OPERATIONAL LOCAL HEALTH ECONOMY OUTBREAK MANAGEMENT PLAN: MANCHESTER

MANCHESTER CITY COUNCIL

GMResilience
Greater Manchester agencies working in partnership

RESILIENT GREATER MANCHESTER

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DOCUMENT CONTROL

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CHANGE HISTORY

Version	Date	Status	Notes
0.01	20-02-17	Initial draft	Following 1st Planning Group meeting
0.02	15-03-17		Following 2nd Planning Group meeting
0.03	05-04-17		Template shared and circulated following Health Protection Confederation discussion
1	15-01-17	1st Draft	Populated with Manchester information
2	31-10-19	2nd Draft	Addition of Manchester Document Control version page Minor changes to titles, addition of Consultant in Public Health Addition of response to single cases needing mass vaccination response EHO/UKHSA role in questionnaires and sampling Additions to contact list
3	23-09-21	3rd Draft	In response to the COVID-19 pandemic, clarification that COVID-related outbreak response and management plans will be captured elsewhere and will not be referred to in this document. Change of title: Community Infection Control Team (CICT) to Community Health Protection Team (CHPT)
4	07-09-23	4th Draft	Refresh of document recommended to all localities as part of Greater Manchester Health Protection Reform.
5	08-09-23	5th Draft	Signed off by Assistant Director of Public Health, Lead for Health Protection and Healthy Environments

FOREWORD

Maintaining and improving the health of our communities is at the heart of public service delivery. Health Protection, and ensuring an effective response to outbreaks of disease is a crucial part of this. Whilst the response to outbreaks isn't new and whilst our local health economy routinely demonstrates that it has effective arrangements in place it is important that we review our arrangements, and that the organisations and people who need to work together in partnership are aware of each other's roles and responsibilities for a range of scenarios.

It is priority for us to keep health equity and tackling health inequality at the heart of what we do through our outbreak response work, including our communications and approach to managing outbreaks in different communities and settings. We will build on learning from our Covid-19 response and follow the latest evidence and insights from our communities. We will work together with our communities, valuing the role of community leaders and neighbourhood working in our health protection system.

This plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for each organisation, having signed off this plan, to support staff to engage in appropriate testing to embed the multi-agency response to an outbreak and create familiarity over key tasks.

Many organisations have proven that they have a role to play in protecting the public from Covid-19 during the last three years. This document aims to identify roles and responsibilities of those across the system to enable the prompt and efficient management of outbreak in a locality. These include the NHS, Environmental Health, Public Health Department and the UK Health Security Agency (UKHSA).

This plan has been completed and agreed by a system wide multi-agency group for use in Manchester. The Plan has been noted and approved by the Health Protection Board

This collaborative approach has enabled local decision makers to manage the challenges presented to the wider system and community members in working together to outbreak manage all infectious diseases and consequences. This partnership approach, together with a robust incident management methodology, has enabled key partners to respond to the significant challenges presented in Manchester during the height of the Covid-19 period, and other infectious diseases during the last 3 years, and the learning of these experiences are incorporated into this outbreak management plan.

David Regan

Director of Public Health, Manchester City Council

CONTENTS

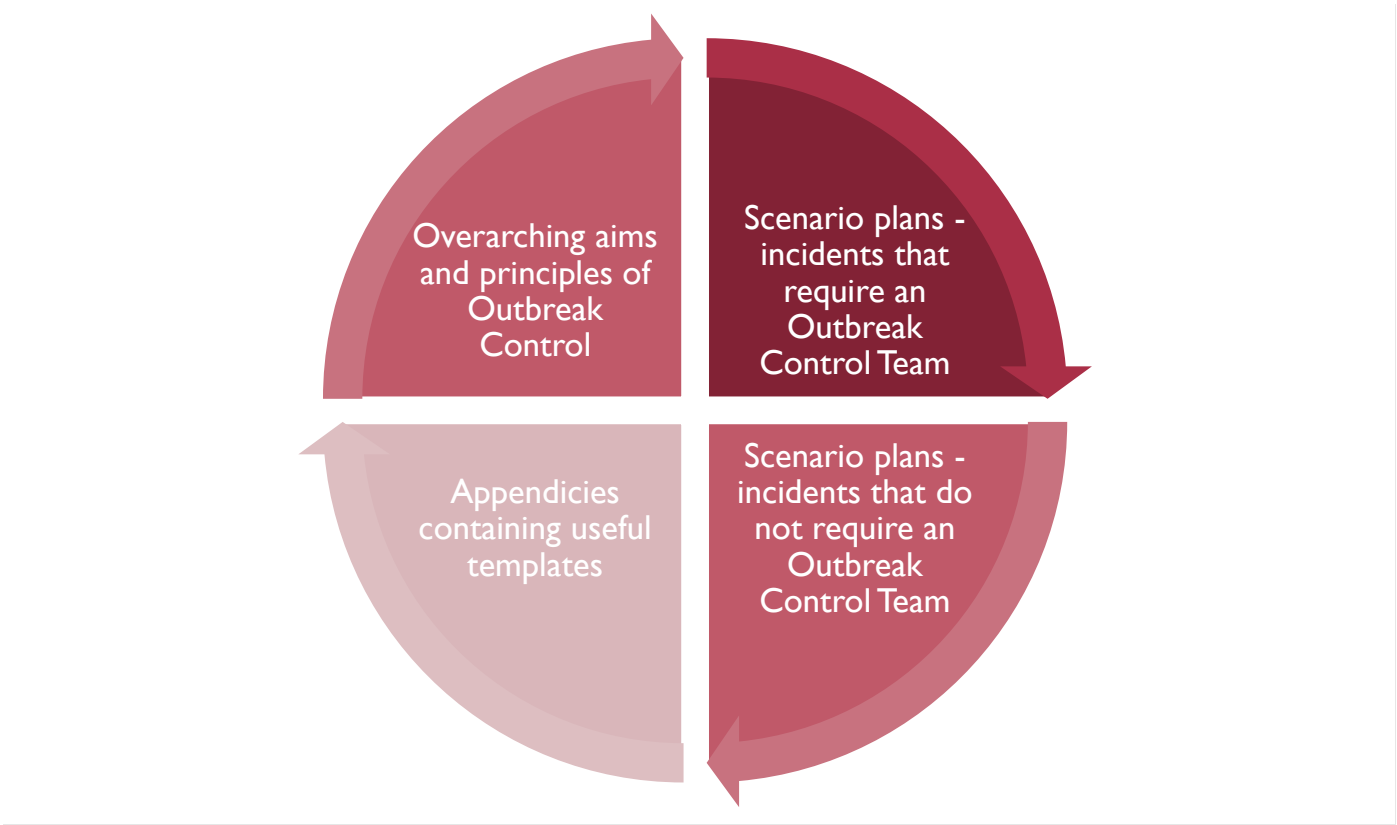
PART 1: AIMS, OBJECTIVES & SCOPE OF THE PLAN

AIM OF THE PLAN

This plan sets out the multi-agency operational arrangements for responding to outbreaks of human infectious diseases within Manchester. This also includes a preventative response to identified single cases of disease, where transmission to others within that population/community could lead to an outbreak or further cases of transmissible infection impacting adversely on the wider public health of that community or population.

This document has been developed to supplement the "Greater Manchester Multi-Agency Outbreak Plan" at a Manchester level and contributes to this statutory responsibility, ensuring the right people are contacted at the right time to ensure that the locality is resilient and can respond appropriately to outbreaks. It focuses on the most likely outbreak scenarios and provides the contact details should an outbreak control team need to be called, and an immediate response made by health and social care partners across the locality.

The structure of the plan is as follows:

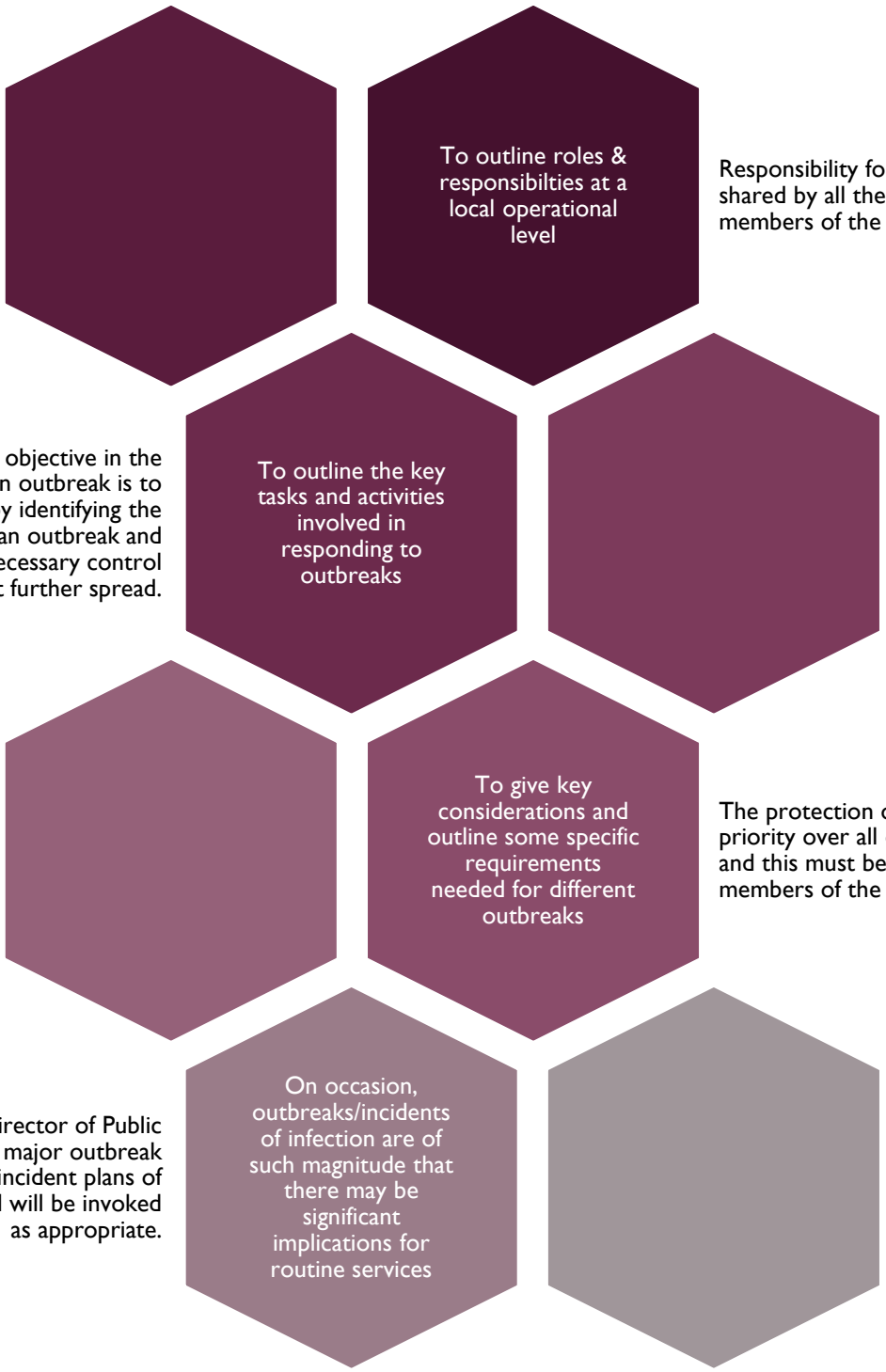


UKHSA, the National Association of Directors of Public Health and the Local Government Association have identified four principles for the design and operation of local Outbreak Control Plans. These can be seen as standards for local systems to test the impact and effectiveness of their arrangements. The prevention and management of the transmission of disease should:

1. Be rooted in public health systems and leadership
2. Adopt a whole system approach
3. Be delivered through an efficient and locally effective and responsive system including being informed by timely access to data and intelligence
4. Be sufficiently resourced.

Further information can be found here: What-Good-Looks-Like-for-High-Quality-Local-Health-Protection-Systems.pdf (adph.org.uk)

OBJECTIVES OF THE PLAN



Responsibility for managing outbreaks is shared by all the organisations who are members of the IMT.

The primary objective in the management of an outbreak is to protect public health by identifying the source of an outbreak and implementing necessary control measures to prevent further spread.

The protection of the public takes priority over all other considerations, and this must be understood by all members of the IMT.

In this instance the Director of Public Health may declare a major outbreak and therefore incident plans of organisations affected will be invoked as appropriate.

KEY CONCEPTS

NOTIFIABLE DISEASES

The UK Health Security Agency (UKHSA, formerly Public Health England) aims to detect possible outbreaks of disease and epidemics as rapidly as possible. Accuracy of diagnosis is secondary, and since 1968 clinical suspicion of a notifiable infection is all that is required.

'Notification of infectious diseases; is the term used to refer to the statutory duties for reporting notifiable diseases in the Public Health (Control of Disease) Act 1984 (legislation.gov.uk) and The Health Protection (Notification) Regulations 2010 (legislation.gov.uk).

Registered medical practitioners have a statutory duty to notify of suspected cases of certain infectious diseases. They can do this by completing a notification form immediately on diagnosis of a suspected notifiable disease.

Consult the Notifiable Diseases poster for further information.

DEFINING AN OUTBREAK

An outbreak or incident may be defined as:

- An incident in which two of more people experiencing a similar illness are linked in time or place
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- A single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
- A suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

Is it recognised that some cases and clusters of disease are handled within routine business of the Local Health Protection Team/CHPT without the need to formally convene an Outbreak Control Team or an Incident Management Team meeting.

OUTBREAK CONTROL TEAM OR INCIDENT MANAGEMENT TEAM MEETING

An OCT or IMT may be convened locally or by UKHSA and this a formal meeting of all partners to address the control, investigation and management of an incident, or a discussion between two or more stakeholders following the identification of a case or exposure of concern. As such all discussions should be appropriately recorded.

Responsibility for managing outbreaks is shared by all organisations who are members of the OCT or IMT.

It should be noted that the terms Incident Management Team and Outbreak Control Team are often used synonymously, however both have very similar aims, membership and procedures.

A suggested agenda, protocol and key roles and responsibilities are described in Appendices C and D Roles and Responsibilities of usual members of an OCT/IMT

CROSS BOUNDARY INCIDENTS

If the situation includes a neighbouring Local Authority (LA), close liaison is vital, with neighbouring LAs and a decision made as to who will lead the investigation. This decision needs to be made as soon as possible. The lead

area will most likely be where the outbreak is first identified, or where the majority of cases reside. Where incidents cross LA boundaries, respective Health Protection teams will need to establish and maintain effective communication with the neighbouring authority.

Some incidents response lead is based on GP location. If the resident lives in another area but has a Manchester GP then Manchester will be the lead locality.

There are some businesses for which Manchester City Council is the Primary Authority. This enables the main regulatory Teams (importantly for this Plan, our Environmental Health Team) to improve compliance and build better relationships with businesses whilst supporting local economic growth. Under Primary Authority, we as the Local Authority partner with a business or National group to provide them with regulatory advice that other authorities must take into consideration during interventions. The service aim of our Environmental Health Team is to ensure the Council fulfils its statutory duties through this partnership work with businesses providing reliable advice in the transparent way.

LIFE CYCLE OF AN OUTBREAK: A SUMMARY

Declaration of an Outbreak

In the case of complex or unusual infections/situations an outbreak will be declared and led by UKHSA. An IMT will be convened by UKHSA and attended by key staff across the health economy.

Community Health Protection Team (CHPT) may be contacted by a variety of settings to report an outbreak, typically these include: UKHSA, nursing/care home staff, schools/nurseries, IPC Team from an NHS Trust, Microbiology/virology or Environmental Health officers.

It is usual that locally confined smaller outbreaks will be recognised and declared by CHPT, with the response being led locally.

Following the recognition and declaration of an outbreak, if needed, ULHSA will make a decision regarding the need and urgency to convene an IMT. This decision should be guided by risk assessment.

The DPH will lead the local response to an outbreak within Manchester. This may be delegated to the Consultant in Public Health (Health Protection) or other appropriate member of CHPT.

When a decision has been made not to declare an outbreak or establish an IMT, the DPH/Consultant should be informed at appropriate iintervals to determine if the formal declaration of an outbreak is subsequently required.

A suggested list of IMT members can be found in Annex 6 and embedded within scenario plans. This is not an exhaustive list and depending on the nature of the outbreak representation from additional organisations may be required.

Investigation and Control of Outbreaks

Control measures should be documented with clear timescales for implementation and responsibility.

A case definition should be agreed and reviewed as required during the investigation.

Basic descriptive epidemiology is essential and should be reviewed at the IMT.

Legal powers relating to the investigation of food posoning outbreaks are vested in Local Authorities. If, during the investigation, it is determined that the outbreak is related to food rhen the management of this would be handed over to the Environmental Health Team and UKHSA.

Communications

The communications response will depend on the nature of the incident/outbreak and the outcome of IMT discussions if an IMT is convened.

For smaller contained outbreaks, CHPT will distribute a Community Oubtreak Summary at agreed times to partner organisations.

Larger outbreaks with an IMT: it is expected that the IMT will idenfity and nominate which agency will lead the media response at the outset of the outbreak.

The MCC Communications Team will work closely with UKHSA to produce communications/information for the public. Social media will be used in accordance with existing MCC policies.

End of the Outbreak

CHPT will decide when outbreaks of a smaller, contained nature are over. The CHPT will make a statement to this effect via the Outbreak Summary email. IT will be based on an ongoing risk assessment and considered when:

- There is no longer a risk to public health that requires further investigation or mangement of control measures.
- The number of cases has declined.
- The probable source has been identified and is no longer a risk/infectious.

Any lessons learnt and recommendations will be discussed at the debrief. If relevant information will be disseminated and refinements to practice considered for implementation where appropriate.

COMMAND & CONTROL

In the event of UK Health Security Agency (UKHSA) calling an Outbreak Control Team (OCT) or Incident Management Team (IMT) meeting, Manchester's DPH/Assistant and members of the Community Health Protection Team (CHPT) will participate in that group along with any key responders such as Medicines Optimisation, Environmental Health, key Commissioners and the Local Care Organisation's School Health Service.

It is likely that an IMT will be supplemented by a Local Coordination Team (LCT), established by CHPT; the purpose of this group is to coordinate necessary actions and feedback to the IMT.

COMPLIMENTARY GUIDANCE AND DOCUMENTATION

GUIDANCE AT NATIONAL LEVEL

Communicable disease outbreak management: operational guidance

Influenza-like illness (IL): managing outbreaks in care homes

Health protection in children and young people settings, including education

Health and Social Care Act 2008: code of practice on the prevention and control of infections

UKHSA A-Z of infectious diseases

UKHSA Inactivated influenza vaccine: PGD

GUIDANCE AT GREATER MANCHESTER LEVEL

GM Multi-Agency Outbreak Plan: this includes descriptions of the role of the DPH, CHPT, GM IC Manchester, Environmental Health Officer, NHS Trust and UKHSA Consultant/nurse in outbreak situations

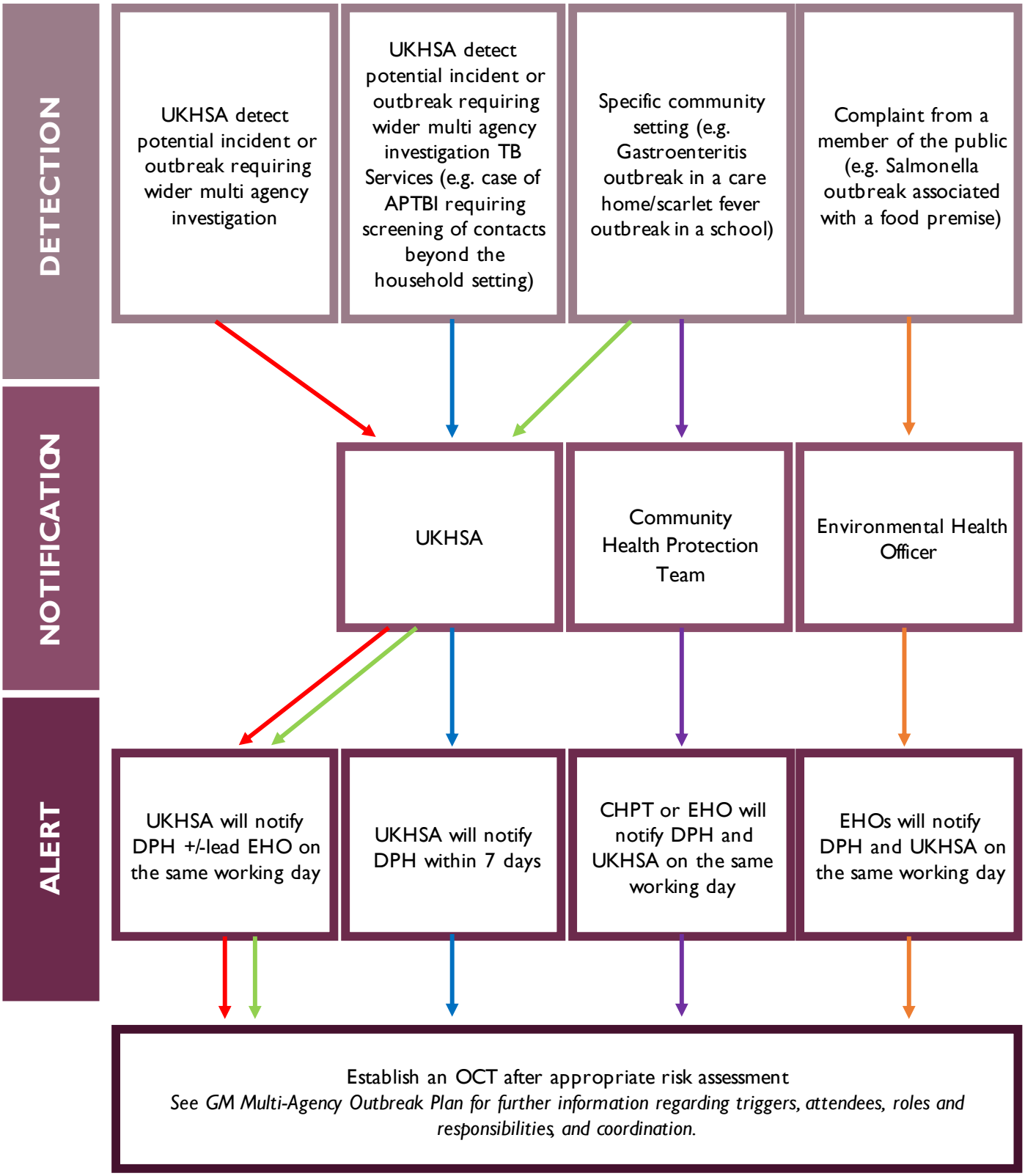
PART 2: KEY ASPECTS OF INCIDENT MANAGEMENT

This section of the Plan will describe the following in turn:

- Detection of a potential incident, notification, and alert to relevant authorities.
- Investigation, including roles and responsibilities
- Control measures available
- Communications
- Funding arrangements

DETECTION AND COORDINATION

INCIDENTs of disease are usually detected and alerted in the following ways:



INVESTIGATION ROLES & RESPONSIBILITIES

Prior to an IMT being set up, UKHSA will liaise directly with relevant partners to recommend and coordinate investigations. Once an IMT is set up, the IMT will agree on coordination of investigations.

The types of investigation involved usually include:

- Epidemiological investigation: establishing links between cases/sources based on questioning of cases/NOK and information on settings.
- Microbiological investigations: where a sample is taken and sent for analysis to a laboratory. There are 2 types:
    - Clinical sampling: from human tissue (blood, respiratory secretions, salivary, faeces etc)
    - Environmental sampling: e.g. water, work surfaces etc

N.B. Any setting where staff affected have access to Occupational Health, the investigation will be delivered through them.

RESPONSE ACTIVITY		POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
		In hours (9 – 5)	*Out of hours*	
Questionnaires/ Interviews/ Consent		UKHSA 0344 2250562 option 3	UKHSA 0151 434 4819	
		Hospital IPC team	Hospital IPC team	For Acute Trust incidents: MFT Oxford Rd 0161 276 4042 Wythenshawe site 0161 291 2632 NMGH 0161 720 2935
		UKHSA (MCC EHO – Legionella only) Tel: 0161 234 5004 (internal: 34853)	UKHSA	UKHSA undertake the patient questionnaires and sampling for MCC (except in the case of Legionnaires Disease, where MCC officers do undertake the questionnaire).
		LCO Children's Services –School Imms team	UKHSA	Consent to immunisation forms: Schools/Children: Contact: LCO School Immunisation Leads Contact details in contact list.
Sampling	Respiratory samples (e.g. swabbing)	NHS Provider/Nursing Home Staff/GP/School Imms Team Primary care provider	UKHSA/Primary Care Provider	Clinical sampling will be undertaken by Care staff in care setting. Uni/over 18: To be decided at IMT Nursery/Under 5 years – To be decided at IMT Those not registered with GP e.g Homeless/Rough sleepers Option 1: GP option 2: PRIMARY CARE PROVIDER (dependant on INCIDENT) Flu: Flu Swab Kits arrangements yet to be agreed/confirmed and circulated by UKHSA for 2023/24 season. Proposed arrangements likely to require CHPT to undertake ARI risk assessment with home, obtaining Ilog & arranging swabs to be couriered to and from the care setting via the lab. Results via elab to CHP T Further stocks of swabs can be accessed via UKHSA lab. Out of hours ;

			Arrangements also to be confirmed by UKHSA. Other out of hours work will be via NHS GM IC Director on call and meds optimisation response
Faecal (GI Incident)	UKHSA/GP /EHO	UKHSA/ EHO emergency out of hours: 07887916848	UKHSA undertake the patient sampling for MCC for environmental health related incidents UKHSA may notify EHO and CHPT of incident, Samples posted back to UKHSA labs If more than 2 cases unconnected – to see GP GP may be asked to obtain samples depending on organism. E.g. Clostridium difficile
Faecal (GI incident in a care home)	Care /Care Home Staff/ GP	Care home staff/OOH	Initial sampling taken by care home on GP instructions or with advice from CHPT. CHPT coordinate incident response and advise the home. CHPT may contact UKHSA or EHO for advice. Care home staff take samples.
Oral fluid (e.g. Hep A incident)	GP/NHS Provider/LCO/primary care provider	N/A	Risk assessment and contact tracing undertaken by UKHSA Self-administered arranged by UKHSA. If wider community incident : e.g. School/nursery : option 1: School nursing team option 2: PC provider Care Home: Care home nurses/NH team/GP University: PC provider Commercial Premises: UKHSA/CHPT may support staff self sampling GP- for Rough sleepers (Urban Village/The Vallance)
Urine test	UKHSA/GP/Care Home	N/A	If legionella: Care Home – Care Home Staff on request by UKHSA. Primary care: GP
Environmental (e.g. food / water)	Environmental Health Officers / HSE	UKHSA	e.g. Legionella/cryptosporidium Where EH are the enforcing authority then EHO to undertake sampling For certain premises or complex sampling e.g legionella linked to cooling towers EHO to discuss with HSE /and or use Bureau Veritas. 0161 446 4600
Blood test	NHS provider/GP	N/A	e.g Phlebotomy services for adults and children
TB skin test	TB nurses	N/A	e.g Mantoux/IGRA testing : 0161 276 1234 extension 64387.
Scabies (clinical assessment)	GP/Dermatologist	N/A	Most cases treated based on clinical assessment by GP or referral to dermatologist without testing. Advice from CHPT for single cases and incidents. Follow NICE Scabies Guidance

Mass blood tests (e.g. IGRA testing) for TB	TB Nurses MFT	N/A	0161 276 1234 extension 64387. TB service lead nurse. PC provider
Mass X-Ray (incl. mobile x-ray)	NHSE/UKHSA/TB nurses	N/A	When/if required coordinated by MFT TB team as above
Sexually Transmitted Infections	NHS Trust Sexual Health Clinic/GP	N/A	The Northern Sexual Health Services would provide screening/immunisation as required. Sexual Health Commissioning manager- to response & communicate with partner services.
Transport to lab	Local lab transport system	EHO via UKHSA system	GP routine samples in-hours. EHO would liaise with Manchester Public Health Lab for posting of samples.
	UKHSA Postal	N/A	e.g measles on individual cases, Flu packs, UKHSA packs have paid return envelope.
	Hand deliver		Care home flu swab samples Flu swabs – via UKHSA MRI lab process courier

CONTROL MEASURES

Prior to the first IMT meeting, UKHSA will liaise directly with relevant partners to recommend and coordinate initial control measures. Once an IMT meets, they will agree on coordination of control measures.

Control measures usually include:

- Identifying and controlling on-going sources. e.g. A cooling tower suspected of aerosolising Legionella, or a food premise with unsafe food preparation practice
- Preventing/limiting onwards spread
- Reducing likelihood of severe illness in specific vulnerable groups: usually by prompt post-exposure prophylaxis (PEP)

Where compliance with recommendations around control measures is an issue, enforcement powers may be used. For the purposes of incidents, enforcement powers lie with MCC. Further info can be found here: Chartered Institute of Environmental Health Toolkit / DoH guidance on Health Protection regulations

The key partners involved depend on which control measures are recommended, but are most commonly:

- EHOs: IPC advice for cases/contacts of GI illness + enforcement powers
- CHPTs: IPC advice and monitoring for community settings
- GPs: prescribing of treatments and PEP
- School nurses: delivery of PEP in a school setting
- NHS community providers: delivery of PEP in community settings (excluding schools) e.g. traveller sites
-

RESPONSE ACTIVITY	POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
	In hours (9 – 5)	*Out of hours*	
Advice on infection, prevention & control measures	Community Health Protection Team communityhealthprotectionteam@manchester.gov.uk EHO Tel: 0161 234 5004 (internal: 34853) UKHSA 0345 225 0562 opt 3	UKHSA 0151 434 4819 EHO	9am-5pm The CHPT have a central email address communityhealthprotectionteam@manchester.gov.uk UKHSA also provide some infection control information and advice if related to a specific notifiable disease not routinely dealt with by CHPT or if unusual situation EHO for commercial food premises/preparation
Exclusion advice	CHPT /UKHSA	UKHSA	Using national UKHSA guidelines and advice. Would depend on the incident
Enforcement of control measures	Local Authority(Proper officer) with UKHSA support	Local Authority with UKHSA support	Proper Office EH for Part 2a Order (EHO team)
Treatment and Prophylaxis (including immunoglobulin, vaccines, antivirals, antibiotics and anti-toxins)	Trust Pharmacy – order vaccines for use by MFT staff NHS IC Manchester Medicines Optimisation – order vaccines/coordinate delivery. Identify local of antiviral stock pile in key pharmacies. Antivirals for ARI available from general community pharmacies on prescription May use Immform or order direct from manufacturer for non- immunisation programme vaccines	UKHSA to order vaccines in specific cases Trust pharmacy/NHS IC Manchester meds op Out of hours arrangements also to be confirmed by UKHSA. Other out of hours work will be via NHS IC Manchester Director on call and meds optimisation response use of LCS /PC provider etc for antivirals – assessment	There may be vaccine manufacturing shortages or ordering issues, ordering at short notice in some unusual outbreaks. – UKHSA to advise/support if vaccination recommended by them

	UKHSA may order direct in some circumstances/use own stocks- antivirals/vaccines at UKHSA discretion PGDs to be available from Trust for imms team GM SIT to advise primary care with use of PSD	of patients/contacts and prescribing.	

COMMUNICATIONS – ROLES AND RESPONSIBILITIES

RESPONSE ACTIVITY		POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
		In hours (9 – 5)	*Out of hours*	
To public	Setting specific advice letters (eg businesses, care homes)	IMT: NHS IC Manchester/EHO/UKHSA	UKHSA	Dependent on topic and setting. Template letter provided by UKHSA for Infectious Diseases Template letter provided by UKHSA/EHO for food related or Environmental
	Update NHS 111	UKHSA	UKHSA	UKHSA/MCC Comms Team
	Helpline	Contact centre	Contact centre	Script and algorithm provided by UKHSA for any MCC comms via the Contact Centre. This would need to be pre-agreed.
	Websites / social media	UKHSA/MCC/NHS IC Manchester	MCC//NHS IC Manchester	Comms Lead for UKHSA//NHS IC Manchester /MCC
	Door to door	MCC /NHS IC Manchester /UKHSA	MCC//NHS IC Manchester /UKHSA	Need would have to be clearly identified and resourced.
To health partners	Briefings / sitreps from IMT	UKHSA /NHS IC Manchester Comms & PC Commissioner	UKHSA /NHS IC Manchester – Comms & PC Commissioner	see list of contacts for community cases in appendix
	Other relevant groups	Responsibility of each agency	Responsibility of each agency	
To the media		Coordinated by UKHSA//NHS IC Manchester /MCC via IMT	UKHSA//NHS IC Manchester /MCC via IMT	Include all partner agencies in discussion of key comms messages
To Elected Members / Committees e.g. Health and Wellbeing Boards		DPH	DPH NHS IC Manchester on call director	David Regan Director of Public Health
		NHS IC Manchester /MCC	NHS IC Manchester /MCC	NHS IC Manchester Comms lead 0161 765 4004 communicationsmanchester@nhs.net Senior Communications Manager 07976883111

MCC Comms 0161 234 3166
communications@manchester.gov.uk

FUNDING ARRANGEMENTS

Guiding principles:

- Protection of human health takes priority over funding challenges/financial discussions
- Where a local arrangement is in place re delivery of a certain aspect of the response (e.g. delivering an immunisation session in a school setting): partners must actively:
    - Involve key decision makers form the relevant agency to formally approve the agreement (i.e. do not assume that the organisation will do it)
    - Consider whether activity should be absorbed in existing contracts or whether additional funding is required and if so, which commissioner will sort this.
- Key commissioners in Manchester health economy include:
    - NHS IC Manchester which commissions: Primary care and acute and community/social care providers
    - LA PH, which commission public health services (school nurses and HVs) –
    - GM Health and Social Care Partnership (GMHSCPICS), Dentists and GPs which are jointly commission with NHS IC Manchester
    - Specialist Commissioning commissioned by NHS IC Manchester
    - LA Environmental Health

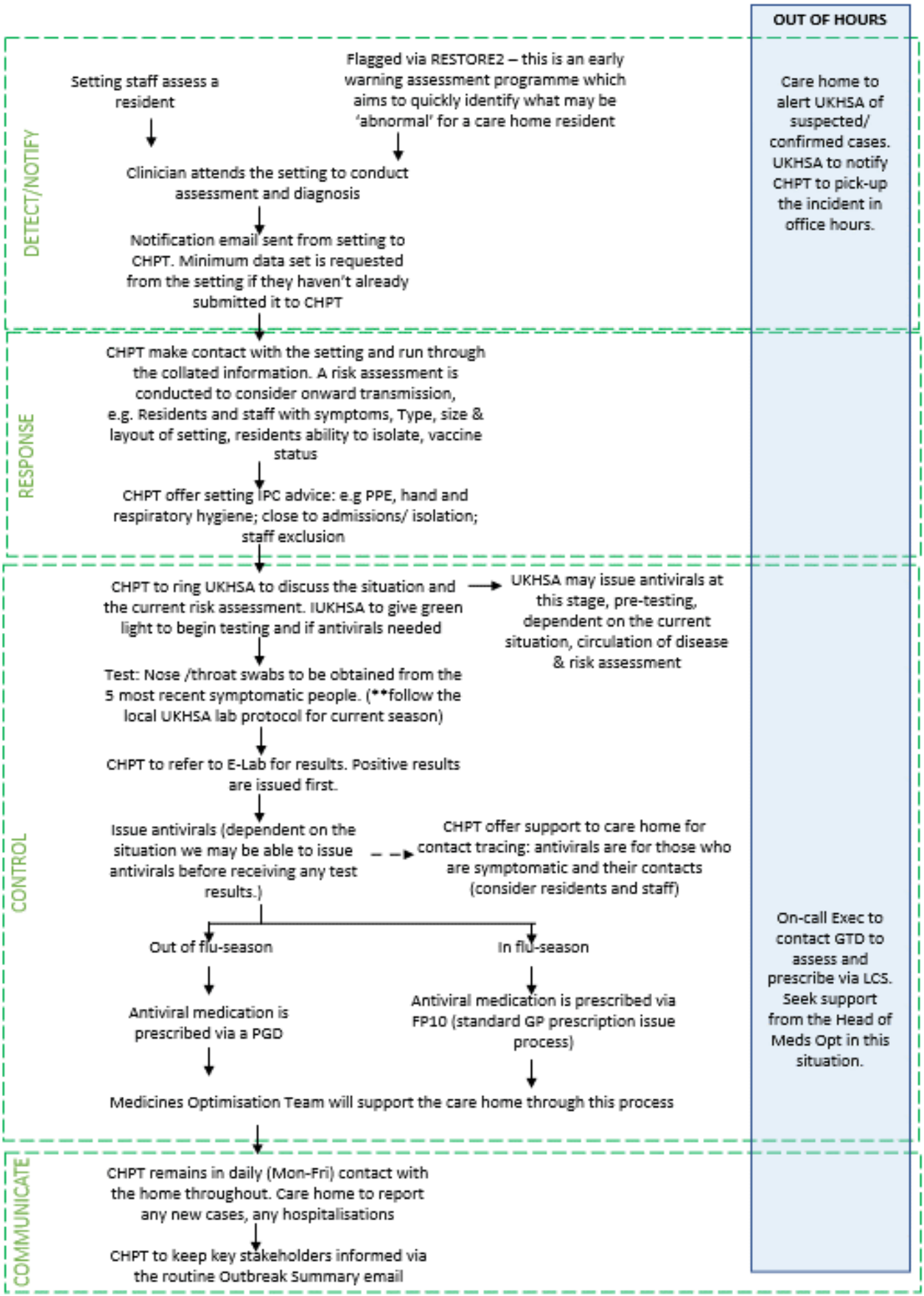
N.B. NHS IC Manchester Medicines Optimisation: A Locally Commissioned Service Specification is agreed for use with GPs including OOH in case of outbreak responses for antiviral treatment/prophylaxis and vaccination

RESPONSE ACTIVITY	POTENTIAL RESPONDER(S)		CONSIDERATIONS, COMMENTS OR POTENTIAL ISSUES
	In hours (9-5)	*Out of hours*	
Vaccination session arrangement and provision by MLCO Schools Immunisation Team	Response by NHS Trust	N/A	Response to outbreak to be undertaken. Funding agreed after event.
Obtaining vaccines from Immform or other sources	NHS Trust NHS IC Manchester meds Opt		Response to outbreak to be undertaken. Funding agreed after event.
Vaccination and prophylaxis activity	GPs/PC provider	GPs/PC provider	LCS used for payment
Legionella Testing **D+V sampling (specific outbreaks/cases)**	EHO		Specific situations identified by UKHSA/EHO
Immunisation/Prophylaxis for under 5 years and over 18 years/Uni	PC provider/GPs		Use of LCS

PART 3: LOCAL OPERATIONAL ARRANGEMENTS FOR SPECIFIC TYPES OF OUTBREAKS REQUIRING AN IMT

- Arrangements for an outbreak of acute respiratory illness (ARI) in a care home
- Arrangements for responding to Tuberculosis in a university setting
- Arrangements for responding to Meningococcal disease in a university setting
- Arrangements for responding to Hepatitis A in a school or childcare setting
- Arrangements for responding to Diphtheria in an asylum seeker setting
- Arrangements for responding to MPox
- Arrangements for responding to Measles in a school setting

ARRANGEMENTS FOR AN OUTBREAK OF ACUTE RESPIRATORY ILLNESS IN A CARE HOME



Key reference documents

Seasonal influenza: guidance, data and analysis - GOV.UK (www.gov.uk)

Respiratory viruses - GOV.UK (www.gov.uk)

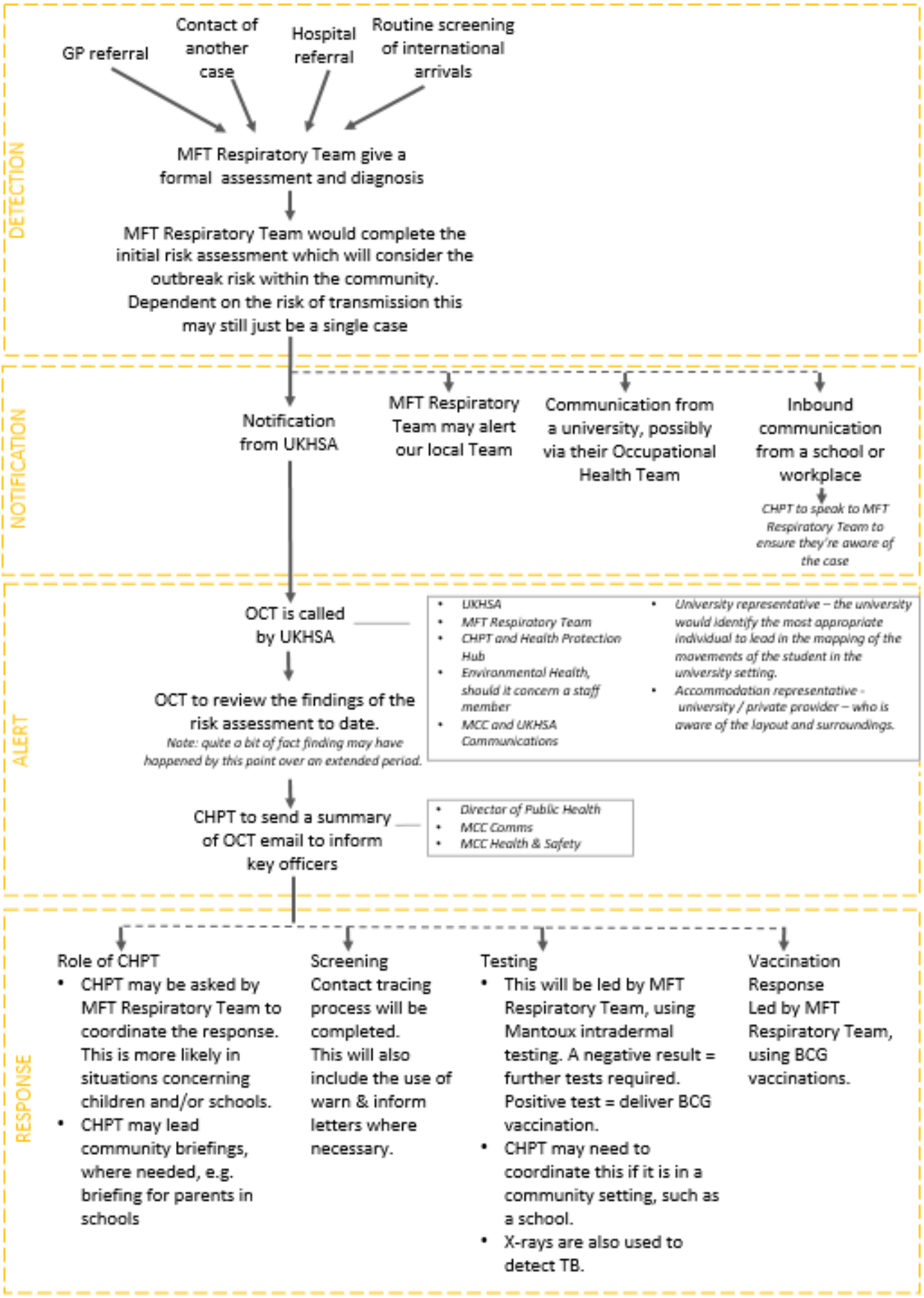
Influenza-like illness (ILI): managing outbreaks in care homes - GOV.UK (www.gov.uk)

Guidance on outbreaks of influenza in care homes poster - GOV.UK (www.gov.uk)

Influenza post exposure prophylaxis and treatment: PGD templates - GOV.UK (www.gov.uk)

Investigation and management of outbreaks of suspected acute viral respiratory infection in schools: guidance for health protection teams - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO TUBERCULOSIS IN A UNIVERSITY SETTING



Signs and Symptoms

- Infection: may be asymptomatic, cause primary progressive systemic illness, or reactive months to years later.
- Active disease: fever, night sweats, poor appetite, and weight loss
    - Pulmonary TB: prolonged cough, sputum, chest pains, shortness of breath. May present as acute pneumonia, especially in immunocompromised patients.
    - Other symptoms of TB depend on the affected body part (e.g. bone, brain, gastrointestinal system, urinary system, lymph nodes etc)

Incubation Period and Infectivity

- The incubation period is usually 3-8 weeks; the latent period (time to development of disease) may be many decades, but is accelerated in immunosuppressed (e.g. HIV infection)
- The infectious period is for as long as viable organisms persist in the sputum. Most cases of TB are non-infectious after two weeks of treatment.

Mode of transmission

- Respiratory droplet transmission requires prolonged, close contact with sputum-smear positive cases.

Confirmation (diagnosis)

- Clinical
    - Symptoms, and indicative Chest X-ray but need to be confirmed by laboratory tests.
- Laboratory
    - Microscopy of stained sputum samples indicates presence of mycobacterial organisms.
    - Culture and drug sensitivity testing
    - Rapid molecular testing is becoming increasingly available.

Differences in response from other settings

- The MFT Respiratory Team will lead on the majority of TB case response. There is often no community link which causes concern. For this reason, we may not be made aware of cases at all.
- CHPT are more likely to be asked to lead the outbreak response to an outbreak in a setting in the community concerning vulnerable/complex cohorts. For example, the testing response to an outbreak in a school may require a mobile testing unit. This is different to outbreaks concerning adult, who can be asked to attend clinic at MFT.
- Environmental Health will be involved in outbreaks which concern workplace settings. UKHSA will notify CHPT, who will then reach out to Environmental Health for involvement in the Outbreak Control Team meetings as appropriate.
- Unlike many other infectious diseases, the response to cases of Tuberculosis may be extended over a period of time.

Key reference documents

- Tuberculosis (TB): diagnosis, screening, management and data - GOV.UK (www.gov.uk)
- Tuberculosis: the green book, chapter 32 - GOV.UK (www.gov.uk)
- Tackling tuberculosis in under-served populations - GOV.UK (www.gov.uk)
- Managing tuberculosis (TB) in prisons - GOV.UK (www.gov.uk)

- Tuberculosis (TB) and asylum seekers - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MENINGOCOCCAL DISEASE IN A UNIVERSITY SETTING

Signs and Symptoms

- Symptoms: meningism, nausea & vomiting, rash
- Signs: petechial non-blanching rash and/or Kernig's sign

Incubation period and infectivity

- Incubation period is 2-5 days.
- Infectivity: while organism is present in nasopharynx.

Mode of transmission

- Invasive disease caused by Gram-negative bacterium (meningococcus) spreads through exchange of respiratory and throat secretions.

Confirmation (diagnosis)

- Clinical
    - Possible case: other diagnosis at least as likely
    - Probable: most likely diagnosis
    - Confirmed: by laboratory tests.
- Laboratory
    - Blood: culture, PCR
    - Nasopharyngeal swab (normally through mouth): bacterial culture

Action

- Early detection: Treatment; Isolation and Infection Control
    - Arrange urgent admission if petechial non-planching rash and/or Kernig's sign
    - Immediate parenteral antibiotics; do not delay transfer to complete
- Prophylaxis (Vaccination/immunoglobulin/antibiotics/antivirals)
    - Chemoprophylaxis: Ciprofloxacin is antibiotic of choice.
    - Identify close contacts; arrange chemoprophylaxis as soon as possible (ideally within 24 hours); can be given up to 4 weeks after onset if reporting delayed.
    - Consider, arrange appropriate meningococcal vaccinations for cases and contacts.

Key reference documents

- Meningococcal disease: guidance, data and analysis - GOV.UK (www.gov.uk)
- Meningitis and septicaemia: prevention and management in higher education institutions - GOV.UK (www.gov.uk)
- Meningococcal disease and ciprofloxacin: PGD template - GOV.UK (www.gov.uk)
- Meningococcal disease: guidance on public health management - GOV.UK (www.gov.uk)

Scenario to consider

You are contacted by UKHSA to advise that a 4yo child attending the nursery at a local Primary School has been confirmed as a case of acute hepatitis A following recent travel abroad. The child attended the setting during their infectious period.

UKHSA would like to convene an urgent Outbreak Control Team (OCT) or Incident Management Team (IMT) meeting to confirm the facts and assess the degree of exposure at the school in order to consider whether hep A vaccination needs to be offered in the school as post-exposure prophylaxis

Stage 0: Local notification

Case is seen by their treating clinician who has clinical suspicion of a *probable* case – appropriate public health action is taken without delay

Direct notification from the laboratory of a *confirmed* case

UKHSA Duty Team are notified and take as much detail as possible, using the set questionnaire which considers:

- Awareness of the source of the infection
- Recent travel history
- Details of household contacts
- Any contacts within the community setting

Consideration given at this early stage if the case has attended an educational setting.

Via email, UKHSA alert:

- Director of Public Health
- Consultant in Health Protection
- Lead Nurse in Health Protection

Likely telephone conversation between UKHSA & Lead Nurse Health Protection at this stage to share the details gathered so far.

Lead Nurse in Health Protection to send a brief email summary to key officers as an early alert for the case:

- Council Health & Safety team
- Press Office
- Director of Education
- Cc. Director of Public Health

Possible request at this stage from the DPH & DOE to inform key members. Lead Nurse would prepare this.

Lead Nurse to also alert the Community Health Protection Team of the case

Stage 1: steps to take pre-Incident Management Team meeting

If the Community Health Protection Team and UKHSA share similar concerns regarding the setting:

The Community Health Protection Team may conduct a visit to gather further information, inc. discussing IPC policies & procedures and assessing the set-up/ environment.

On some occasions, UKHSA may have already gathered key information to feed into the incident risk assessment, such as class sizes, ages, school routines and layout. Sometimes this may be done at this stage by CHPT upon request from UKHSA

The Community Health Protection Team will ensure the setting are aware of their role and the support they can offer, in addition to offering reassurance and answering any questions

The Education Business Partner will work with the setting's Quality Assurance Officer (SSQA) to support the headteacher and wider setting. This is particularly important from an employment perspective, should staff be identified as contacts, for example.

Stage 2: Convening an Incident Management Team (IMT)

UKHSA will take leadership in convening an IMT, and decide who will be the Chair (Typically UKHSA).

UKHSA may reach out to the Lead Nurse in Health Protection to agree the membership list, and to establish who is expected to bring particular pieces of information (which may need to be outlined when partners are first invited to the IMT)

Proposed membership list for IMT:

- UKHSA
- Community Health Protection Team
- Education Business Partner/SSQA
- UKHSA/MCC Comms
- Medicines Optimisation Team
- Rep from the setting
- Rep from the laboratory
- Medicines Optimisation Team
- Provider commissioned to deliver the response, OR Primary Care if it still needs commissioning
- Child Health Information Service (CHIS)
- If an outbreak – UKHSA Field Epi Service
- If an outbreak - UKHSA national swabbing team

Unlikely we would send out any details to the IMT pre-meeting for this scenario due to it being a single case.

Stage 3: Conducting an Incident Management Team (IMT) meeting

Important to ensure members of the IMT understand their role and responsibility in attending, e.g.:

Education Business Partner/ SSQA	Considerations for employment – potential need for communications to involve Unions if staff are involved. Also providing support if staff cover and capacity are a concern as a consequence of the incident.
Specialist Vaccinations & Immunisations Nurse	Would attend with knowledge of the Green Book, and an overview of the potential vaccination response

↓

IMT to explore & agree on control measures required to respond to the case (continued below)

↓

Post-IMT, if any members were not able to attend they will be contacted and any tasks allocated explained.

↓

Lead Nurse Health Protection to prepare a summary email outlining the key decisions that have been made

- Council Health & Safety team
- Press Office
- Director of Education
- Director of Public Health

↓

UKHSA to share minutes of the meeting with all IMT members.

Stage 4: Implementing the agreed response

IMT agrees who is offered post-exposure prophylaxis. The general principle is to keep the response small if you are able to. Pragmatically in this scenario it would be the group sharing the same room(s).

Children identified as contacts

↓

Ideally this response is delivered on site. CHIS would support the IMT to establish a line list.

↓

PGD is already prepared for Hep A (on a GM level). Responsibility for ordering the vaccine would be dependent on the provider.

Staff identified as contacts

↓

IMT would prepare a letter for them to use to attend their GP. In addition, the IMT would directly advise Primary Care of the names of adults who require vaccination.

Details of the response would be tailored to the incident and dependent on the setting and the provider

In the event of a Hepatitis A incident/outbreak occurring in Manchester, CHPT will act as a facilitator, providing the link between UKHSA and various parts of Manchester Health Economy (these will vary according to location of outbreak and who is involved). The CHPT will also act as a point of contact for individuals seeking advice

Signs & Symptoms

- Children: acute onset with non-specific features, including fever, malaise, appetite loss, abdominal discomfort, vomiting, diarrhoea; 30% develop jaundice.
- Adults: frequently symptomatic; ~70% develop jaundice
- Illness usually a few weeks; may last 6 months; longer duration in older people

Incubation period and infectivity

- Incubation about 28 days (range 15-50 days)
- Infectivity:
    - Maximum from latter half of incubation period (approx. 2 weeks before symptom onset) to 7 days after jaundice onset; and
    - Asymptomatic patients: during first few days when liver enzymes maximally elevated.

Mode of transmission

- Spread mainly through faecal-oral route; through blood transfusion; and may be transmitted sexually

Confirmation (diagnosis)

- Clinical and laboratory
    - Appearance of IgM in a patient with compatible illness confirms the diagnosis; IgM appears at the onset of symptoms, lasting about 6 months.
    - IgG appears during convalescent phase, lasting many years; may be lifelong.

Action

- Early detection; treatment; isolation and infection control
    - Advise index case about good hygiene practices, exclude from work, school or nursery for 7 days after jaundice onset; seek source of infection
- Prophylaxis (Vaccination/immunoglobulin/antibiotics/antivirals)
    - Offer vaccine to household and sexual contacts seen within 14 days of exposure to index case.
    - Offer Human Normal Immunoglobulin (HNIG) to contacts aged 50+ and to those with chronic liver disease.

Key reference documents

- Hepatitis A: guidance, data and analysis - GOV.UK (www.gov.uk)
- Hepatitis A infection: prevention and control guidance - GOV.UK (www.gov.uk)
- Hepatitis A: oral fluid testing for household contacts - GOV.UK (www.gov.uk)
- Hepatitis A: the green book, chapter 17 - GOV.UK (www.gov.uk)
- Immunoglobulin: when to use - GOV.UK (www.gov.uk)
- Hepatitis A: outbreak information - GOV.UK (www.gov.uk)

Infectious Disease Care Pathway

20 December 2022

for AS Accommodation Settings

Legend

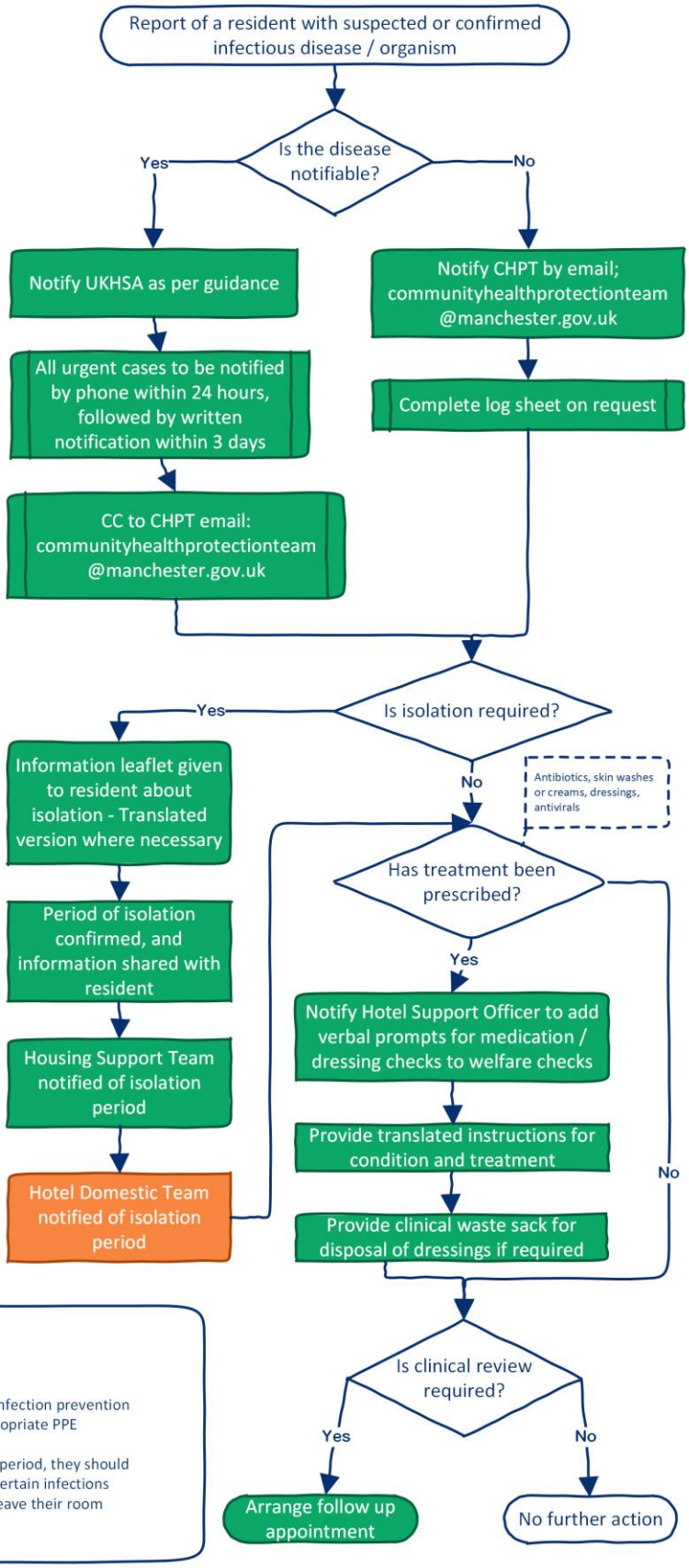
Housing Support Team | Hotel Domestic Team | GTD

Actions for Housing Support Team

- Update spreadsheet to identify residents and contact isolating and date of expected isolation end
- Resident provided with laundry bags & waste bags with instruction for use – advised to double bag and tie securely & confirm date for leaving outside room
- Arrange for delivery of meals during isolation period
- Ensure regular welfare checks (at least once a day):
  - Check resident compliant with treatment; medication taken, or creams applied. If wounds dressed ask if dressing intact.
  - Continue to check on residents' health and wellbeing and speak to GTD if further assessment or review required - If residents need to see a clinician out of hours seek advice from 111 or call 999 in an emergency

Actions for Hotel Domestic Team

- Update room cleaning schedule – rooms where residents isolating NOT to be cleaned by staff until isolation ends
- Resident provided with cleaning wipes for period of isolation
- Collection of bagged waste and linen from outside resident's room
  - Waste should be double bagged and tied securely before disposal
  - Linen to be double bagged and tied securely and marked as infectious linen prior to collection
    follow laundry provider guidance for infectious linen including use of red soluble bags if provided
    *follow IPC standard precautions when handling bags including appropriate use of PPE & hand hygiene
- Arrange for full clean on completion of isolation – ensure infection prevention and control precautions



ADDITIONAL NOTES / CONSIDERATIONS
***During isolation period:**

Only enter patients' rooms in an emergency and ensure infection prevention and control precautions maintained including use of appropriate PPE

If residents need to leave their room during the isolation period, they should avoid contact with others or using communal areas. For certain infections residents can be advised to wear a mask if they need to leave their room during isolation period.

Signs & symptoms

- Usually asymptomatic or mild; occasionally severe upper respiratory tract infection, localised skin infection or systemic infection. Bacterial exotoxin can damage other organs.
- Initial symptoms frequently non-specific (low-grade fever, malaise, headache), resembling viral upper respiratory tract infection.
- Sore throat with pharyngitis, dysphasia, and hoarseness, with pseudomembrane
- Cutaneous diphtheria: indolent, poorly healing ulcers covered with grey membrane, frequently co-infected with other pathogens.

Incubation period & infectivity

- Incubation period usually 2-5 days (range 2-10)
- Without antibiotics, patients can be a source of infection for 2-6 weeks.
- Cases no longer infectious after 3 days of antibiotic treatment.

Mode of transmission

- Transmitted through aerosolized secretions from patients with pharyngeal/respiratory disease; direct contact with skin ulcers can spread infection.

Confirmation (diagnosis)

- Clinical
    - Symptoms not diagnostic; toxigenicity vital (laboratory confirmation)
- Laboratory
    - Diagnosis based on both culturing organism and demonstrating toxin production; culture takes 48 hours.

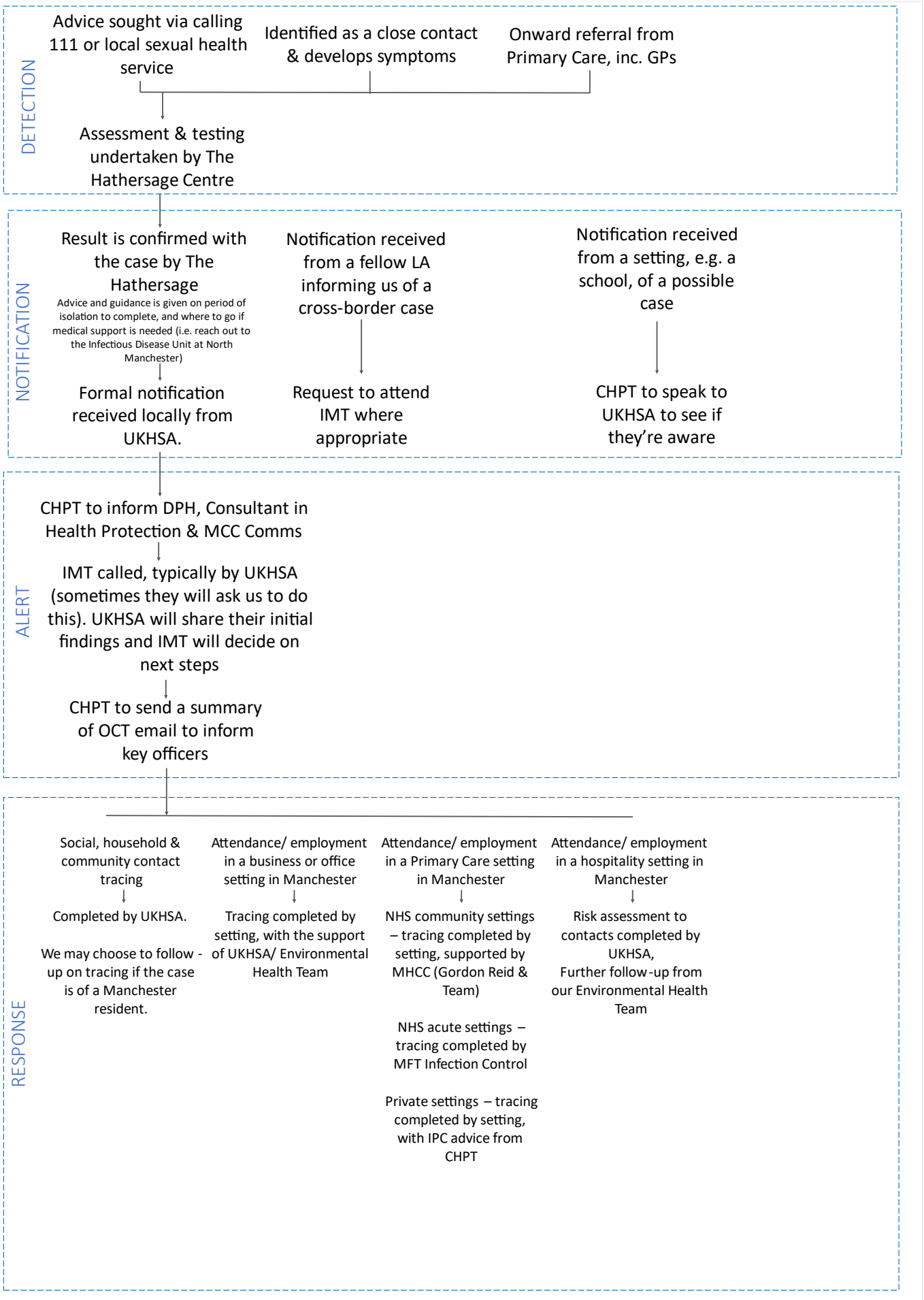
Action

- Early detection; treatment; isolation and infection control
    - Confirmed or probable case should be isolated in hospital.
    - Implement appropriate precautions for droplet-borne infection or direct contact
    - Non-hospitalised patient should restrict contact with others until 3 days course of antibiotics.
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
    - Five doses needed: vaccine given at 2,3,4 months of age, pre-school and school-leaving booster.
    - Following completion, >99% develop protective antibodies expected to last many years, if not life-long.

Key reference documents

- Diphtheria: guidance, data and analysis - GOV.UK (www.gov.uk)
- Diphtheria: public health control and management in England - GOV.UK (www.gov.uk)
- Diphtheria: the green book, chapter 15 - GOV.UK (www.gov.uk)
- Diphtheria disease and azithromycin: PGD template - GOV.UK (www.gov.uk)
- Diphtheria warn and inform letter - GOV.UK (www.gov.uk)
- Diphtheria: vaccination resources - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MPOX



Signs & symptoms

- Fever, headache, muscle aches, backache, swollen lymph nodes, chills, exhaustion, joint pain
- Not all people who have mpox will experience these symptoms.
- Within 1 to 5 days after the appearance of fever, a rash develops, often beginning o the face and then spreading to other parts of the body including the soles of the feet and palms of the hands. Lesions can also affect the mouth, genitals and anus. The rash changes and goes through different stages before finally forming scabs which eventually fall off.
- Some individuals may not have a widespread rash, and in come cases only genital lesions are present. These may be blisters/vesicles, scabs or ulcers.

Incubation period & infectivity

- An individual is contagious until all the scabs have fallen off and there is intact skin underneath. The scabs may also contain infectious virus material.
- The incubation period of the situation/time between contact with the person with mpox and the time that the first symptoms appear is between 5 and 21 days.

Mode of transmission

- Prevention of transmission of infection by respiratory and contact routes is required. Appropriate precautions are essential for suspected and confirmed cases.
- It spreads from contact with infected:
    - Persons, though touch, kissing or sex. Respiratory droplets or short-range aerosols from prolonged close contact.
    - Animals, when hunting, skinning, or cooking them
    - Materials, such as contaminated sheets, clothing or needles. Scabs are infectious and care must be taken to avoid infection through handling bedding and clothing.

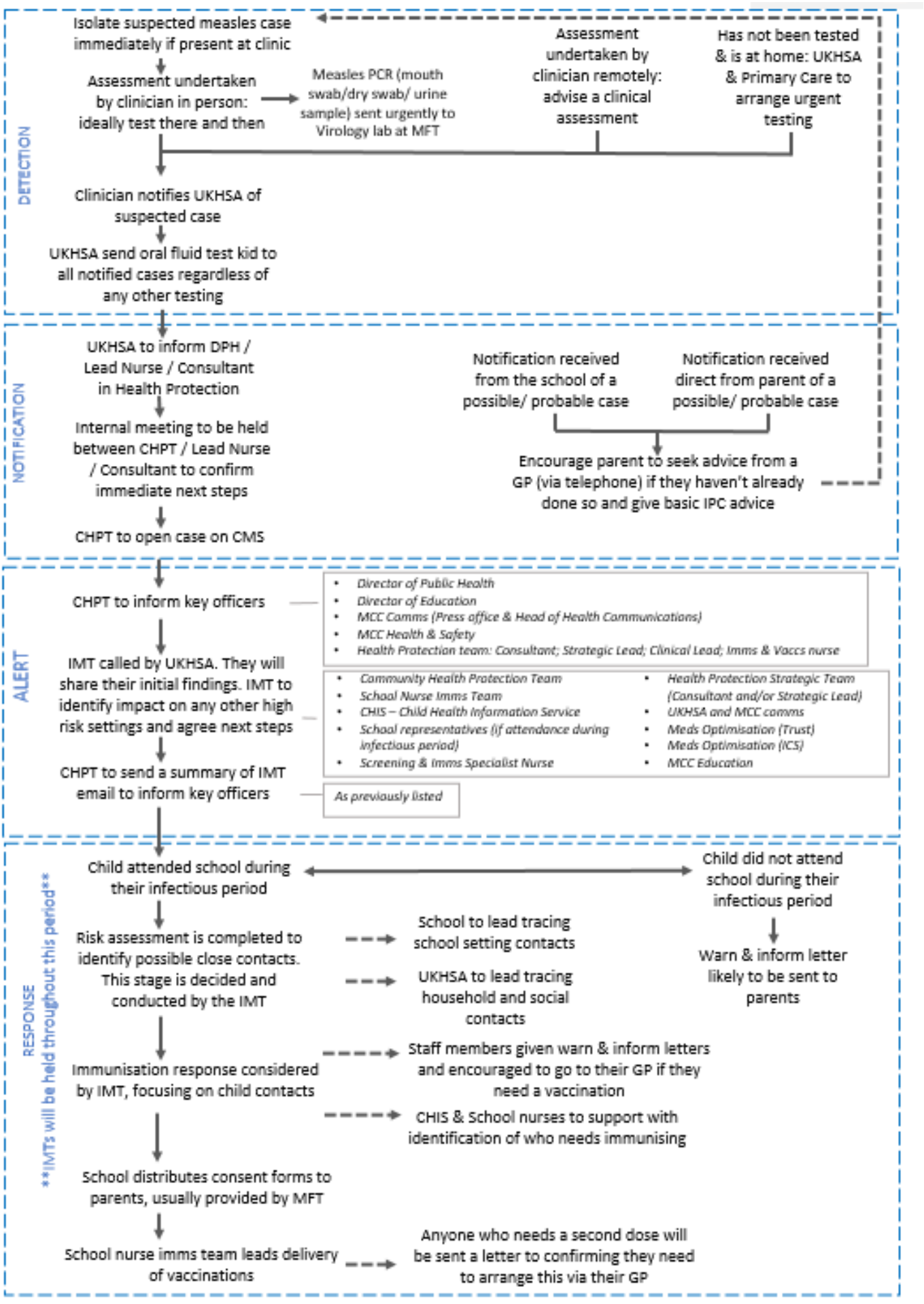
Confirmation (diagnosis)

- Clinical diagnosis of mpox can be difficult, and it is often confused with other infections such as chickenpox. A definite diagnosis of mpox requires assessment by a health professional and specific testing in a specialist laboratory.
- Laboratory confirmation of mpox is done by testing skin lesion material by PCR.

Key reference documents

- Mpox (monkeypox): guidance - GOV.UK (www.gov.uk)
- Mpox classification and appropriate infection prevention and control (IPC) pathways - GOV.UK (www.gov.uk)
- Mpox (monkeypox): case definitions - GOV.UK (www.gov.uk)
- Monkeypox: contact tracing - GOV.UK (www.gov.uk)
- De-isolation and discharge of mpox-infected patients: interim guidance - GOV.UK (www.gov.uk)
- Mpox (monkeypox): prisons and places of detention - GOV.UK (www.gov.uk)
- Mpox (monkeypox): cleaning sex-on-premises venues - GOV.UK (www.gov.uk)
- Mpox (monkeypox): planning events and mass gatherings - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO MEASLES IN A SCHOOL SETTING



Signs & symptoms

- Infection starts with high fever, runny nose, red watery eyes, sore throat: Koplik spots (small red spots, bluish-white centres) seen in 1/3 patients on buccal mucosa opposite molar teeth.
- Several days later: rash, first on face; upper neck, spreading over body; reaching hands, feet. Rash lasts 5-6 days, disappears in order it started. Rash appears about 14 days after first exposure.
- Complications include primary viral or secondary bacterial pneumonia, encephalitis, exacerbation of tuberculosis, diarrhoea, hepatitis, pancreatitis, myocarditis
- May be worse in susceptible infants, pregnant women, and immunocompromised individuals.

Incubation period & infectivity

- The incubation period: 7-14 days (average 10 to 12 days)
- Infectivity from about 4 days before to about 4 days after onset of rash.

Mode of transmission

- Fifteen minutes of face to face contact sufficient for transmission.
- Highly infectious: 90% susceptible close contacts develop disease following exposure.

Confirmation (diagnosis)

- Clinical
    - Frequently clinical: generally unreliable in non-outbreak/non-epidemic situations
    - In liaison with the reporting clinician, experienced health protection professional will classify case as likely (probable), unlikely (possible) based on clinical assessment plus epidemiological information.
    - Assessment plus cases' occupation, location, household contacts, local measles epidemiology determines actions.
- Laboratory
    - Laboratory confirmation on oral fluid or serum for IgM, IgG antibodies, +/- measles RNA.
    - Take diagnostic laboratory samples at earliest opportunity; send oral fluid samples by post to national viral reference department

Action:

- Early detection; treatment; isolation; infection control
    - Confirmed or likely case prompts immediate public health action, for patient and community.
    - Cases should be excluded from school/workplace for 4 days from onset of rash.
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
    - Individual: assess immune status, as MMR vaccination or immunoglobulin may be recommended.
    - MMR can be given to susceptible contacts up to five days after exposure to modify/prevent disease.

Should there be an escalation in a situation to community transmission

Primary Care would hold the ultimate responsibility for a vaccination response.

IMT would consider:

- Community hubs to vaccinate larger groups
- Ward level intervention – support with data from Public Health Intelligence needed
- Support from CHIS on vaccination uptake levels in young people

- Neighbourhood teams needed to support engagement
- Comms support needed to promote sessions, inc. developing easy reads, organising key messages to be translated etc
- IMT to give extra consideration for vulnerable groups, inc. pregnant women
- Members to be briefed.

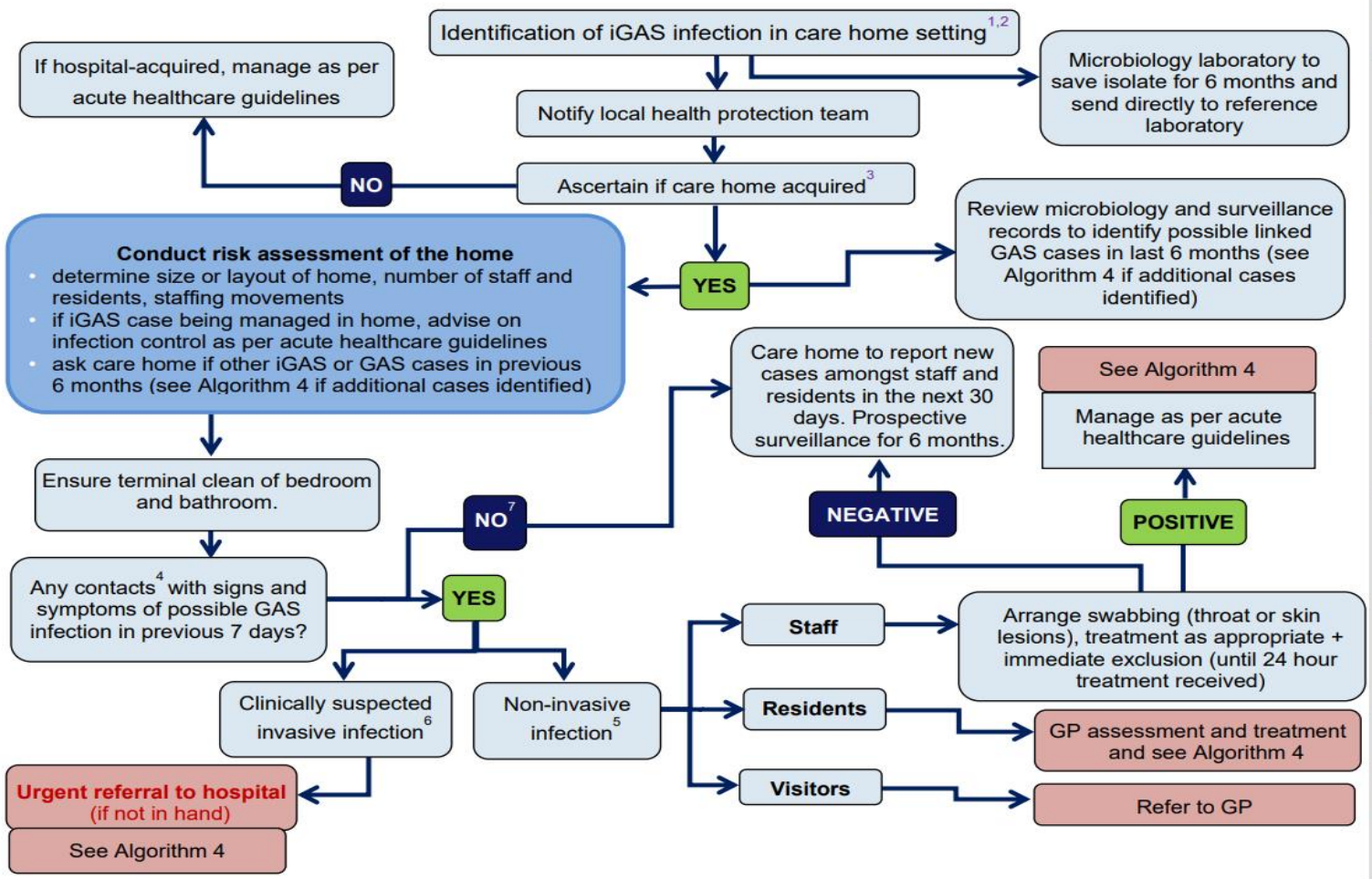
Incident vaccination response

Individual has had two prior does of vaccination	→	Do not need a booster even if they're a contact of the confirmed case. There would need to be documentation of two doses received – if there is any uncertainty they will be assumed to be unimmunised and offered a vaccine to bring them in line with the UK schedule
Individual has not had a full course of MMR	→	Would be offered first/second dose as part of the incident response. If the incident is related to a setting (e.g. school), even if they are not identified as a close contact they will be encouraged to receive a vaccination.

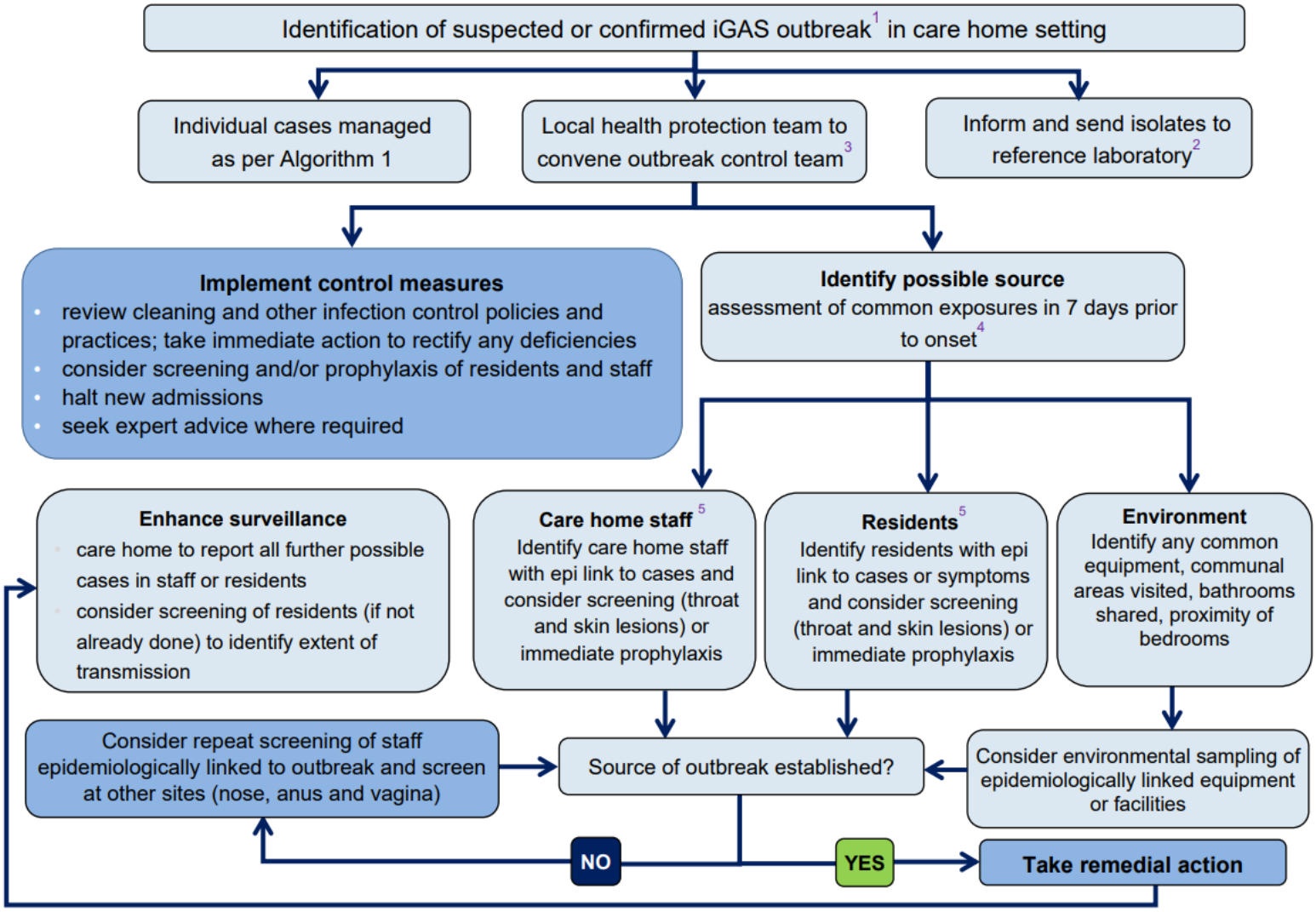
Key reference documents

- National Measles Guidelines, published by UKHSA in Nov 2019
- Measles: the green book, chapter 21 - GOV.UK (www.gov.uk)
- The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)
- Managing outbreaks and incidents - GOV.UK (www.gov.uk)
- Vaccination of individuals with uncertain or incomplete immunisation - GOV.UK (www.gov.uk)

ARRANGEMENTS FOR RESPONDING TO INVASIVE GROUP A STREP (IGAS) IN A CARE HOME



1. Patient resided in a care home in 7 days prior to onset
2. Invasive GAS infection (iGAS) is defined through isolation of GAS from a normally sterile body site. GAS isolated from non-sterile site in combination with severe clinical presentation should be managed as per iGAS.
3. Consider care home acquired if symptoms or signs of infection not present on entry to care home and no other possible source of transmission identified, such as from recent hospital stay.
4. Carers, peripatetic staff, visitors, other residents with direct contact or close proximity to case.
5. Symptoms suggestive of non-invasive GAS infection include sore throat, fever, minor skin infections
6. Symptoms suggestive of invasive disease include high fever, severe muscle aches or localised muscle tenderness +/- a high index of suspicion of invasive disease. In the absence of a more likely alternative diagnosis then emergency referral to A&E (contact A&E to advise of incoming patient).
7. Consider whether asymptomatic staff contacts should be screened. Indications may include strong epidemiological link, absence of alternative potential source and/or where recent transmission of GAS within the home suspected.



1. Two or more cases of confirmed or probable iGAS infection related by person or place. These cases will usually be within a month of each other but the interval may extend to several months.
2. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventive measures should not await results of typing.
3. Outbreak control team may include care home manager, consultant microbiologist, occupational health adviser, local GP, local commissioning lead and communications adviser.
4. Assess possible sources according to case's movements or contacts in the home 7 days prior to onset. Carers, other residents, equipment and the environment are possible sources of outbreaks. Develop time lines and network analyses to identify common exposures (2 or more cases).
5. Carers, peripatetic staff (hairdressers, podiatrists, GPs, district nurses etc), visitors, other residents with direct contact or close proximity to case within 7 days prior to diagnosis. Consider kitchen staff.

Signs & symptoms

- Symptoms: toxic shock syndrome, necrotizing fasciitis, bacteraemia, peritonitis, puerperal sepsis, osteomyelitis, septic arthritis, myositis, surgical site infection.
- Signs: localised pain, localised inflammation, fever, shock

Incubation period & infectivity

- Incubation period: 1-3 days (up to 7 days)
- Infectivity: 2-3 weeks for untreated sore throat. Treatment with penicillin reduces infectivity within 48 hours.

Mode of transmission

- Direct contact: blood, bodily fluids, infected tissues
- Droplet exposure: respiratory secretions, splashes with blood, body fluids

Confirmation (diagnosis)

- Clinical and laboratory
    - Group A Streptococci (also known: Streptococcus pyogenes) isolated from sterile site, or from non-sterile site along with severe clinical presentation.
    - Sites indicating iGAS: blood, tissues, wound swabs, aspirates, exudate, or pus positive for Group A Streptococci
    - All samples consistent with iGAS should be sent to reference lab for further typing.
    - It is best practice for the lab to store all Group A Streptococci samples for 6 months for retrospective outbreak investigation.

Action

- Early detection; treatment; isolation and infection control
    - Check lab result, clinical presentation consistent with iGAS. Check patient receiving appropriate antibiotics. Check patient isolated (minimum 24 hours after commencing antibiotics)
- Identify contacts
    - Anyone with prolonged close contact with case in household-type setting: 7 days before onset; includes: living and/or sleeping in same household; boy/girlfriends; students sharing kitchen in a hall of residence
    - Healthcare workers (and others) with direct exposure to eyes, nose or mouth or non-intact skin by respiratory droplets, wound exudate, blood, bodily fluids
- Prophylaxis (vaccination/immunoglobulin/antibiotics/antivirals)
    - Recommend antibiotics to close contacts with symptoms (sore throat, fever, superficial skin infection); entire household if two or more cases within 30 days; healthcare workers with high risk exposure

Key reference documents

- Group A Streptococcus - GOV.UK (www.gov.uk)
- Guidelines for prevention and control of group A streptococcal infection in acute healthcare and maternity settings in the UK (his.org.uk)
- Invasive group A streptococcal disease: managing close contacts in community settings - GOV.UK (www.gov.uk)
- Invasive group A streptococcal outbreaks: home healthcare - GOV.UK (www.gov.uk)

PART 4: OPERATIONAL ARRANGEMENTS FOR MANAGING SPECIFIC TYPES OF INCIDENTS – LOCALLY LED

The detail included in this section is for incidents which are typically managed locally, without requiring an IMT/OCT. These are typically non-notifiable diseases.

Arrangements for responding to these incidents is flexible and situation dependent. Some incidents, although not requiring an IMT will still be discussed with UKHSA e.g. respiratory outbreaks in care settings. Equally some incidents may escalate and require an IMT. Response will continue to be led by risk assessments.

Detail is included on the following common situations:

- Investigating & controlling outbreaks of viral gastroenteritis in schools/nurseries
- Investigating & controlling outbreaks of viral gastroenteritis in care homes
- Investigating & controlling outbreaks of respiratory disease in care homes (excluding seasonal ILI-covered in part 3a)
- Investigating an outbreak of a HCAI
- Investigating & controlling outbreaks of scabies in care homes

*In the event of any of these incidents a daily summary email is sent out stating the location and nature of the outbreak, and the number of people affected. This is used to notify the following where appropriate:

- Infection Prevention Teams : MFT, PAHT, GMMHSCT, MLCO
- Adult Social Care
- Education and Early Years (when appropriate)
- NW Ambulance Service
- Environmental Health
- UKHSA
- LCO key contacts

INVESTIGATING & CONTROLLING OUTBREAKS OF VIRAL GASTROENTERITIS IN SCHOOLS/NURSERIES

Detection/Alerting

- Community Health Protection Team will be contacted by the setting when two or more cases are noted. This will be via telephone, email or the online notification form.

Response

- Phone call between school & CHPT to discuss symptoms and numbers of affected staff & students
- CHPT daily contact updates with school via phone
- Outbreak form details added to outbreak spreadsheet daily.
- Stool sample to collect by school nurse supported by the HP Nurse

Control

- Ill pupils & staff to stay home for 48hours post last symptoms
- Outbreak email sent out daily*
- Notify LA Education Directorate and Health and Safety
- Extra hygiene measures advised
- Deep clean of school 48 hours after last symptoms

Treatment/Prophylaxis

- Unnecessary in most cases

Reference Documents

Gastrointestinal infections: guidance for public health management - GOV.UK (www.gov.uk)

Gastrointestinal illness: outbreak investigation following a mass-participation River Thames swim - GOV.UK (www.gov.uk)

INVESTIGATING & CONTROLLING OUTBREAKS OF VIRAL GASTROENTERITIS IN CARE HOMES

Detection/Alerting

- Community Health Protection Team will be contacted by the setting when two or more cases are noted. This will be via telephone, email or the online notification form.

Response

- Phone call between home & CHPT to discuss symptoms and numbers of affected staff & residents
- Home contacts MRI lab for Ilog number
- CHPT contact home daily during the outbreak (mon-fri) for update. Can contact UKHSA OOH
- Outbreak details added to daily outbreak summary sheet
- Home to take stool samples (type 5-7) from affected residents and sent to laboratory (see outbreak Management doc)

Control

- Ill residents isolated for 48hours post symptoms
- Ill staff excluded for 48 hours post symptoms
- Closure to admissions, avoid unnecessary appointments and restrict visitors until 48 hours post symptoms
- Extra hygiene measures advised
- Deep clean before reopening (48 hours after last symptoms)
- Outbreak summary email updated and sent out daily*

Treatment/Prophylaxis

- Unnecessary in most cases

Reference Documents

Gastrointestinal infections: guidance for public health management - GOV.UK (www.gov.uk)

Gastrointestinal illness: outbreak investigation following a mass-participation River Thames swim - GOV.UK (www.gov.uk)

INVESTIGATING & CONTROLLING OUTBREAKS OF RESPIRATORY DISEASE IN CARE HOMES

Detection/Alerting

- CHPT contacted by home/other source when 2+ cases are noted
- CHPT alert UKHSA to alert of cases and discuss approach

Response

- Phone call between home & CHPT to discuss symptoms and numbers of affected staff & residents
- CHPT email outbreak form to Care Home to be completed and emailed to HP team on daily basis
- Outbreak form details added to outbreak spreadsheet daily
- CHPT Obtain Ilog number
- Arrange for swabs, Urine and sputum samples if needed s to be taken from affected people, and sent to laboratory

Control

- Depends on cause.
- Ill residents & staff to stay home for 5 days post last symptoms
- Flu/other vaccinations up to date
- Outbreak summary email sent out twice weekly
- Isolation where possible, respiratory hygiene measures advised
- Deep clean of home before reopening, must be 5 days after last symptoms

Treatment/Prophylaxis

- Resident's GP to clinically assess and prescribe or use PRIMARY CARE PROVIDER - LCS

Reference Documents

- UKHSA ILI national document

Seasonal influenza: guidance, data and analysis - GOV.UK (www.gov.uk)

Respiratory viruses - GOV.UK (www.gov.uk)

Influenza-like illness (ILI): managing outbreaks in care homes - GOV.UK (www.gov.uk)

Guidance on outbreaks of influenza in care homes poster - GOV.UK (www.gov.uk)

Influenza post exposure prophylaxis and treatment: PGD templates - GOV.UK (www.gov.uk)

Investigation and management of outbreaks of suspected acute viral respiratory infection in schools: guidance for health protection teams - GOV.UK (www.gov.uk)

INVESTIGATING AN OUTBREAK OF A HCAI

Detection/Alerting

- CHPT contacted by processing laboratory or another source e.g IPN at NHS Trust, GP
- Notify UKHSA of outbreak

Response

- Outbreak form to be completed
- Visit by CHPT to premises
- Excel spreadsheet updated
- I log number to be obtained by CHPT
- Sampling as required or as advised by UKHSA e.g. stool,swabs
- Obtain ribotyping in discussion with microbiologists

Control

- Dependent on causal organism
  - MRSA
  - PVL
  - ESBL
  - C.diff
  - CPE
- See relevant national or local protocol document

Treatment/Prophylaxis

- Antibiotic treatment or decolonisation if needed – Provided by GP on advice from microbiologist
- See relevant national or local protocol document

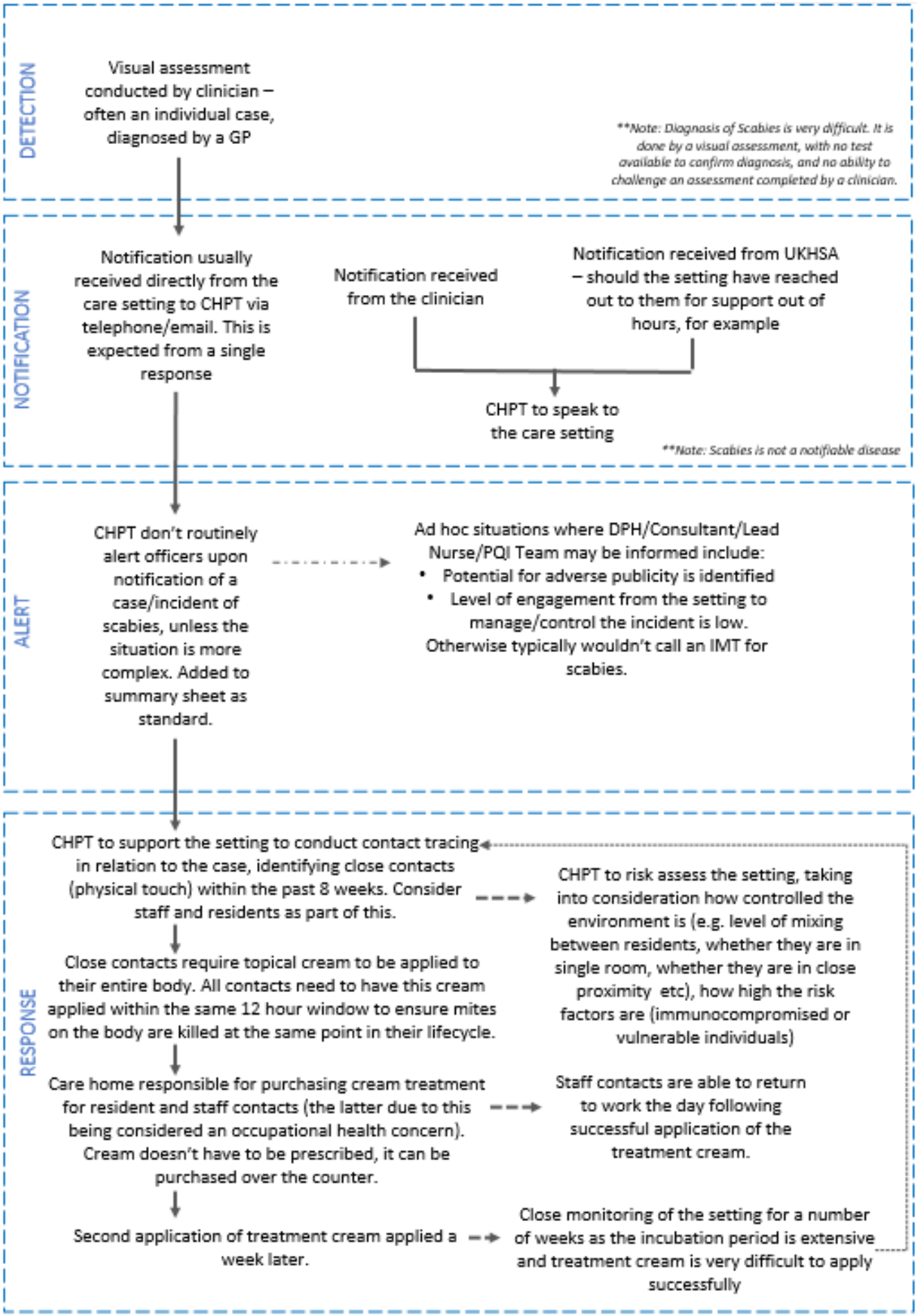
Reference Documents

- Outbreak spreadsheet

Healthcare associated infections (HCAI): guidance, data and analysis - GOV.UK (www.gov.uk)

Healthcare associated infection (HCAI): operational guidance and standards - GOV.UK (www.gov.uk)

Care homes: infection prevention and control - GOV.UK (www.gov.uk)


DETECTION
Visual assessment conducted by clinician – often an individual case, diagnosed by a GP
**Note: Diagnosis of Scabies is very difficult. It is done by a visual assessment, with no test available to confirm diagnosis, and no ability to challenge an assessment completed by a clinician.
NOTIFICATION
Notification usually received directly from the care setting to CHPT via telephone/email. This is expected from a single response
Notification received from the clinician
Notification received from UKHSA – should the setting have reached out to them for support out of hours, for example
CHPT to speak to the care setting
**Note: Scabies is not a notifiable disease
ALERT
CHPT don't routinely alert officers upon notification of a case/incident of scabies, unless the situation is more complex. Added to summary sheet as standard.
Ad hoc situations where DPH/Consultant/Lead Nurse/PQI Team may be informed include:
• Potential for adverse publicity is identified
• Level of engagement from the setting to manage/control the incident is low.
Otherwise typically wouldn't call an IMT for scabies.
RESPONSE
CHPT to support the setting to conduct contact tracing in relation to the case, identifying close contacts (physical touch) within the past 8 weeks. Consider staff and residents as part of this.
CHPT to risk assess the setting, taking into consideration how controlled the environment is (e.g. level of mixing between residents, whether they are in single room, whether they are in close proximity etc), how high the risk factors are (immunocompromised or vulnerable individuals)
Close contacts require topical cream to be applied to their entire body. All contacts need to have this cream applied within the same 12 hour window to ensure mites on the body are killed at the same point in their lifecycle.
Care home responsible for purchasing cream treatment for resident and staff contacts (the latter due to this being considered an occupational health concern). Cream doesn't have to be prescribed, it can be purchased over the counter.
Staff contacts are able to return to work the day following successful application of the treatment cream.
Second application of treatment cream applied a week later.
Close monitoring of the setting for a number of weeks as the incubation period is extensive and treatment cream is very difficult to apply successfully

PART 5: APPENDICIES

To include:

A. Stocks of laboratory testing kits, medication, and other equipment
B. Outbreak or Incident Meeting Details and Protocol
C. Template Outbreak Control Team meeting Agenda
D. Roles and Responsibilities of usual members of an OCT/IMT
E. Common Acronyms list
F. Key Contacts List

APPENDIX A: STOCKS OF LABORATORY TESTING KITS, MEDICATION, AND OTHER EQUIPMENT

Type of Stock (e.g. swabs, tubes etc.)	**Where Located**	**Quantity**	**Arrangements for Access**
Antivirals	Key pharmacies and Community Pharmacies Lloyds (Sainsbury's) Fallowfield: Lloyds Sainsbury's Heaton Park: UKHSA contingency stock as required.		Pharmacies via prescription via Med management- Stephanie Pacey UKHSA stock access via UKHSA GM Team
Swab kits for influenza	UKHSA MRI Public Health Lab hold main stock	UKHSA –Lab	Influenza -See Manchester swabbing procedure contact Clare Ward at MRI for replacement swab kits 2021/22 process TBC
Measles/hep A	UKHSA		Others e.g measles UKHSA arrangements
Vaccines	Immform urgent order Order directly from manufacturer by MFT Pharmacy or NHS IC Manchester meds opt	Depends on size of outbreak	Order via immform web site. Local SIT Team may be able to expedite when needed. UKHSA MFT Pharmacy NHS IC Manchester Meds Optimisation
Stool sample pots	UKHSA GP EHO		Obtain from GP- Little/no stock in most care homes for early response to outbreak samples
Sterile Food Pots **Stomacher Bags (Sterile Food Bags)** **Water Bottles (500ml & 1 Litre)** **Charcoal (Probact) Swabs**	Environmental Health, 1 Hammerstone Road, M18 8EQ	If any further stock was required, Environmental Health would liaise with Food, Water and Environmental Microbiology Services – York or via the	Monday to Friday, during office hours: Jonathan Owen, Environmental Health: Jonathan.owen@manchester.gov.uk Or 07947 360 215.

Neutralising Buffer (SRM) Swabs **SpongeSicle Swabs** **Sterile Templates (use with swabs) 10cm x 10cm** **Sterile Scoops** **Sterile Scalpels** **Single use PPE; Gloves, Overcoats, coveralls, foot covers and masks** **Postal Faecal Kits** **Ice Packs** **Cool Boxes** **Data Loggers** **Food Grade Bags** **Security Tags** **Lockable Fridge, Freezer and Ambient Store**	Public Analyst, Lancashire County Scientific Services to obtain additional stock as required.	**If Jonathan is out of office, an alternative contact will be provided on his email. If this function is not available, please call the Contact Centre on 0161 234 5004 and they will make contact with the team. Emergency Out of Hours, Monday to Friday 6pm to 8am, San – Sun 24 hours: Duty Officer: 07887 916 848

APPENDIX B: OUTBREAK OR INCIDENT MEETING DETAILS AND PROTOCOL

Meeting invite to include link e.g Microsoft Team link

In order for a teleconference to run smoothly, participants must follow certain rules of etiquette while on the call.

CONFERENCE CALL ETIQUETTE- CHAIR

- Send handout materials/documents in advance if possible so attendees will have an opportunity to review beforehand.
- Be on time, and stress the importance of being on time to other participants.
- Choose a location with little background noise.
- Determine who will take minutes for the meeting (this should not be the conference chair).
- Draft and if possible agree an agenda prior to or at the beginning of the meeting.
- Compile a list of attendees in advance if possible.
- At the start of the meeting establish who is present. Ask them to introduce themselves and their agency.
- Emphasise to all participants that they MUST remain on mute unless they wish to speak.
- Direct questions to a specific person instead of posing them to the audience at large where appropriate.
- Speak clearly and pause frequently especially when delivering complicated material.
- Before ending the meeting ask for AOB
- At the end of the meeting, summarise the key actions and agree the next meeting date and time.

MEETING ETIQUETTE – PARTICIPANTS

- Remain on mute when not speaking. Choose a location with little background noise
- If you do have to use a mobile phone in a car, please park up and turn off the radio and engine to reduce background noise when speaking.
- Make a list of any issues you need to raise and note where they can slot into the agenda.
- Take care not to rustle paper, type or make a noise that might disturb the call when your line is open.
- Speak clearly and pause frequently when delivering complicated material

APPENDIX C: TEMPLATE OUTBREAK CONTROL TEAM MEETING AGENDA

Manchester Health Protection

MANCHESTER CITY COUNCIL NHS

Title of meeting:
Date:
Time:
Chair:
Venue/Teams link:

1	**Introduction and Apologies**
2	Purpose of Meeting
3	Overview of Incident
4	Review of Evidence
5	Current risk assessment
6	Control measures
7	Further investigations
8	Communications
9	Next Steps
10	AOB
11	Further meetings

APPENDIX D: ROLES AND RESPONSIBILITIES OF USUAL MEMBERS OF AN OCT/IMT

Consultant in Communicable Disease Control/Health Protection / Epidemiologist

- declare an outbreak following appropriate consultation
- convene the OCT and ensure appropriate membership
- chair the OCT unless a different chair has been agreed
- ensure initial response and investigation begins within 24 hours of outbreak reported
- identify resources that might be needed to manage the situation
- liaise with clinicians over need for testing and management of cases
- agree with OCT who will lead the media response
- ensure communications such as letters/bulletins/press statements and so on are agreed and disseminated
- arrange for appropriate identification and follow up of contacts
- provide advice on and arrange with partner organisations the provision of prophylaxis or immunisation as necessary
- provide epidemiological advice and support analysis and interpretation of data
- ensure appropriate stakeholders are informed and updated, including LA, NHS England, ICSs, acute trusts, microbiologists, FES and CIDSC Colindale
- inform relevant UKHSA director as necessary
- ensure all documentation relating to the outbreak is correctly managed and disseminated, incorporating information governance and data protection requirements
- ensure the constructive debrief is held and lessons learnt disseminated and acted on
- coordinate production of outbreak report and ensure recommendations are acted on

Environmental Health Officer (representative of Chief Environmental Health Officer)

- investigate potential sources of outbreak and secure improvements where the LA is the enforcing authority or where it is the home authority for companies that operate across LA boundaries
- advise the OCT where enforcement falls to another body, for example the HSE
- provide help and advice including the investigation of cases or contacts
- provide mechanisms for out of hours communications with the OCT and stakeholders
- arrange collection of samples from cases and contacts and undertake appropriate sampling of food, water and environmental samples
- arrange delivery of all samples to appropriate laboratories
- liaise with the office of the public analyst and PHE laboratories for analysis of samples if chemical contamination is suspected
- provide reports to the LA and undertake necessary enforcement actions
- inform relevant food and non-food businesses of hazards as appropriate
- arrange for the identification, seizure, removal and safe disposal of contaminated food within their LA area
- ensure infection control advice is implemented, using relevant legal powers as necessary and working with UKHSA staff, NHS Infection Control Nurse or others
- ensure arrangements for collection and disposal of clinical waste remain appropriate. discuss with OCT and contractors any changes required
- identify resources so that tasks can be undertaken efficiently
- monitor the progress of the investigation and provide updates to the OCT
- report to colleagues in the Environmental Health Department and liaise with those in neighbouring districts
- be jointly responsible for communicating the cessation of the outbreak to the stakeholders and the general public, in collaboration with UKHSA
- ensure continuity of evidence in case results are needed for subsequent criminal prosecution

Director of Public Health (Lead Nurse Health Protection as deputy)

Under the Health and Social Care Act (2012) the Director of Public Health (DPH) is responsible for the MCC contribution to health protection, including planning for and responding to incidents that present a threat to the public's health. They are also responsible for:

- overall executive responsibility for reviewing the health of the population including surveillance, prevention and control of communicable diseases
- ensuring, in liaison with NHS England and NHS IC Manchester, that appropriate resources are available to support the investigation and control of outbreaks
- ensuring 24-hour MCC emergency management availability
- ensuring that hospital trusts are alerted and able to cope with a potential influx of patients
- Informing MCC Chief Executive and Chairman, as appropriate
- liaison with other LAs as appropriate
- agree who will lead the media response

UKHSA communications lead

- liaise with incident lead to establish an incident spokesperson
- coordinate media handling for local HPTs in close liaison with partners
- ensure appropriate heath protection advice is made available to the public and media throughout, including appropriate messages articulating HPT advice locally
- provide a regional lead for communications relating to high impact outbreaks
- manage the reputation of UKHSA in the region, specifically horizon scanning for issues that might damage that reputation and as appropriate provide high level advice to the Director of Public Health and other colleagues on any action required
- monitor press and social media coverage of the outbreak

Administrator

Administrative support should be provided to each outbreak control team. Responsibilities include:

- taking accurate and detailed minutes of OCT meetings including a record of actions and the individual or organisation responsible
- timely circulation of minutes to members of the OCT
- organisation and circulation of dates for OCT meetings or associated activities
- act as task manager for incidents where this is required
- other administrative support as required

APPENDICIES E: COMMON ACRONYMS LIST

APTBI	Acute Pulmonary Tuberculosis Infection
ARI	Acute Respiratory Infection
BBV	Blood Borne Viruses
CMS	Case Management System
CCG	Clinical Commissioning Group
CHPN/P	Community Health Protection Nurse/ Practitioner
CHPT	Community Health Protection Team (sits within Dept of Public Health, MCC)
CICT	Community Infection Control Team
DPH	Director of Public Health
EHO	Environmental Health Officer
GI	Gastrointestinal
HSE	Health and Safety Executive
HCAI	Healthcare Acquired Infection
ICS	Integrated Care System
ILI	Influenza-Like Illness
IPC	Infection Prevention & Control
LA	Local Authority
MCC	Manchester City Council
MFT	Manchester Foundation Trust
MLCO	Manchester Local Care Organisation
MRI	Manchester Royal Infirmary
MSM	Men who have sex with men
NWAS	Northwest Ambulance Service
OOH	Out of Hours
IMT	Outbreak Control Team
PGD	Patient Group Directive
PAHT	Pennine Acute Hospital Trust
PEP	Post-exposure Prophylaxis
TB	Tuberculosis
UKHSA	UK Health Security Agency
UEC	Urgent and Emergency Care

APPENDICES F: KEY CONTACTS LIST

In the event of an outbreak, the following contact details may be of assistance:

Out of hours contact for NHS IC Manchester is via NWAS ROCC on 0345 113 0099, Option 1 for GM team. Ask for NHS IC Manchester Director On Call.

Manchester Council: Public Health	David Regan- Director of Public Health	Mobile: 07770 981699	david.regan@manchester.gov.uk
	Sarah Doran - Assistant Director of Public Health & Consultant in Health Protection	Mobile: 07976 226 866	sarah.doran@manchester.gov.uk
Manchester City Council: Environmental Health	Sue Brown - Manager	Mobile: 07944 166 142	Susan.brown@manchester.gov.uk
	Tim Birch - Manager	Mobile: 07940 758 258	tim.birch@manchester.gov.uk
Manchester City Council: Pest Control		Tel: 0161 234 4928	pest.control@manchester.gov.uk
Manchester City Council: Children's & Education	Amanda Corcoran		amanda.corcoran@manchester.gov.uk
	Sharon Gardner - Strategic Lead Safeguarding	Mobile: 07950 359 752	sharon.gardner@manchester.gov.uk
	Liz Clarke - Schools QA & SEND	Mobile: 07971 587 112	liz.clarke@manchester.gov.uk
Manchester City Council: Early Years	Gillian Blackwell – Quality Assurance Lead (Early Years)	Mobile: 07960 592 913	gillian.blackwell@manchester.gov.uk
Manchester City Council: Rough Sleeping Team	Laura Stevenson, Outreach Coordinator (Rough Sleepers)	Mobile: 07989 132 910	laura.stevenson@manchester.gov.uk
Manchester City Council: Communications	Penny Shannon - Head of Health Communications	Mobile: 07734137407	penny.shannon@manchester.gov.uk
	Safika Munshi - Deputy Head of Communications	Mobile: 07814 082403	safika.munshi@manchester.gov.uk
	Alun Ireland - Head of Strategic Communications	Mobile: 07971 385049	alun.ireland@manchester.gov.uk
Manchester City Council: Risk & Resilience	Kimberley Hart	Tel: 0161 234 3313 Mobile: 07899 664 614	k.hart@manchester.gov.uk
Manchester City Council: Internal Audit and Risk Management	Simon Gardiner - Health and Safety Manager	Tel: 0161 234 5260 Mobile: 07810 557 473	simon.gardiner@manchester.gov.uk

Manchester City Council: Waste/recycling/Cleansing Team	David Sabet, Contract Manager	Tel: 0161 234 1155	d.sabet@manchester.gov.uk
Manchester City Council: Homelessness	Nicola Rae, Strategic Lead	Mobile: 07940795195	nicola.rea@manchester.gov.uk
Manchester City Council: ASC Commissioning and Contracting	Paul Bickerton	Mobile: 07960 728 403	paul.bickerton@manchester.gov.uk
Manchester City Council & NHS Manchester Locality Team	Jenny Osborne - Assistant Director, Integration & Population Health	Mobile: 07773 474 945	jenny.osborne4@nhs.net
Manchester Community Health Protection Team (MCC)	Leasa Benson, Lead Nurse in Health Protection	Mobile: 07939 995 154	leasa.benson@manchester.gov.uk
	Helen Fabrizio, Deputy Lead Nurse in Health Protection	Mobile: 07506 959 356	helen.fabrizio@manchester.gov.uk
	Specialist Nurses and Practitioners		communityhealthprotectionteam@manchester.gov.uk
Manchester University Foundation Trust – Infection Prevention & Control	Office	Tel: 0161 276 4042	
	Michelle Worsley - Assistant Chief Nurse IPC and Tissue Viability	Mobile: 07929 861 190	michelle.worsley@mft.nhs.uk
	Lorraine Durham - Lead Nurse	Mobile: 07929 729 048	lorraine.durham@mft.nhs.uk
	Julie Mullings - Infection Control in Community	Mobile: 07970 146 566	julie.mullings@mft.nhs.uk
	Rajesh Rajendran - Associate Medical Director for Infection Control	Mobile: 07960 772 744	rajesh.rajendran@mft.nhs.uk
Manchester Foundation Trust/UK Health Security Agency Laboratory	Andrew Fox - Consultant in Public Health Infections for North West	Mobile: 07736 244 920	andrew.fox@UKHSA.gov.uk
	Rachel Jones - UKHSA Regional Head of Operations for North West	Tel: 0161 276 5747	rachel.jones@UKHSA.gov.uk
Manchester Foundation Trust: TB Team	Ryan Noonan – TB Lead	Tel: 0161 276 4387	ryan.noonan@mft.nhs.uk

Manchester Foundation Trust	Lorraine Ganley - Director of Nursing and Professional Lead	Mobile: 07812 063 219	l.ganley@mft.nhs.uk
North Manchester General Hospital IPC	Mike Beesley - Matron IPC	Tel: 0161 720 2935	michael.beesley@mft.nhs.uk
Manchester Locality ICS: Medicines Optimisation	Lorraine Durham - Lead Nurse IPC	Tel: 0161 922 3933	lorraine.durham@mft.nhs.uk
	Meds optimisation team antiviral advice line	Tel: 0161 213 1640	gmicb-mh.medsoptimisation@nhs.net
	Stephanie Pacey - Deputy Head of Medicines Optimisation - Operational		stephaniepacey@nhs.net
	Sana Chaudhry- Lead Pharmacist – Practice Based Medicines Optimisation Team (Manchester)		sana.chaudhry@nhs.net
Manchester Locality ICS: Primary Care Commissioning	Gordon Reid - Deputy Head of Primary Care	Mobile: 07814 411 122	gordon.reid2@nhs.net
Local Care Organisation: School Health Immunisations and Screening Team	Sarah Jennings - Team Lead	Mobile: 07580 796 154	sarah.jennings@mft.nhs.uk
Local Care Organisation: School Health Service	Denise Gaston – Head of service	Mobile: 07811 989 659	denise.gaston2@mft.nhs.uk
Local Care Organisation: Children's Community Services	Claire Duggan - Lead Manager	Tel: 0161 946 8274 Mobile: 07870275360	claire.duggan@mft.nhs.uk
NHS GM Integrated Care	Carolina Ciliento - Associate Director of Safety, Quality & Nursing (Manchester)	Administration: 0161 765 4726 mobile: 07779 546 663	carolina.ciliento@nhs.net
	Joanne Oakes – Lead Nurse	Tel: 0161 765 4710 Mobile: 07980 944 073	j.oakes@nhs.net
Manchester Local Care Organisation	Alex Barker - Head of Adult Nursing	Mobile: 07970 185 526	alexandra.barker@pat.nhs.uk
	Michelle Proudman - Lead Nurse	Tel: 0161 549 6678 Mobile: 07811 123 932	michelle.proudman@pat.nhs.uk

Manchester Local Care Organisation: Neighbourhood Lead	Lizzie Hughes	Mobile: 07976 884 540	lizzie.hughes@mft.nhs.uk
Homeless Health	Roz Hughes (Urban Village), Specialist Nurse Homeless Health Rachel Withey, Team Lead Homeless Health		roz.hughes1@nhs.net r.withey@nhs.net
UK Health Security Agency (UKHSA)	Caroline Rumble, Consultant for Manchester	Between 9-5 hours Tel: 0344 225 0562 opt 3 for GM Out of Hours SPOC Tel:0151 434 4819	Icc.northwest@UKHSA.gov.uk – non urgent issues
UKHSA Screening and Immunisations Team	Jo Howarth	Tel: 0113 825 5197	joanne.haworth2@nhs.net