on the outcome, including recommendations and epidemiological report (if required).

4.3.10 Once the incident is clearly under control, an interim report should be prepared and shared with all the relevant bodies including Welsh Government, DWI, the affected LAs, as well as all IMT members (this is distinct from the reports which the water companies are required to submit to DWI). A final report including recommendations should be produced but may need to be delayed until any epidemiological studies can be completed. Consideration should be given to publishing the incident in a peer-reviewed journal to strengthen the evidence base.

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

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

#### **4.4 MEDIA AND COMMUNICATION ISSUES**

4.4.1 The IMT should agree a media and communication strategy including which agency should lead communication issues. For mains water, this is usually the Water Company since they will have considerable experience of communicating directly with consumers and will have arrangements in place to deal with issuing advice to people, and the capabilities to handle calls from concerned members of the public during incidents. Furthermore, water companies will be able to identify and map the extent of the affected area and should be able to provide details of the affected area by postcode on their website.

4.4.2 For incidents involving private water supplies, LAs will have the responsibility for communication issues with the duty holder and/or consumer (if affected).



4.4.3 LAs have responsibility for contacting high risk premises including food and drink premises, social housing<sup>9</sup> and public buildings such as schools.

4.4.4 Public health professionals will have an important role in communicating the risk to health during a drinking water incident and in alerting health services. They should provide technical and medical advice to any Frequently Asked Questions (FAQs) that may be prepared and disseminated by the Water Company or Local Authority staff to affected areas. These FAQs should be agreed at the IMT and disseminated in a controlled fashion to key partners. The IMT should ensure that every effort is made to ensure that consistent media communications are used by all partners in their call centres, helplines and websites.

4.4.5 The core actions of the media/communications strategy include:

- Consider the best means of communication with colleagues, patients and the public, including the need for an incident room, websites and social media and/or helplines.
- Agree which agency will take the lead on communication.
- Ensure appropriate information and advice is given to the public, especially those at high risk. Consider use of drinking water warning notices (see [Box 4](#)).
- Agree common lines to take and FAQs to be used by all organisations.
- Ensure accuracy and timeliness of the messages.
- Include all those who need to know, public, professionals, politicians (local and national), police and administrations.
- Liaise with other agencies as appropriate.
- Consider using social media to obtain intelligence about community impacts/concerns.
- Advise people when the incident is over.
- Prepare a written report (if required) and disseminate information on any lessons learnt from managing the incident. Clarify the route for dissemination of the report and recommendations – this may be via submission to LA, HB and Welsh Government.

## 4.5 ROLE OF THE WATER COMPANY

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

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

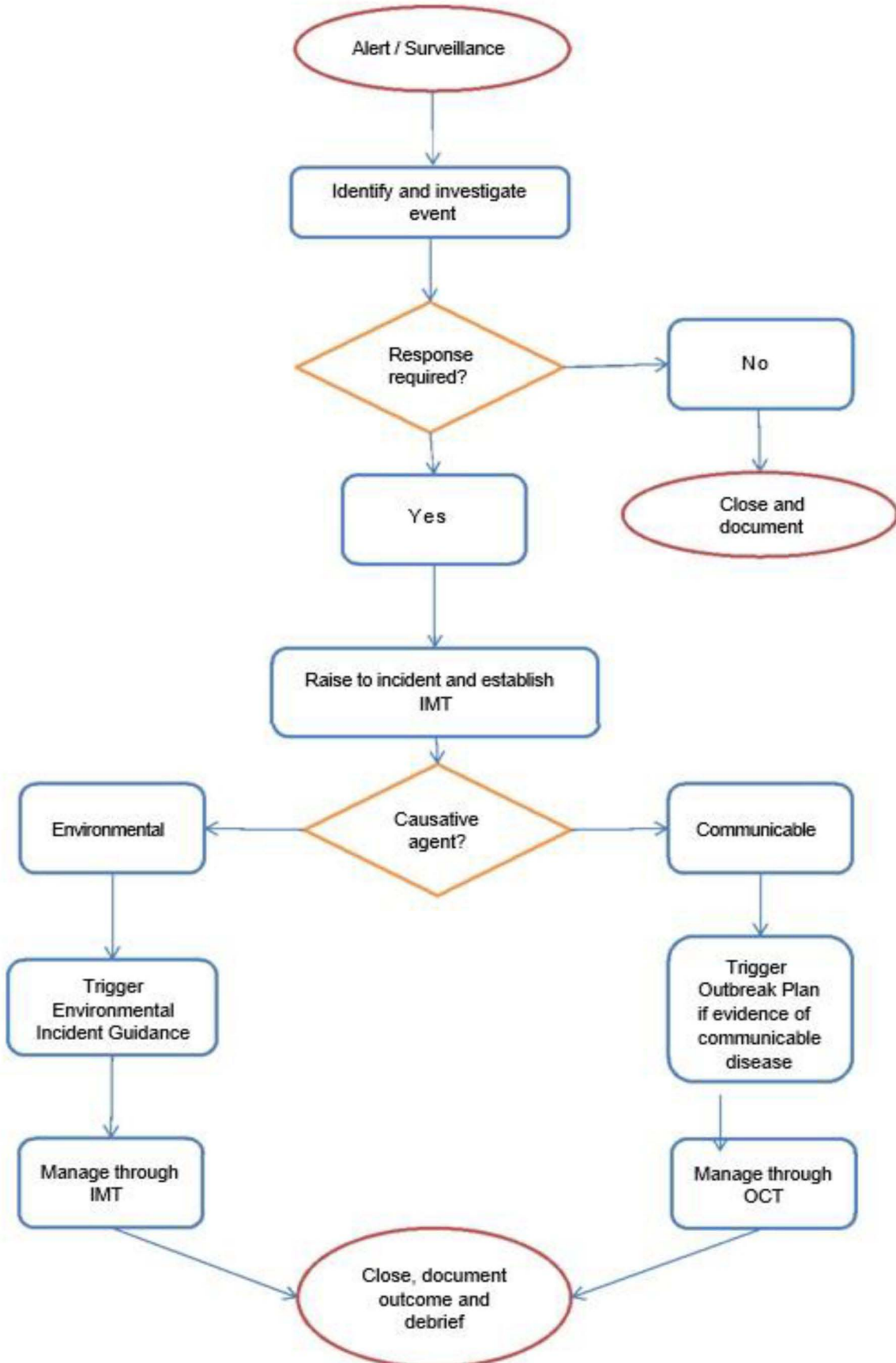
- Understand the cause, effects and extent of the issue and inform the IMT/OCT fully of any events before the incident or outbreak was declared.
- Make the appropriate operational decisions on behalf of the IMT or OCT and ensure that they are immediately and fully implemented by the water company.
-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

## 4.6 DRINKING WATER TESTING

4.6.1 Water Companies have a duty to test drinking water for the parameters set out in the Regulations. This includes routine compliance tests at consumers' taps, service reservoirs, Water Companies have a duty to test drinking water for the parameters set out in the Regulations. This includes routine compliance tests at consumers' taps, service reservoirs and at the treatment works. During an incident involving a public water (mains) supply, the Water Company will be responsible for testing the water, identifying the source and the extent of any contamination. They will also undertake tests to ensure that it is safe to restore the supply.

4.6.2 Local authorities are responsible for collecting and analysing samples from private water supplies. As local authorities do not have their own laboratories, they will use an external laboratory which should be suitably accredited. They are able to charge the owners/users of private water supplies for monitoring their supply. In the event of an incident involving a private water supply the local authority will undertake monitoring.

4.7 FLOWCHART 1. IMT ESCALATION PROCESS



#### 4.8 BOX 1. CRITERIA FOR ESTABLISHING AN INCIDENT MANAGEMENT TEAM (IMT)

An **exceedance** of drinking water standards (e.g. a prescribed concentration or value (PCV)) and guidelines as set out in the Water Supply (Water Quality) Regulations (Wales) 2018 and the Private Water Supplies (Wales) Regulations 2017 that is unacceptable in terms of public health (termed a non-compliance event).

- Reports of an **unusual deterioration or changes** in water quality that may have an implication on public health. For example, analytical data suggesting increase metal or pesticide concentrations, changes in colour or turbidity that may indicate a change in the water treatment process.
- Reports of **failure or poor performance** of water treatment and disinfection activity.
- Reports of **potential external contamination of** a water supply or water catchment area that could result in a future non-compliance event or near miss (for example diesel spillage threatening water supply).
- Reports of **site security issues** associated with water supply or treatment process. Note: An Incident of this type would be managed by the water company through their emergency security protocol and may involve other agencies such as the police that may affect the conduct of the incident as described in section 2.4.5 - 2.4.8
- Any evidence of **unusual and unexplained clustering of cases** in the community related to a water supply.
- Any significant **perceived risk** to the health of consumers.
- Significant **consumer perception or concern** about the quality of the water supplied or changes in water quality.
- One or more core partners have already declared the event a public health incident.

## 4.9 BOX 2. EXAMPLES OF CONTROL MEASURES

### Immediate:

- Stop water abstraction
- Flushing of supply system or individual supply pipes (e.g. lead pipes)
- Issue warning advice/ notices:
  - Boil before Use for drinking and food preparation (BWA)
  - Do not use for Drinking or Cooking (DND)
  - Do not use for Drinking, Cooking or Washing (DNU)
- Providing alternative supplies, such as:
  - Bottled water (also see <http://www.legislation.gov.uk/wsi/2015/1867/contents/made>)
  - Bowsers and tankers
  - Diverting sources or Re-zoning (introduction of water from a different supply)

### Long-term / permanent:

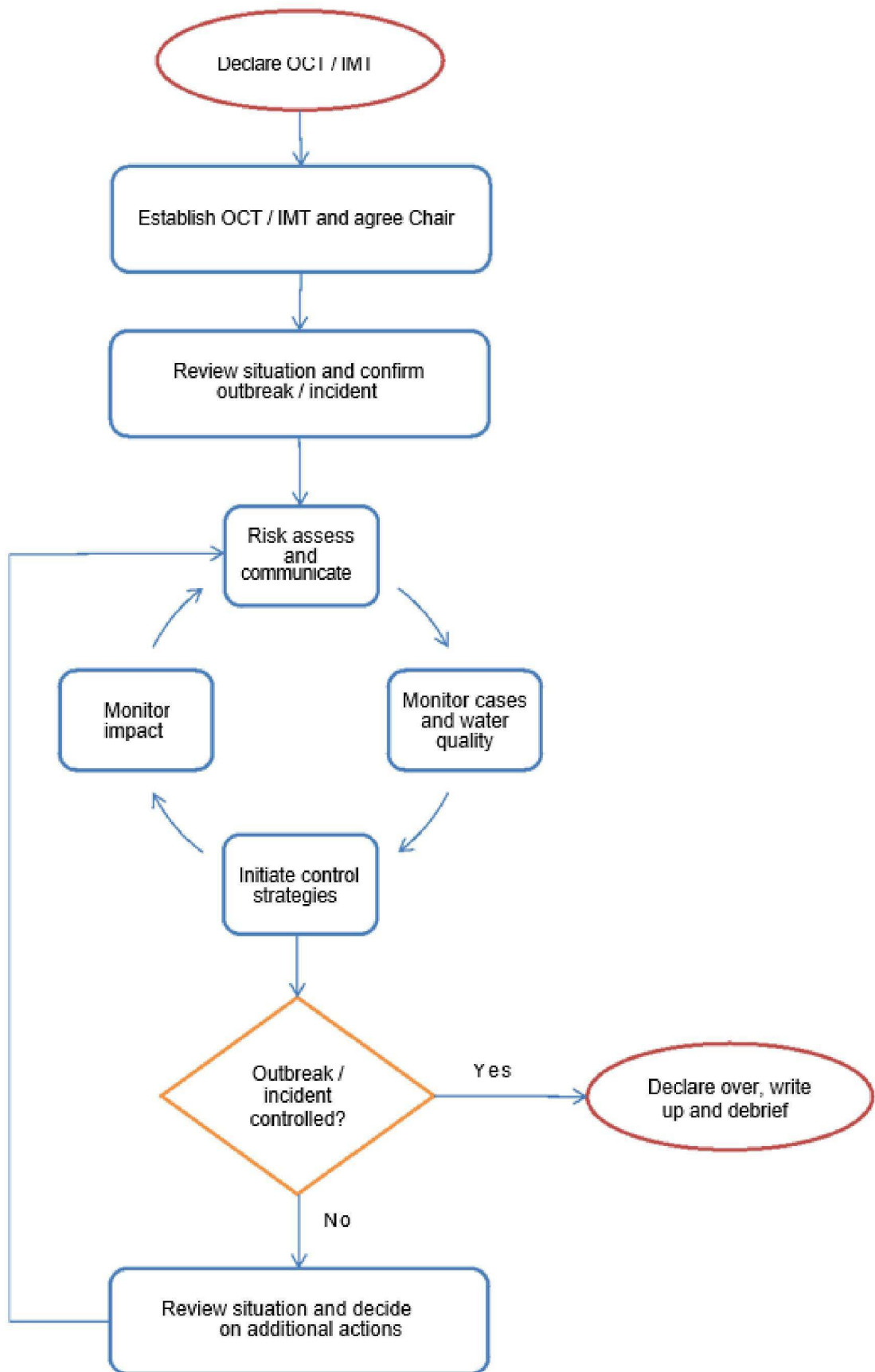
- Additional water treatment processes (process control)
  - Activated carbon
  - Water filters
  - Increased disinfection
  - Phosphate dosing
- Replacement of water pipes e.g. lead pipes
- Permanent provision of different supply (e.g. moving from private water supply to mains)

### Public Health Controls:

- Isolate or exclusion of cases and contacts
- Screening and monitoring of contacts
- Immunisation or prophylaxis
- Specific advice and interventions to highly susceptible groups e.g. protection measures for:
  - for immunocompromised groups
  - recommend home dialysis patients receive treatment in hospital
  - lead exposure and children
  - bottled water and infants



### 4.11 FLOWCHART 3. CORE ACTIONS OF IMT



#### 4.12 BOX 3. EPIDEMIOLOGICAL EVIDENCE USED TO DETERMINE LIKELY ASSOCIATION WITH DRINKING WATER

The following evidence that may contribute to defining an outbreak or environmental incident independently of findings related to water treatment and supply:

- Numbers exceeding expected background level for time and place or linked cases.
- Descriptive evidence (person, place, time): A large proportion of cases clustered in water distribution area.
- Strength of statistical association by an analytical epidemiological approach (e.g. case-control or cohort), especially with dose response (risk increased with amount of water consumed).
- Biological plausibility and consistency with natural history of pathogen or chemical.
- Plausibility in terms of descriptive details, outbreak dynamics, spatial and temporal distribution of the chemical contaminants etc.
- Analogy with other waterborne outbreaks (such as the high proportion of adult cases in suspected *Cryptosporidium* outbreaks).
- Strength of likely association increased by recovery of pathogen from supply or confirmation of chemical exposure.
- Lack of evidence for plausible alternative explanation.
- Case numbers decrease following the introduction of appropriate control measures.



#### 4.13 BOX 4. DRINKING WATER WARNING MESSAGES

The type and nature of the warning advice given will depend upon the type and nature of the contaminant and the overall risk assessment

In all cases there is an issue with the public following advice when incidents are prolonged and the IMT should consider repeating warning messages in these circumstances.

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##### **Boil before Use for drinking and food preparation (BWA)**

- Most frequently used.
- Typically for microbial contamination.
- Can cause inconvenience among the public and can be disruptive to certain businesses (food and drink retailers etc.) and public buildings (health care premises).
- Public are familiar with the concept.

##### **Do not use for Drinking or Cooking (DND)**

- Less frequent.
- Used for events which cause acute health effects such as chemical contamination.
- Public and businesses may be less familiar with such restrictions and will require careful communication.
- Can present a more significant challenge due to the need to provide alternative water supplies for drinking and cooking.

##### **Do not use for Drinking, Cooking or Washing (DNU)**

- Rare
- Used for events where contamination presents both an acute risk and where contact is potentially hazardous.
- Public and businesses may be less familiar with such restrictions and will require careful communication.
- Potential hygiene issue relating to the need to restrict/prevent access to water for showering and bathing.
- It is recommended that DNU notices are reserved for use only in those circumstances where there is unequivocal evidence of persistent contamination of the water supply with a chemical or radioactive substance at a concentration where short-term exposure is likely to give rise to adverse health effects including dermal effects.

**The responsibility for the issue of these notices rests with the Water Company at all times.**

#### 4.14 CHECKLIST: RISK ASSESSMENT

### Checklist: Risk Assessment (1 of 3)

#### Assessing the Hazard

What is the source of the water? Surface water, groundwater, public or private supply

What is affected?

- Treated water supply
- Boreholes / well reservoir/river
- Residential, commercial property
- Public building

Identify actual or suspected contaminants

- Chemical
- Biological
- Radiological

What testing has been undertaken or is planned?

- What samples have been taken and what analysis should be done
- Analytical techniques and timescale for analysis.
- Availability of historical water quality testing data (e.g. is this a recurring event)

Is it biological?

- What is the organism involved?
- What is the incubation period?
- Seriousness of the disease – pathogenicity, virulence.
- Mode of transmission.
- Susceptible / vulnerable persons?

Is it chemical / radiological?

- Acute and chronic toxicity
- Is there a latency period and/or delayed effects?
- Main route of exposure?
- Susceptible / vulnerable persons
- Identify possible cross reactions with water treatment chemicals and potential for harmful by-product formation

Is the current data sufficient or is more data needed?

## Checklist: Risk Assessment (2 of 3)

### Assessing Exposure

Define the population at risk

- Who is currently affected/exposed?
- Populations at risk of future exposure?
- Identify high risk populations (e.g. hospitals, nursing homes, dialysis patients, children, areas at risk from back siphonage)
- Consider mapping affected areas.

What is the likely duration of the incident?

- Travel time within the water supply system or water course under normal operating conditions.
- How will remedial measures such as re-zoning, high velocity flushing affect time estimates.

How long have people been exposed?

Collect epidemiological information on cases / exposed

- Person (age, sex, occupation)
- Place (residence, recent travel history etc)
- Time (onset of symptoms)

Laboratory results, confirmation of diagnosis or exposure (e.g. biomonitoring)

Is the current data sufficient or is more data needed?

### Operational Issues

What water treatment is in use?

Gather information:

- Any loss or any change in water treatment
- Water treatment performance
- Proposals for any additional treatment
- Risks of ingress through e.g.: ingress or back-siphonage

Proposed water storage and distribution measures?

- Provision of tankers
- Bowers
- Bottled water
- Re-zoning

## Checklist: Risk Assessment (3 of 3)

### Key Public Health Actions

Define case

Compare measured concentrations in drinking water with relevant health based guidelines and standards.

Assess plausibility (biological, temporal, spatial) between exposure and symptoms

Determine probable health effects following exposure especially for high risk individuals

Consider population health surveillance.

Consider descriptive or analytical epidemiological study to evaluate impact on health

Consider other risks such as back-siphonage and disinfection by-products.

Issue advice to public, health professionals, local authorities etc.

Consider use of helplines and/or social media to communicate with public, patients and partner agencies.

Ensure provision of medical care such as GPs/Primary Care, Hospitals etc.

Agree and initiate control measures to reduce exposure such as immediate issuing of warning notices, provision of alternative supplies, additional water treatment.

Developing the criteria for declaring incident over.

Prepare a written report on the incident.

Debrief and disseminate any lessons learnt.

## PART 5: LEGIONNAIRES' DISEASE SPECIFIC ISSUES

### 5.1 PRACTICAL ADVICE NOTE FOR SAMPLING AT INDUSTRIAL PREMISES IN LEGIONNAIRES' DISEASE OUTBREAKS

#### Context

5.1.1. This informal practical advice note only covers practical issues relating directly to urgent sampling and should not be used as a guide to other aspects of dealing with the outbreak. Detailed guidance on outbreaks potentially involving industrial premises can be found in the HSE operational guidance at: <http://www.hse.gov.uk/foi/internalops/og/og-00095.pdf>

#### Warning

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

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

5.1.4. PCR detects both (living viable) and dead bacteria. For the HSE current position on qPCR testing see: <http://www.hse.gov.uk/legionnaires/faqs.htm#Testing-monitoring>

#### *Issues to consider - legal powers of entry and to undertake sampling*

- In outbreak situations the company may co-operate fully. However the powers in the Health Protection (Wales) Regulations 2010 under the Public Health (Control of Disease) Act 1984 can be used. The Request to Co-operate Letter under this legislation is useful in this situation.
- Powers of entry under the Environmental Protection Act 1990 could be used to gain access to the premises. Section 79 of this Act allows LA's to deal with "any dust, smell or other effluvia arising on...premises and being prejudicial to health or nuisance", which includes pathogenic organisms. EHO's are allowed to enter premises and take samples, regardless of whether the premises are enforced by HSE or the LA under health and safety legislation.
- The HSE advise that case law (R v Board of Trustees of Science Museum) has confirmed that evidence of actual *Legionella* (i.e. from sampling) is not required to support enforcement under the Health & Safety at Work etc Act 1974.

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

#### Who will sample

5.1.6. Each sampling exercise must be subject to an individual risk assessment before commencement so that samplers are not put at risk.

5.1.7. Samples in industrial premises should only be taken by appropriately trained and experienced individuals.

5.1.8. Samplers could be:

- Appropriately trained Local Authority Officers
- Appropriately trained Local Authority Officers from a neighbouring authority
- Reputable private contractors offering these services

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

### Progression through workplace

5.1.10. The sampler should be accompanied by:

- The Responsible Person from the company/site to ensure safety on site.
- A Regulatory officer from the Local Authority/HSE if the sampler is not a LA officer.

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

### Chain of evidence

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

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

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

## PART 6: PRISON PLAN

# MULTI-AGENCY CONTINGENCY PLAN FOR THE MANAGEMENT OF OUTBREAKS OF COMMUNICABLE DISEASES OR OTHER HEALTH PROTECTION INCIDENTS IN PRISONS IN WALES

## 6.1 INTRODUCTION

### Background

- 6.1.1 Effective pre-planning and robust collaborative arrangements between partner organisations with responsibility for the health & welfare of prisoners need to be in place to manage incidents or outbreaks of communicable diseases, water contamination incidents or other events that pose a risk to the health of staff, prisoners and/or others entering the prison. This document provides an outline plan to manage such events and has been developed in partnership between Public Health Wales and HMPPS (HMPPS in Wales; National Operations Unit; and Health and Wellbeing Co-Commissioning).
- 6.1.2 The plan builds on and is supplementary to the Communicable Disease Plan for Wales, which sets out the core principles for how all outbreaks in Wales are managed. This plan should be read and used in conjunction with the Communicable Disease Outbreak Plan for Wales. The plan complements the English version 'Multi-agency contingency plan for the management of outbreaks of communicable diseases or other health protection incidents in prisons and other places of detention in England'. Where cross-border incidents or outbreaks occur, both plans should be considered. Additional supporting guidance for the management of gastro-intestinal (GI) infections in prisons can be found in [appendix 1](#).
- 6.1.3 This document describes both specific actions required to identify and manage an incident or outbreak, as well as describing the roles and responsibilities of partner organisations involved.
- 6.1.4 The local setting (such as whether prisoners are in open or closed conditions) will affect how this plan is implemented and whether, or how far, the wider system of justice and detention is impacted by an outbreak. National leaders at the Ministry of Justice and Home Office may need to be engaged at an early stage where there are indications of potential impact beyond the local establishment.
- 6.1.5 The **Governing Governor/Director** has a statutory responsibility to ensure the health & safety of both prisoners and staff in his/her care and a duty to cooperate with appropriate agencies to ensure that any threats to health are identified and effectively managed.
- 6.1.6 The **Health Board** has a statutory duty to protect the health & well-being of prisoners in any prisons in its geography and to work collaboratively with partners to manage any health protection issues identified.
- 6.1.7 **Public Health Wales**, through its Health Protection Teams (HPT's), works with both Health Boards, prisons and appropriate others, to investigate and manage incidents and outbreaks of communicable diseases, or other threats to health protection, in

the community. The HPT will also provide strategic coordination for the multi-agency management of such events, often relying on the NHS and other partners to provide resources and support.

6.1.8 **HMPPS** is responsible for the strategic command of incident management in prisons where incidents reach the threshold for activation of this function.

6.1.9 **Aims of the Contingency Plan:**

- To ensure that the roles and responsibilities of all partner organisations involved in protecting the health of prisoners are explicit, mutually agreed and well understood by all.
- To ensure that any outbreaks or health protection incidents are identified in a timely way and that processes for notification, collaborative work and investigation are in place to investigate the outbreak/incident, and to assess the risks to health.
- To ensure that effective measures are taken to control the outbreak/incident, to mitigate the health risks, to limit the spread of infection and to prevent its recurrence.
- To ensure that appropriate arrangements are in place for timely, effective and satisfactory communications with all relevant external agencies and the public.
- To inform national structures and capture learning to assist in the development of practice and strategic management of risk

## 6.2 ACTIVATING THE PLAN

### 6.2.1 Identifying an Outbreak/Incident:

- Any incident which may have the potential to develop into an outbreak must be reported by the prison to local HPT. In the event of uncertainty about whether to report, the prison should still contact the local HPT for their advice. Reports to the HPT are most commonly made through the clinical lead however, in their absence, reports can be made by the Governor/Director/Duty Governor/Duty Director or other senior custodial or clinical staff member on duty at the time of the incident (see [appendix 2](#) for an algorithm of reporting and [appendix 3](#) for local contact details).
- Similarly if the HPT becomes aware of a single case or cluster of cases from or affecting the prison they will inform the prison directly by contacting the clinical lead in the first instance or Governor/Director/Duty Governor/Duty Director where the clinical lead is unavailable. The clinical lead will then be responsible for ongoing communication with their Governor/Director/Duty Governor/Duty Director.
- Where the Governor/Director/Duty Governor/Duty Director has received initial contact from the HPT, they will be responsible for ongoing communication with their clinical lead.
- Following communication with the HPT, the incident will be assessed and monitored closely by the Consultant in Communicable Disease Control (CCDC) and Governor/Director in conjunction with relevant partners (e.g. Consultant Microbiologist/Virologist, Director of Public Protection (DPP) and Environmental Health).



- The following are examples of suspected or confirmed incidents which may need to be assessed:
  - An incident in which two or more people experiencing a similar infectious 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 monkeypox.

### 6.2.2 Preliminary Assessment

The HPT will advise the Governor/Director on the need to activate the outbreak plan. In making the decision to activate the plan the following factors will be considered:

- Does the disease/incident pose a risk to health or staff, visitors or prisoners?
- How many people are potentially affected?
- Is there evidence of spread within more than one location in the prison?
- Is there evidence of spread between prisons, or between prison and community?
- Is the disease or incident unusual?
- Does the disease/incident create significant operational difficulties for the prison?

6.2.3 Onset details and symptoms should be collected as per [appendix 4](#) to aid the decision to call an Incident Team or Outbreak Control Team (OCT). As a guide, the calling of an OCT will be considered when one or more of these conditions apply:

- The disease poses an **imminent or immediate health hazard** to the prison population.
- There is a **significant number** of cases.
- The disease is **important** in terms of its severity and/or its capacity to spread.

6.2.4 In close consultation with the Governor/Director, the DPP, CCDC/CHP, and Health Board Clinical Lead for Microbiology will jointly consider the facts available and will determine whether or not an outbreak does exist, in consultation with the EDPH. If required, the DPP, CCDC/CHP and Consultant Microbiologist can declare an outbreak, in conjunction with the EDPH. The prison Governor/Director/Deputy Governor/Deputy Director will be responsible for notifying the PSP Operational Manager at HMPPS in Wales, and HMPPS NOU where appropriate.

## 6.3 FRAMEWORK OF THE PLAN

6.3.1 Once an outbreak/incident has been declared, the CCDC, DPP and HB Clinical Lead for Microbiology, in close consultation with Governor/Director and EDPH, will convene an Outbreak Control Team (OCT). A draft agenda, which can be adapted for the first meeting, is shown in [appendix 5](#). Actions throughout the investigation should be logged within the 'Outbreak Diary of Events' form as shown in [appendix 6](#).

### 6.3.2 Membership of the Outbreak/Incident Control Team

- The CCDC from Public Health Wales will chair the meetings of the OCT.
- The Governor/Director will lead on all the operational issues pertaining to the effective functioning of the prison while the CCDC will lead on the expert management of the specific incident or outbreak. Governors/Directors will have to submit a dynamic risk assessment to HMPPS in Wales and the HMPPS population management to advice on any impact of public health advice on operation of prison settings (see [appendix 8](#)).
- Membership will vary dependent on the circumstances but would normally mirror the core and co-opted members as per the Communicable Disease Outbreak Plan for Wales. (If a core member is unable to attend meetings, then an appropriate representative should be asked to attend):

### 6.3.3 Core members from non-prison agencies

- CCDC/CHP(Chair)
- Health Board Clinical Lead for Microbiology
- Executive Director of Public Health (EDPH) for the Health Board
- Director of Public Protection (DPP) (or their nominated officer of sufficient seniority)
- Lead Officer for Communicable Disease for the Local Authority

### 6.3.4 Core members from the custodial provider

- Governor or Deputy Governor/Director or Deputy Director

### 6.3.5 Core members from the healthcare provider to the prison

- Clinical Lead
- Lead GP

### 6.3.6 Dependent on the nature and size of the outbreak/incident, co-opted members need to be invited to the OCT. These may include:

- Regional Epidemiologist, Public Health Wales
- Representative from HMPPS in Wales
- Representative from Health and Justice Team, England
- Occupational Health Advisor
- Pharmaceutical Advisors
- Head/Manager of relevant departments
- Youth Offending Team
- Health Board Representative
- Establishment Health and Safety Representative
- Union Representation
- Administrative and secretarial support
- HSE
- Others as appropriate

6.3.7 Additional professional support may be required from:

- Communications Officer(s)
- Epidemiologists/Data Analysts

6.3.8 The roles and responsibilities of the core members of the OCT/ICT are included with this plan as action cards in [appendix 7](#). Responsibility for handling the outbreak must be given to the OCT by the parent organisations, and representatives must be of sufficient seniority to make and implement decisions, and to ensure that adequate resources are available to undertake outbreak management.

6.3.9 Whichever organisation hosts the OCT meetings will normally also provide administrative support as appropriate.

#### 6.4 ESTABLISHMENT OF THE OUTBREAK/INCIDENT CONTROL TEAM

- Responsibility for managing outbreaks is shared by **all** the organisations who are members of the OCT.
- Core OCT Members are responsible for ensuring that all relevant organisations are co-opted onto the OCT.
- This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak to a successful conclusion.
- Others can make a request to join the OCT if there is a case to do so but the final decision on membership resides with the core OCT.
- The Chair of the OCT will be appointed at the first meeting. The Chair will normally be the DPP or the CCDC as appropriate, but there may be occasions when it is more appropriate that another core member of the OCT is appointed as Chair.
- It shall be the duty of the Chair to ensure that the OCT is managed properly and in a professional manner.

#### 6.5 COMMUNICATION

- It is essential that effective communication be established between all members of the team and maintained throughout the outbreak. A clear line of internal communication should be agreed by the OCT.
- The Chair will ensure that minutes will be taken at all meetings of the OCT and circulated to participating agencies. The minute taker is accountable to the Chair for this function.
- Use of communication through the media may be a valuable part of the control strategy of the outbreak. The OCT should consider the risks and benefits of pro-active versus reactive media engagement in any outbreak.
- The OCT will endeavour to keep the prisoners, prison staff, visitors, the public and media organisations as fully informed as necessary without prejudicing the investigation and without compromising any statutory responsibilities or legal requirements and without releasing the identity of any patient/case.
- The OCT will conduct media relations in accordance with section 2.57 and 2.6 of The Communicable Disease Outbreak Plan for Wales. Arrangements for dealing with the media should be discussed and agreed at the first

meeting, this should include nominating a spokesperson to liaise with the Ministry of Justice press office ensuring they are fully consulted, who, in consultation with the OCT will commonly lead on media briefings in relation to the outbreak or incident.

- **No other member of the OCT or the participating agencies will release information to the press or arrange press conferences without the agreement of the OCT and full knowledge of the Ministry of Justice press office.**

## 6.6 TASKS OF THE OUTBREAK CONTROL TEAM

6.6.1 The OCT role is to ensure that the outbreak or incident is appropriately investigated and managed, and to advise the Governor/Director on measures required to control it, which may impact on operational issues for the setting. Tasks to be undertaken by the OCT may include:

- Review the evidence and establish whether a significant outbreak or incident really exists.
- Log, record and co-ordinate decisions on the investigation and control of the outbreak and ensure the decisions made are implemented, allocating responsibility to specific individuals who will then be accountable for taking action.
- Agree a case definition- including possible, probable and confirmed case definitions;
- Conduct a dynamic risk assessment to include health and operational/custodial considerations.
- Prevent further cases of infection/illness by taking all necessary steps to ensure that the source of the outbreak is controlled and the risk of secondary person to person transmission is minimised.
- Agree appropriate active case finding strategy to include consideration of both clinical and laboratory diagnoses among prisoners and staff- this may include people who have been recently released or transferred.
- Agree contact tracing activities if appropriate to include those no longer in the establishment where the outbreak is currently in play; Give due consideration to the nature of population movements within the prison, between prisons, and between the prison and community, including cross border movements with England or other nations.
- Monitor epidemiological progress of the incident/outbreak.
- Agree and co-ordinate policy decisions on the investigation and control of the outbreak and ensure the decisions made are implemented, allocating responsibility to specific individuals who will then be accountable for taking action.
- Determine the resource implications of the outbreak / incident and how they will be met including the possible need for an incident room (e.g. board room), the costs for testing cases or contacts, the costs of other diagnostic interventions (e.g. Mobile X-ray Unit for TB outbreaks), the costs associated with producing materials for information e.g. printed posters/leaflets or National Prison Radio broadcasts.
- Ensure that adequate communication arrangements are in place, these will include:

- Nominating a lead person to be the point of contact with the MoJ Press Office who will lead on briefing the news media throughout the duration of the outbreak / incident;
- Accurate and consistent information for prisoners, employees, relatives and other internal and external agencies.
- Arrange for the necessary interviews, inspections and other investigations, such as samples to identify the nature, extent and source of the outbreak / incident.
- Arrange for an outbreak number (a unique identifier for samples that are part of an outbreak) to be obtained from the regional Public Health Wales laboratory.
- Prevent further cases of infection / illness by taking all necessary steps to ensure that the source of the outbreak is controlled and the risk of secondary person to person transmission is minimised through implementation of appropriate infection control practice including isolation or cohorting of probable/confirmed cases.
- Via the prison Governor/Director, or their delegate, to notify HMPPS in Wales and HMPPS Population Management of any recommendations from the OCT that may affect population management through completion of the Operational Dynamic Risk Assessment ([appendix 8](#)).
- Ensure that arrangements are in place for the appropriate treatment for those infected or affected by the outbreak including consideration of transfers out to acute hospitals.
- Liaise with local hospitals where there may be increased demand on hospital services
- Consider the need for and, if necessary, arrange long-term follow up of those affected.
- Collect the contact details within and out of working hours for all agencies involved.
- Declare the end of the outbreak / incident.
- Develop systems and procedures to prevent further occurrence of similar episodes.
- At the end of an outbreak / incident review the management of the outbreak / incident and produce a written report within 3 months of the close of the outbreak.
- Ensure that the lessons identified from the review are reported to the management of the partner organisations including HMPPS (HMPPS in Wales, National Operations Unit (NOU) and Health and Wellbeing Co-commissioning) as appropriate, to be disseminated and acted upon.

## 6.7 CROSS BORDER MANAGEMENT

Cross border prison outbreaks should be managed in accordance with the principles of the All Wales Outbreak Plan. Where an outbreak crosses the border and affects people living in one or more of the other UK countries, the OCT arrangements may differ. For example, the team may be chaired by a representative of an agency outside of Wales, but the principles of this plan should still apply and the Welsh response should be guided by the requirement to protect the public's health. Other authorities will be invited to participate at an appropriate level and to provide resources at a proportionate level.

## 6.8 RECOMMENDATIONS FROM THE OCT THAT MAY IMPACT ON PRISONER MOVEMENT

In some cases the OCT may recommend restrictions on prisoner movements. This may include the need to isolate individuals or a cohort within the prison, the restrictions of movements within the prison, or restrictions on transfers in or out of the prison. It is recommended that the OCT completes the 'Operational Dynamic Risk Assessment' (see [appendix 8](#)) which should be submitted by the Governor to HMPPS in Wales and NOU (cc'd for information to HMPPS Health and Wellbeing Co-commissioning) for their decision making of any operational restrictions.

## 6.9 CONCLUSION AND OUTBREAK REPORT

- Where an OCT is convened, a record of proceedings will be made and circulated to a distribution list agreed by OCT members. In the event of a significant outbreak, a report, which should be anonymised as far as possible, will be circulated to the Communicable Disease Surveillance Centre (CDSC) in Wales, Welsh Government, the Health Board, Food Standards Agency Wales (FSAW) (where food is the implicated vehicle), Drinking Water Inspectorate (DWI) (where drinking water is the implicated vehicle), HMPPS (HMPPS in Wales, HMPPS NOU and HMPPS Health and Wellbeing Co-commissioning), Prison Governors/Directors, all local authorities involved and any other parties as deemed appropriate by the OCT.
- This report will contain details of the investigation, compilation of the results and conclusions, as per section 2.10 of the Communicable Disease Outbreak Plan for Wales. Minutes of all OCT meetings will usually be appended. The report should be completed within 3 months of the close of the outbreak.
- The OCT report is owned jointly by all the organisations represented on the OCT. The OCT should agree when and how the report is to be first released, paying due consideration to impending legal proceedings, freedom of information issues, learning and prison population movements.

## 6.10 REVIEW OF THE PLAN

This plan will be reviewed alongside review of 'The Communicable Disease Outbreak Plan for Wales'; after each occasion when the plan is put into operation or earlier if new national guidelines are issued by the Welsh Government or Public Health Wales. Review of the plan will be undertaken in consultation with stakeholders, including UKHSA, with a view to maximising the alignment of respective plans.

## PART 7: ACTIVATION OF CIVIL CONTINGENCY ARRANGEMENTS

### Communicable Diseases: Activation of Civil Contingency Arrangements

There will be rare occasions where an outbreak or incident may necessitate the activation of civil contingency arrangements. This is likely to be where the nature and scale of the communicable disease overwhelms services, or where it creates wider strategic issues or risks that may have a serious impact on the public.

Scenarios where this is likely to be necessary include:

- A widespread national communicable disease emergency (as in the case of novel virus eg. pandemic flu)
- A suspicion of a bioterrorism event
- A widespread uncontrolled communicable disease outbreak that creates a substantial risk that essential services will be overwhelmed
- A communicable disease outbreak that presents a significant risk to community cohesion and public order
- A communicable disease outbreak that creates significant social, economic or humanitarian issues or risks requiring urgent strategic multi-agency response to ensure effective mitigation that cannot be dealt with under usual outbreak response [For example, rehousing of a local population, disruption of food supply chains, activation of excess deaths protocols, significant disruption to communications and transport infrastructure],
- A communicable disease outbreak that may necessitate the implementation of civil restrictions on health protection grounds ["Containment"] on a local or regional basis,
- Multiple escalating communicable disease outbreaks in a Local Resilience Forum (LRF) area that requires a coordinated strategic response by public authorities or a requirement for mutual aid, including Military Aid to the Civil Authority (MACA).

In such scenarios, the Wales Resilience Emergency Civil Contingency structures may need to be invoked.

#### 7.1 INITIAL ASSESSMENT

In the first instance, as soon as the Outbreak Control Team (or Core Members in prior discussion to assess the facts) identifies or suspects a potential scenario that may necessitate escalation to the relevant Local Resilience Forum (LRF), initial contact should be made with the relevant LRF Coordinator to discuss the circumstances of the outbreak. Core members should ensure that an appropriate Executive or the CEO in their own organisation is informed urgently that this escalation is being considered.

The LRF Coordinator will assist the Chair of the OCT (with support from the CCDC / CHP if they are not the Chair) to prepare an initial assessment using the [Joint Decision Model](#) to

determine whether the outbreak should be escalated to the Chair of the LRF or another strategic commander.

## 7.2 EMERGENCY ACTIVATION

Outside of core hours or in an emergency, the Chair of the Outbreak Control Team should contact the Force Incident Manager in the police force where the communicable disease emergency has been declared.

In such cases, the Senior Duty Officer / Police Gold Commander will consider whether the LRF local activation procedures should be used or whether the matter should be referred to LRF Coordinator during core hours.

## 7.3 RESPONSES

### 7.3.1 Management under the Communicable Disease Outbreak Plan for Wales

In the vast majority of cases, the tactical responses set out in the Communicable Diseases Outbreak Plan for Wales 2020 will be sufficient to address the wider implications of any outbreak and is likely to be achieved through enhanced representation within the Outbreak Control Team.

In the rare situation of an outbreak necessitating the activation of civil contingency arrangements, the co-opting of appropriate Category One and Two responder agency representatives as required onto an Outbreak Control Team by the OCT Chair, as set in section 2, will ensure that the broader implications and risks of a communicable diseases outbreak can be addressed in an efficient and timely manner in co-ordination with overall outbreak response.

In such cases, the OCT retains primacy of the response and there is no requirement for the activation of a Strategic Coordination Group. However, where there is a prospect that a serious communicable disease could escalate into an uncontrolled outbreak or “rising tide” major incident, the early inclusion of the LRF Coordinator as a co-opted member into the OCT will provide effective situational awareness should the need for an SCG grow.

### 7.3.2 Activation of a Strategic Coordination Group

Should the Chair of the Local Resilience Forum believe the threshold for activating a Strategic Coordination Group is met, they will instruct the LRF Coordinator to convene a meeting and identify a suitable chair.

The activation of a Strategic Coordination Group will take place in accordance with the most appropriate doctrines, namely:

- **LRF local activation procedures**
- **LRF Infectious Disease Plan**
- **Wales Framework for Managing Major Infectious Disease Emergencies**

The SCG meeting may be held in person or through the use of video or telephone conferencing and should be held as soon as reasonably possible.



Representation at the SCG should be in accordance with the most appropriate doctrine but should include the Chair of the OCT. In some circumstances, the Core OCT Members from the Health Board, PHW and Local Authority may also be required.

### 7.3.3 Notification to Welsh Government Emergency Coordination Arrangements

Unless a Strategic Coordination Group has been convened, notification of a communicable disease outbreak to the Welsh Government should be undertaken through existing channels.

Where Strategic Coordination Group is convened, however, then the duty Welsh Government Civil Contingencies Coordinator or the Emergency Coordination Centre Wales (ECC(W)), if in operation, should be notified as soon as possible by the LRF Coordinator or SCG Chair.

This is in addition to existing public health reporting mechanisms that will be used by Outbreak Control Teams and Public Health Wales. Notification shall be in parallel.

## 7.4 COMMAND, CONTROL AND COORDINATION (C3) ARRANGEMENTS: STRATEGIC COORDINATION GROUP

If mobilised, the purpose of a Strategic Coordination Group will be to take overall responsibility for the multi-agency management of a communicable disease outbreak and will establish the policy and strategic framework within which lower tier command and co-ordinating groups will work.

The SCG will:

- Determine and promulgate a clear strategic aim and objectives and review them regularly,
- Establish a policy framework for the overall management of the event or situation; prioritise the requirements of the tactical tier and allocate personnel and resources accordingly,
- Formulate and implement media-handling and public communication plans, potentially delegating this to one responding agency and,
- Direct planning and operations beyond the immediate response to facilitate the recovery process.

The Strategic Coordination Group will not have the collective authority to issue executive orders to individual responder agencies. Each organisation retains its own responsibilities and command authority, operating in the normal way.

Where a SCG is convened to manage the strategic response to a communicable diseases outbreak, the Outbreak Control Team will represent a Tactical Coordination Group (Silver) sitting under the overall direction of the Strategic Coordination Group.

An additional Tactical Coordination Group and / or functional or geographical Operational Coordination Group (Bronze) may also be convened to ensure the wider implications of the outbreak are effectively managed. In Tactical matters to control the outbreak, the OCT will have primacy. The activities of these groups are likely to focus on consequence management or the mitigation of risks outside of the scope of Outbreak Control Group.

To ensure the effective coordination of the multi-agency response and to prevent duplication of efforts, a command protocol or Concept of Operations (CONOPS) will be agreed by Chairs of the SCG and OCT.

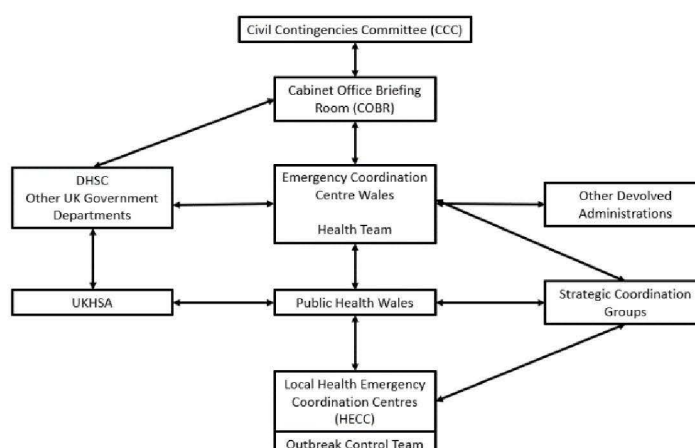
Ongoing effective communication between the OCT and other coordinating structures will also be critical to ensure the effectiveness of the public health and wider response.

Where the OCT becomes a Tactical Coordination group (Silver) of the SCG, any reporting duties and accountabilities will be in addition and not in place of existing mechanisms.

## 7.5 COMMAND, CONTROL AND COORDINATION (C3) ARRANGEMENTS: WALES FRAMEWORK FOR MANAGING MAJOR INFECTIOUS DISEASE EMERGENCIES

If the Wales Framework for Managing Major Infectious Disease Emergencies is activated, the diagram below outlines the co-ordination arrangements and where Outbreak Control Teams (and thus the arrangements in the Communicable Disease Outbreak Plan for Wales) sit.

In exceptional circumstances, there are also specific UK arrangements for bioterrorism or other particular infectious disease threats which take precedence over these plans. If a Strategic Coordination Group is already in existence for a different concurrent incident, the strategic response to any communicable disease incident will be undertaken by the Outbreak Control Team, which will represent a Tactical Coordination Group (Silver) sitting under the overall direction of the Strategic Coordination Group.



Adapted from: Welsh Government: Wales Framework for Managing Major Infectious Disease Emergencies. October 2014

## APPENDICES

### APPENDIX 1: GUIDANCE FOR THE MANAGEMENT OF GASTRO INTESTINAL (G.I.) INFECTION OUTBREAKS IN PRISONS AND OTHER CUSTODIAL SETTINGS

Outbreaks of diarrhoea and vomiting can occur in prisons and other places of detention.

Micro-organisms causing illness can be spread:

- from person to person
- from infected food
- from contaminated water supplies
- from other contaminated drinks (milk, fruit juices etc.)
- from a contaminated environment
- through all these means

Micro-organisms have the propensity to cause diarrhoea and vomiting, but some can cause very serious disease, including high fever or shock. However, most will be mild and self-limiting in nature and can be managed within the prison estate. More serious cases may need care in hospital.

This appendix provides quick guidance on how to deal with such outbreaks in prisons and other places of detention. **However, on detection of an outbreak, prisons/places of detention should urgently seek advice from their local health protection team** (See [appendix 3](#) for contact details).

#### **ACTIONS TO TAKE IN RESPONSE TO AN OUTBREAK OF GI INFECTION\*:**

Governors/Directors or their delegates must notify HMPPS National Operations Unit (NOU) of significant outbreaks via the single incident line, especially if they involve closure of part or all of the prison/place of detention to transfer and/or receptions. Simultaneously the NOU will report the same to HMPPS in Wales.

- Contact the local health protection team (HPT) on suspicion of an outbreak.
- Details of cases, including date of onset, location within the prison/place of detention, symptoms of illness and if cell-sharing with another case should be recorded by the prison based healthcare team and reported to the local HPT (a specially designed form for GI infection outbreaks is attached to this appendix).
- The HPT will convene an outbreak control team (OCT) to determine and direct appropriate investigations and control measures.
- Stools should be collected from symptomatic cases, especially at the onset of the outbreak, to confirm microbiological diagnosis. Identification of the microorganism responsible for the outbreak is a priority, as some of the action necessary to control the outbreak and stop further spreading, depends on the type of micro-organism responsible\*\*.
- **On advice of the OCT, it may be advisable to restrict movements within the prison/place of detention** (e.g. from a wing with a large number of cases to one with no or low numbers) or to avoid association activities e.g. education, training and exercise.

- **On advice of the OCT, it may be advisable to seek permission to close all or part of the prison/place of detention to receptions and transfers for a period of time (usually until the end of the outbreak).**
- Prisoners/detainees who are ill should be isolated in their cells/rooms, usually until free of symptoms for 48 hours
- Cell/room-mates of prisoners/detainees who are ill may be incubating the illness themselves and should be similarly isolated
- If there are no in-cell/room sanitation facilities, make sure to reserve some toilet facilities for the use of symptomatic prisoners/detainees only (e.g. all those with symptoms and up to 48 hours after symptoms have disappeared)
- Place appropriate and clear signage on the toilet areas, such as “for D&V patients only” and make sure the signs are clear for people with learning difficulties or poor literacy to understand
- Where toilet seats present, make sure they are down before flushing
- Make sure cleaner(s) cleaning affected areas do not visit other parts of the prison/place of detention
- Clean regularly and frequently throughout the day all hand held surfaces in affected areas with a bleach-containing agent or other appropriate product as advised by the OCT
- Handwashing is crucial for effective control: ensure that hand-cleaning facilities (liquid soap and warm water, paper towels, pedal-bins for the paper towels) are available and encourage people (both prisoners/detainees and staff) to wash hands often and every time they use the toilet and before eating
- Personal protective equipment (PPE): Follow advice of the OCT on use of appropriate PPE such as single-use gloves and aprons. These products should be available within the prison/place of detention. If not contact your PPE suppliers and place an urgent order for next day delivery
- The OCT will declare when the outbreak is over
- Before resumption of normal regime, deep cleaning (terminal cleaning) may be needed (especially in norovirus outbreaks). The OCT will provide detailed advice

\* What follows is specifically designed for diarrhoea and vomiting (D&V) (norovirus) outbreaks, which are the most common GI infection outbreaks. However, the recommended action is applicable to all other GI infection outbreaks. Additional and more specific action required by other specific bugs, will be decided by the OCT.

\*\* Once the first 2-3 stool samples are available, it is not always necessary to routinely test all other prisoners/detainees displaying similar symptoms, as the microorganism responsible for outbreak has been identified and further testing would not probably add value to the control and management of the outbreak. Advice on testing strategy (after first few sample results have been obtained) should be sought from the local HPT, which will also convene the OCT as appropriate.

**GI INFECTION OUTBREAK – LOG SHEET – PRISONER CASES**

Name of Prison / Establishment: \_\_\_\_\_

Date of report: \_\_\_\_\_

Surname (Print)					
First Name					
Prison Number					
DOB					
Date of reception					
Location - Wing					
Location - Cell					
Is prisoner due for release/transfer imminently? If yes, please provide details					
Shares a cell with how many people?					
Prisoners occupation and whether this is within or external to the prison setting					
Did any of the cell mates have similar symptoms before illness onset in this case please indicate how many					
Symptoms					
Diarrhoea Y/N					
Vomiting Y/N					
Fever Y/N					
Other(s) (list)					
Date/ Time of onset					
Date of recovery					
Isolated Y/N					
Duration of symptoms					
If specimen taken please specify date specimen was sent for testing					
State results of test					
Comments including dates/times of any movements outside of the prison					

**SHEET NO:**

## GI INFECTION OUTBREAK – LOG SHEET – STAFF CASES

Name of Prison / Establishment: \_\_\_\_\_

Date of report: \_\_\_\_\_

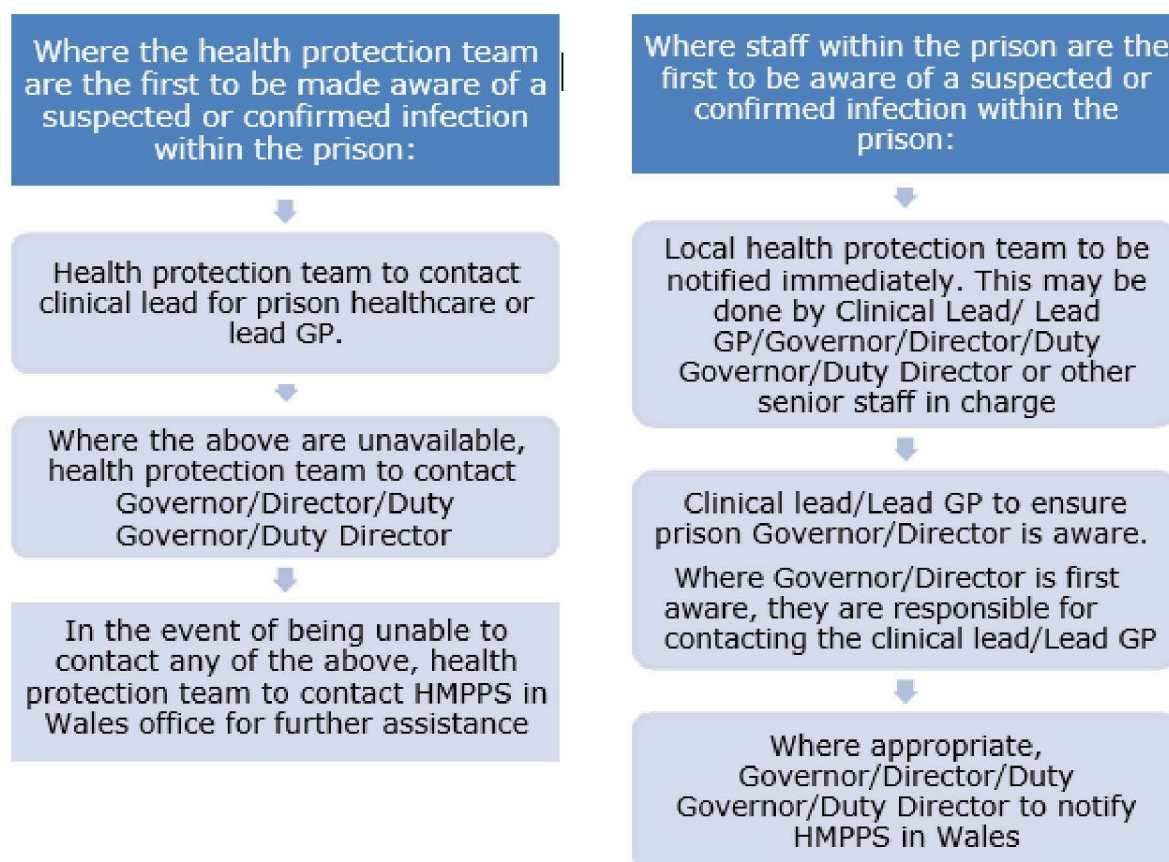
Surname (Print)					
First Name					
Staff Title					
Sex					
DOB					
Date/ Time of onset					
Date of recovery					
Food Handler					
Symptoms					
Diarrhoea Y/N					
Vomiting Y/N					
Fever Y/N					
Other (s) (list)					
Sent Home? Y/N					
Duration of symptoms (HRS)					
If specimen taken please specify date specimen was sent for testing					
State results of test					
Comments					

**SHEET NO:**

## APPENDIX 2: ALGORITHM FOR NOTIFICATION OF INFECTIOUS DISEASES TO AND FROM PRISONS

As soon as an infectious disease is suspected or confirmed it must be notified to the health protection team for further investigation. This algorithm demonstrates the reporting of infectious diseases to and from prisons based two scenarios:

1. The health protection team are the first to be made aware of suspected or confirmed cases of infection in a prison, this would normally be through notification from microbiology or through awareness of cases in other prisons or the community which may affect the prison in question **OR**
2. Prison staff are the first to be aware of suspected or confirmed cases of infection, this would normally be as a result of clinical investigation by the healthcare team, or through observation of symptoms by custodial staff particularly in establishments where 24 hour healthcare is not provided in-house.



## APPENDIX 3: CONTACT DETAILS

### Health Protection Team in Wales

Telephone: [I&S]  
Email: [I&S]

### Prisons

#### **HMP Cardiff**

Knox Road, Cardiff, CF 24 OTB

Tel: [I&S]

#### **HMP Swansea**

Oystermouth Road, Swansea, SA1 3SR

Tel: [I&S]

#### **HMP & YOI Parc**

Heol Hopcyn John, Bridgend, CF35 6AP

Tel: [I&S]

#### **HMP Usk**

47 Marvport Street, Usk, NP15 1XP

Tel: [I&S]

#### **HMP Prescoed**

Coed-y-Paen, Pontypool, Monmouthshire, NP4 0TB

Tel: [I&S]

#### **HMP Berwyn**

Bridge Road, Wrexham Industrial Estate, Wrexham

Tel: [I&S]

### HMPPS in Wales

Churchill House, Churchill Way, Cardiff, CF10 2HH

Telephone: [I&S]

**PHW Communications:** [I&S] (24/7)

**MoJ Communications:** [I&S] (News desk for 24/7 urgent enquiries)







## APPENDIX 5: DRAFT MEETING AGENDA FOR OUTBREAK CONTROL TEAMS (TO BE TAILORED ACCORDING TO THE INCIDENT/OUTBREAK)

### Minutes

The Chair should ensure that a person not directly involved takes minutes of each meeting and that these are circulated with action points to all members usually within one working day after the meeting.

### Agenda

1. Chair's introduction, including terms of reference
2. Minutes of last meeting (if applicable)
3. Review membership
4. Outbreak résumé and update
  - 4.1 General situation report
  - 4.2 Case report and epidemic curve
  - 4.3 Microbiological report
  - 4.4 Environmental Health report
  - 4.5 Water utility report
  - 4.6 Other relevant reports
  - 4.7 Case definition and case finding
5. Management of outbreak and allocation of responsibilities
  - 5.1 Implications for public health
  - 5.2 Care of patients (prison hospital and community)
  - 5.3 Control measures including contact tracing
  - 5.4 Further investigations:
    - Epidemiology
    - Environmental Health
    - Microbiology
  - 5.5 Microbiological aspects (specimens, analysis and resources)
  - 5.6 Environmental Health Aspects
  - 5.7 Advice to boil water or provision of alternative water supplies
6. Communications
  - 6.1 Issuing information/advice
  - 6.2 Information and advice to employees and prisoners
  - 6.3 Information to the public (need for press release)
7. Media arrangements and spokesperson (interviews, press conferences and so on) if any
8. Consider arrangements for enquiries from the public e.g. relatives (the need for a helpline)
9. Date and time of next meeting

**APPENDIX 6: OUTBREAK DIARY OF EVENTS**

<b>OUTBREAK SUSPECTED/CONFIRMED AS .....</b>		
<b>Signed by: ..... Date:..... Time:.....</b>		
	<b>Date</b>	<b>Time</b>
Governor/Director informed		
Local Health Protection Team informed		
Health Board informed		
HMPPS in Wales informed		
Clinical Lead and Lead GP informed		
Outbreak control team convened		
Information & communication for employees, prisoners and visitors		
Operational Dynamic Risk Assessment Form completed		
Isolation commenced of known cases within the establishment, if appropriate		
Interim report completed		
Outbreak control team closed		
Debriefing meeting for conclusion and recommendation		
Final report completed		
<b>Date/Time</b>	<b>Action Log of Outbreak</b>	<b>Signature</b>

## **APPENDIX 7: ACTION CARDS: ROLES AND RESPONSIBILITIES**

### **Governor / Director**

1. To work in consultation with the CCDC to establish the status of the outbreak/incident.
2. To ensure the OCT is made aware of local and wider population management issues specific to the population concerned including any cross border movements.
3. To escalate any advice from the OCT collated onto the Operational Dynamic Risk Assessment form, that may affect prisoner movements (e.g. the need to isolate areas of the prison or restrict movements in/out of the prison) to HMPPS Population Management and HMPPS in Wales.
4. To oversee the effective delivery of all necessary outbreak control measures from within the prison setting.
5. To co-ordinate effective communications within the prison and with the MoJ press office, keeping them fully consulted.
6. To contribute to the written final report on the outbreak / incident and ensure that the response to the outbreak / incident is audited.
7. To ensure that the lessons identified are communicated to the management of partner organisations and HMPPS in Wales (for their onward dissemination within HMPPS as appropriate).

### **Consultant in Communicable Disease Control/Consultant in Health Protection (CCDC/CHP)**

See [section 3.2](#)

### **Health Board Executive Director of Public Health**

See [section 3.4](#)

### **Health Board Infection Control Nurse**

1. To provide specialist infection control advice on, and input to, management of the outbreak/incident.
2. In conjunction with the prison and prison based healthcare staff to ensure that all appropriate infection control action is taken.

### **Prison Clinical Lead**

1. To implement recommendations as agreed by the OCT.
2. To collect & document relevant information/data on prisoners in a timely manner (see appendix 5a & 5b).
3. To organise provision of appropriate nursing and medical staff to manage increased workload relating to symptom relief and infection control stock requirements etc.
4. To ensure prompt notification and reporting of cases of suspected infectious diseases to the local Health Protection Team (HPT).
5. To keep accurate records of all aspects of the investigation.

### **Prison Occupational Health Advisor (OHA)**

1. To ensure that relevant information/data on employees is collected and documented (see [appendix 4](#)).
2. To implement recommendations as agreed by OCT.
3. To monitor the recommendations implemented.

### **Director of Public Protection**

See [section 3.1](#)

### **Health Board Clinical Lead for Microbiology**

See [section 3.3](#)

### **Administrative and Clerical Support to the Outbreak Control Team**

1. To take minutes of each meeting of the OCT and to produce a timely written record of the meeting.
2. Ensure secure electronic storage of minutes and auditable action log
3. To be involved in other administrative and clerical functions as appropriate to the incident/outbreak.

### **Local Press/Public Relations Officers**

1. To advise and assist the MoJ Press Office in the preparation of communications for the media.
2. To communicate with the media if directed by the OCT and authorised by the MoJ Press Office.
3. To liaise closely with Press/Public Relations Officers of partner organisations as appropriate to ensure that all information is agreed and consistent

## APPENDIX 8: OPERATIONAL DYNAMIC RISK ASSESSMENT

### Public Health Advice from Outbreak/Incident Control Team

ONCE COMPLETED PLEASE EMAIL HMPPS HEADQUARTERS WITH THE SUBJECT LINE "OUTBREAK AT HMP [NAME OF ESTABLISHMENT]"

- HMPPS NATIONAL OPERATIONS UNIT
- HMPPS POPULATION MANGEMENT UNIT
- COPY TO:

I&S

I&S

I&S

Required information for risk assessment- please complete as much as possible but do not delay sending report while awaiting further information e.g. laboratory results.		Additional Notes:
Date of meeting of OCT/ICT	dd/mm/yyyy:	Time of first meeting (00:00)
Nature of incident:	Gastrointestinal disease [ ]  Respiratory disease [ ]  Chemical incident [ ]  Other [ ]	Specify causative agent if known (e.g. norovirus, influenza A/B, TB etc.)
Date of onset of incident or date of first case	dd/mm/yyyy	
Number of people affected	<b>Prisoners:</b>  Suspected [ ]  Confirmed [ ]  <b>Staff:</b>  Suspected [ ]  Confirmed [ ]  Are cases confined to one Wing/Area? <b>Y/N</b>	<ul style="list-style-type: none"> <li>• Has an <b>active case-finding</b> programme been recommended? <b>Y/N</b> <ul style="list-style-type: none"> <li>○ Does case finding include <b>staff</b>? <b>Y/N</b></li> </ul> </li> <li>• Are any staff on sick leave currently? <b>Y/N</b> <ul style="list-style-type: none"> <li>○ If <b>Yes</b>, how many: [ ]</li> </ul> </li> <li>• Have any cases been transferred for care to hospital? <b>Y/N</b> <ul style="list-style-type: none"> <li>○ If <b>Yes</b>, how many:[ ]</li> </ul> </li> <li>• <b>Any other information:</b></li> </ul>

<p><b>Public Health Advice from OCT</b></p>	<p><b>Has OCT provided recommendation to:</b></p> <ul style="list-style-type: none"> <li>• <b>Isolate/cohort cases Y/N</b></li> <li>• <b>Provide separate toilet/washing facilities Y/N</b></li> <li>• <b>Restrictions on internal prisoner movements Y/N</b></li> <li>• <b>Stop transfers out Y/N</b></li> <li>• <b>Stop transfer in Y/N</b></li> </ul>	<p>Have prisoners at risk of infection been transferred to other prisons prior to quarantine? Y/N</p> <p>If Yes, estimate of numbers transferred:[ ]</p> <p>List of establishments receiving:</p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol> <p>Any other information:</p>
<p><b>Staff Health &amp; Safety</b></p>	<p><b>Has OCT recommended any specific actions to protect staff:</b></p> <ul style="list-style-type: none"> <li>• <b>PPE Y/N</b></li> <li>• <b>Vaccinations Y/N</b></li> <li>• <b>Testing Y/N</b></li> <li>• <b>Prophylaxis Y/N</b></li> <li>• <b>Treatment Y/N</b></li> <li>• <b>Restrictions on activities for vulnerable staff Y/N</b></li> </ul>	<p>Specify nature of advice to protect staff:</p>
<p><b>Assessment of mortality risk</b></p>	<ul style="list-style-type: none"> <li>• <b>Has OCT provided mortality risk assessment Y/N</b></li> <li>• <b>Is there a significant risk of multiple mortalities as result of outbreak at this time Y/N</b></li> </ul>	<p>Provide specific information on assessment provided by OCT (e.g. critically ill prisoner(s) in hospital):</p>
<p><b>Report from Governor / Director</b></p>	<p>Please report any additional relevant information which can assist Population Management in undertaking a dynamic risk assessment:</p>	



## FOOTNOTES

1. This Plan is in line with the Food Standards Agency's (FSA) Framework Agreement on Official Feed and Food Controls by Local Authorities. The FSA has a statutory duty to monitor the performance of food enforcement authorities. This includes a Local Authority's handling of cases and outbreaks, of food borne illness. There may be occasions where Agency officials will need to visit a LA in connection with an outbreak – where this need arises, the Agency will have regard to the priority of managing the incident and will do everything possible to ensure that the roles of the FSA official co-opted to the OCT and the FSA official undertaking any monitoring are kept separate.
2. In particular, the microbiology input required may vary depending on the outbreak, and may include the need for local or national expert microbiological or virological advice, sample testing arrangements, and/or local microbiology management. Hence, microbiology attendance at the OCT may be more appropriately delegated to another individual or organisation with the necessary skills and resources. However, the Health Board Clinical Lead for Microbiology is still responsible for ensuring the OCT has access to these resources and skills and retains the core membership responsibilities and accountability outlined on page 21.
3. For example, the investigation of a case of hepatitis A in a food handler will be led by their LA of residence. Discussion with, or action against, the employer regarding their duties as a food business operator will be led by the relevant food authority as this may involve customer notification, remedial action or work activity considerations. Action under health protection legislation to ensure the case does not pose a risk to public health through their work or other activities will however, be led by the resident LA as it is directed at the individual.
4. An outbreak is traditionally defined as an observed number of cases greater than that expected for a defined place and time period, or two or more cases with common exposure. However, since that occurs on countless occasions in Wales annually (for example, two members of the same household passing a cold to each other), the need to activate this plan and formally declare an outbreak requires an expert assessment of the available facts and the risks outlined in 1.3.6.
5. Refer to Public Health Wales' HARP website for most up to date version: <https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/framework-for-the-control-of-an-outbreak-or-incident-of-infection-in-acute-healthcare-premises-in-wales-march-2022/>
6. Template adapted from: World Health Organization. Outbreak control. Evaluation. In: World Health Organization. Communicable disease control in emergencies. A field manual. [Ed M.A. Connolly] Geneva: WHO; 2005. Section 4.5, p.128-9. Available at: [http://apps.who.int/iris/bitstream/handle/10665/96340/9241546166\\_eng.pdf;jsessionid=509A2244BFE79F2E2A972E6E62A592F4?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/96340/9241546166_eng.pdf;jsessionid=509A2244BFE79F2E2A972E6E62A592F4?sequence=1) [Accessed 18th Dec 2018]
7. <http://www.legislation.gov.uk/wsi/2018/647/contents/made>
8. **Examples of “significant” would include outbreaks of water-related illness** or a sizeable population exposed to a chemical contaminant at levels about the prescribed concentration or value.
9. People in social housing may have their water bill paid directly through general rates meaning that they may not know how to contact the Water Company.