Leicestershire Partnership NHS Trust

Managing a Covid-19 Increased Incidence/Outbreak/Cluster within LPT (Patients and Staff)

This policy is to be followed alongside the clinical management of Covid-19 It identifies the escalation process to be followed when there is a suspected or known increased incidence/cluster/outbreak in both patient and staff groups.

Key Words:	Covid-19, Increased incidence, Outbreak, Cluster	
Version:	2.1	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	23 June 2021	
Name of Author:	Amanda Hemsley, Lead Infection Prevention and Control Nurse	
Name of responsible committee:	Infection Prevention and Control Group Quality Forum	
Please state if there is a reason for not publishing on website:	N/A	
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Expiry date:	1 July 2023	
Target audience:	All LPT Staff	
Type of Policy	Clinical √	Non Clinical
Which Relevant CQC Fundamental Standards?	9,10,12,20	

Contents

Version Control and Summary of Changes

Version	Date	Comment
Version 1	26 June 2020	This policy has been developed as a result of the recent Pandemic of Covid-19. It supports the trusts response in managing a suspected or known increased incident/cluster/outbreak for Nosocomial acquired infections of Covid-19 in patients and/or staff. This policy is in line with the requirements as laid out in the recently published document by Public Health England; COVID-19 Hospital Outbreak Pack
Version 1.1	23 July 2020	Further guidance issued regarding the management and reporting of a Covid-19 increased incident/outbreak/cluster
Version 1.2	27 October 2020	Reviewed in line with regional, national and government guidelines
Version 1.3	16 December 2020	Reviewed and updated to reflect changes to national reporting systems
Version 2	3 June 2021	Reviewed and updated to reflect changes to national reporting systems and regional, national and government guidelines
Version 2.1	September 2022	Reviewed and updated to reflect changes to national and government guidelines.

For further information contact: Infection Prevention and Control Team

Definitions that apply to this policy

Cluster	A disease cluster or infection cluster is a group of similar health events that have occurred in the same area around the same time. A number of cases may be described as ‘outbreak clusters’
Coronavirus	A family of viruses that cause disease in animals. Most cause mild cold symptoms
Covid-19	COVID-19 is a disease caused by a new strain of coronavirus. 'CO' stands for corona, 'VI' for virus, and 'D' for disease. Formerly, this disease was referred to as '2019 novel coronavirus' or '2019-nCoV.'
Increased incidence/Outbreak	The occurrence of two or more cases of the same infection linked in time and/or place. It can also relate to a situation when the observed number of cases exceeds the number expected.
Infectious/Infection	Caused by a pathogenic micro-organism or agent that has the capability of causing infection, may exhibit as an inflammatory response.
Infection control incident	Defined as an outbreak of infection or infectious disease that requires an in-depth level of strategic management
Pandemic	A **pandemic** (from Greek πᾶν, *pan*, "all" and δῆμος, *demos*, "local people" the 'crowd') is an epidemic of an infectious disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people.
Public Health	**Public health** specialists and **consultants** are strategists or senior managers or senior scientists. They require skills in all three main 'domains' of **public health** (**health** protection, **health** improvement, **healthcare public health**), but in practice they may specialise in one area.
Social distancing	Social distancing measures are steps you can take to reduce social interaction between people to slow the spread of an infectious disease. 2 Metres is the current national guidance in healthcare
Variant Of Concern (VOC) **Variant Of Interest (VOI)**	All viruses naturally mutate over time, and SARS-CoV-2, the virus that causes COVID-19 disease, is no exception. Over time, changes can build up in the genetic code of the virus, and these new viral variants can be passed from person to person. Most of the time the changes are so small that they have little impact on the virus. But every so often a virus mutates in a way that benefits it, for example allowing it to spread more quickly, and causes concerns about changes in the way the virus might behave. In this case the variant may be considered a ‘Variant of Concern’ by the UK government.

1.0 Purpose of the policy

The purpose of this policy is to ensure that all staff employed by LPT is aware of the processes to be followed when reporting and managing an increased incidence/cluster/outbreak of Covid-19 within the community hospitals, inpatient settings, community teams, or groups of staff that work together. This policy relates to patients and/or staff.

2.0 Summary and Key Points

This policy provides trust wide guidance for the management of an increased incident, cluster or outbreak of Covid-19. It identifies clear and concise roles and responsibilities and the procedures that must be put into place to ensure a situation that has identified a number of patients or staff with the same infection is controlled and managed with minimal risk to patient, staff and public safety. It gives a clear escalation process to be followed where necessary.

It is recognised that with the continued presence of the Covid-19 virus within the United Kingdom and across the globe, the management of patients, staff processes and care delivery changes as more about the virus is understood.

3.0 Introduction

The general public and staff have a right to expect that any potential hazards in a healthcare environment are adequately controlled. All staff must possess an appropriate awareness of their role in the prevention and control of infection in their areas of work. Not only is this part of their processional duty of care to the patients with whom they are involved (NMC 2015), but it is also their responsibility to themselves, to other patients and members of staff under the Health and Safety at Work Act (1974).

Coronaviruses are a family of viruses that cause disease in animals. Seven, including the new virus (Covid-19), have made the jump to humans, but most just cause cold like symptoms

Covid-19 is different to these other coronaviruses in that the spectrum of disease is broad, with around 80 per cent of cases leading to a mild infection. There may also be many people carrying the disease and displaying no symptoms, making it even harder to control.

3.1 What are the symptoms of coronavirus?

Initial symptoms include fever, dry cough, tiredness and a general feeling of being unwell, and a loss of taste (ageusia) and sense of smell (anomsia).

In most cases, individuals are usually considered infectious while they have symptoms. How infectious individuals are, depends on the severity of their symptoms and stage of their illness. The average time from symptom onset to clinical recovery in mild cases is approximately 2 weeks and is 3-6 weeks for severe or critical cases.

3.2 How is it transmitted?

The main way of spreading COVID-19 is through close contact with an infected person. When someone with COVID-19 breathes, speaks, coughs or sneezes, they release particles (droplets and aerosols) containing the virus that causes COVID-19. These particles can be breathed in by another person. Individuals can also be infected from and touching surfaces contaminated with the virus and touching their face (e.g., eyes, nose, and mouth).

Individuals can be asymptomatic, whilst being infected with the virus. This means that transmission can occur without the person knowing and can make it difficult to prevent or control cross contamination.

Limiting transmission of COVID-19 in the healthcare setting requires a range of infection prevention and control measures.

4.0 Case definitions for investigation of hospital increased incidents, clusters or outbreaks of Covid-19

4.1 Case Response

In responding to a disease cluster or outbreak it is important to agree a case definition including a description of time, place, person and clinical features early on in the investigation, with an ongoing review. This enables the incident or outbreak control committee members to gather, analyse and present relevant information to inform decisions on effective outbreak control measures.

It is often helpful to devise a hierarchical set of case definitions depending upon certainty of diagnosis in the individual, moving from a highly specific case- definition (high certainty that the patient has the disease, but with recognition that not all cases will meet this definition) to a high sensitivity definition (high certainty that all cases have been detected, but with the recognition that some identified cases may have a different cause of illness). This hierarchy will usually have 2-3 levels.

Case-definitions are usually based on clinical and/or laboratory criteria, but may also have an epidemiological (e.g. contact with a confirmed case), geographical or setting component (e.g. a specific hospital site, block or ward) and/or a time component (e.g. from a specific date).

4.2 Case Definition

Category	**Criteria**
Confirmed	Laboratory confirmed diagnosis of COVID-19 in a patient who is or has been in a healthcare setting.
	Laboratory confirmed diagnosis of Covid-19 in a member of LPT staff who works at or has been working in a healthcare setting

Probable	A hospital inpatient (*or staff member*) who has one of the following without an alternative diagnosis*: • clinical or radiological evidence of pneumonia; ***or*** • acute respiratory distress syndrome; ***or*** • Fever (≥37.8°C) ***and*** at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing; ***or*** • a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms
Possible	Any acute respiratory symptoms or fever, without other identified cause*, or worsening of a pre-existing respiratory condition

For any increased incident, cluster or outbreak; each patient should be classified using the above definitions; **Confirmed, Probable and Possible** by how likely each case is to be a nosocomial (hospital acquired) case, based on the duration of time between admission and symptom onset:

Community-Onset (CO) positive specimen date <=2 days after hospital admission or hospital attendance.

Hospital-Onset Indeterminate Healthcare Associated (HO.IHA) – positive specimen date 3-7 days after hospital admission.

Hospital-Onset Probable Healthcare-Associated (HO.pHA) – positive specimen date 8 -14 days after hospital admission.

Hospital-Onset Definite Healthcare-Associated (HO.dHA) – positive specimen date 15 or more days after hospital admission.

Any patients who are diagnosed with Covid-19, 8 plus days from admission to an LPT inpatient setting will require a Hospital Onset Covid-19 (HOC) root cause analysis to be carried out. This should be commenced by the ward staff and supported by the IPCT. It should be completed within the identified timescale and reported by the IPC team as above.

Exposure levels of staff contact with a case should be considered, depending upon whether the staff member wore appropriate personal protective equipment (PPE) and/or

- the staff member was exposed to an aerosol-generating procedure.

- there have been any breaches in IPC measures and controls.
- the staff member has been self-isolating previously due to a family/household contact testing positive

If an increased incident, outbreak or cluster of Covid-19 within a staff group is identified then the staff outbreak toolkit and process in line with Occupational health must be followed.

5.0 Reporting and Management of increased incidents/clusters/outbreaks of Covid-19

5.1 Stage 1

The risk of increased incidences/clusters or outbreaks needs to be reduced to a minimum and subsequent organisation disruption through local surveillance and detections of organisms.

Prompt recognition and reporting of symptomatic patients and/or staff to the Infection Prevention and Control team, enables prompt closure of bays or ward areas as a containment measure, whilst identifying the possibility of an investigation into the cause, and ensuring all the correct infection prevention and precaution measurements are in place (appendix 1).

If there are 2 or more patients or staff who have been identified and linked in time and place (as above) then the algorithm for the reporting of an incident should be followed (appendix 2).

Staff, who receive a positive Covid-19 test result, either from community testing or the employees testing portal must be sent home from work immediately. If they are not currently at work when they receive the result they must contact their line manager at the earliest stage to discuss the next steps. The line manager must follow the process outlined in the flowchart (appendix 3).

If it is found that there is an increased incidence of staff positive results for Covid-19; who all work or who have recently worked within the same area then Occupational health should be informed to support the requirements for swabbing staff for Covid-19. Staff members are usually only swabbed if they are symptomatic, however in the event it is deemed appropriate, blanket screening of staff may be required. This should be a joint decision as part of the outbreak meeting which included public health representation. If blanket screening is to be undertaken consideration must also be made of the dynamics of transporting the swabs to virology. This is especially important in an area where porters do not normally visit.

As staff members receive their results, they should inform both their manager and occupational health and an E-irf should be completed if the test is positive.

The infection prevention and control team (IPCT) should be informed on a daily basis

(or as soon as possible) for patients or staff who are displaying symptoms or have tested positive for Covid-19.

Where a number of patients or staff (larger than a cluster) is identified, an outbreak meeting is required. This will be convened and led by the DIPaC, Deputy DIPaC, Head of Nursing or Lead IPC nurse. Decisions such as the need to swab further patients or staff will be made at this meeting (appendix 4).

5.2 Stage 2

Identification of 2 or more patients or staff with a positive Covid-19 result (linked in time and place, within a 48 hour time frame) should be communicated to the IPC team as soon as possible.

A review must be commenced for inpatient areas or teams affected to understand the correlation between contact and timeframe, and inform the requirements for notification of a cluster/increased incident/outbreak.

If it is deemed that there are two or more infections of Covid related and within the 48 hour timescale then the manager of the service must initiate a review of contacts. The toolkit developed to support the management of the outbreak must be used by manager of the service affected and updates reported through to the IPC team Monday to Friday, and to the On-call manager at weekends. This is to facilitate the completion and updates or changes to the data logged on the electronic Outbreak system https://nhsi.okta-emea.com/login.

- During working hours Monday to Friday, IPC data to support the submission of outbreak information is produced by the IPC team and is sent to the following as a minimum:

  england.midsroc@nhs
  icceastmidlands@phe.gov.uk
  EmergencyPlanningLPT@leicspart.nhs.uk
  ICCLead.Covid19@leicspart.nhs.uk
  LPT Director of the day
  Director of Nursing, AHP and Quality
  Associate Director of Nursing and Professional Practice
  Service Manager
  Head of Nursing
  IPC team
  CCG lead

Should any outbreak present a material threat to the organisation's ability to maintain services it is likely that an urgent meeting should be convened to discuss the outbreak and mitigating actions using the agenda attached (appendix 7).

5.3 Stage 3 Management and Surveillance of the Outbreak

Stage 3 is management and surveillance of the outbreak. Dependant on the severity of the outbreak subsequent meetings will be set by the chair of the group.

The purpose of the meetings is to ensure that the cause of the outbreak is identified and controlled and that appropriate measures are taken to reduce the risk of a recurrence.

At subsequent meetings the Chair will ask for an update from each member of the group and agree any further actions required

A weekly outbreak overview meeting will be convened on a Thursday to get a situation report for the weekend and agree reporting leads, share and identify emergent themes and learning.

A decision to move the outbreak to a 28 day monitoring period must involve members of the outbreak meeting; it should be considered when no further patients or staff have tested positive 14 days after the last positive result

5.4 Stage 4 Closing an Outbreak

The decision to close an outbreak will be carried out in conjunction with external partners including UKHSA. Outbreaks can be closed a minimum of 28 days post latest positive result.

5.5Transfer of patients between care settings (NHSEI/PHE Outbreak Cell)

Inter-facility Transfers: Good Practice Guidance

Transferring patients between care settings to meet patient medical or nursing need during Covid-19 might be required for in patients, either as part of step-down or rehabilitation arrangements or change in clinical need.

This may include the need for a specialist procedure or treatment for example, cardiac angioplasty or renal dialysis.

Where possible, patients should be deemed clinically fit for discharge or transfer to other clinical settings. As far as possible, transfer should be avoided if the patient is:

- Pyrexial or acutely unwell
- Currently on a ward where there is an ongoing Covid-19 outbreak

If transfer is essential, **the ambulance service/patient transport service and receiving hospital must be advised in advance of the infectious status of the patient. The patient should be encouraged to wear a FRSM if it can be tolerated.**

The Covid-19 risk of a patient is based on:

- the length of time they have already been an inpatient
- their testing schedule and outcomes
- their symptomatology

The Covid-19 status of a patient should be known prior to their transfer (see below for transfer of patients in an emergency)

IPC measures should continue for Covid-19 patients until 10 days have elapsed since their first positive SARS-CoV-2 test. This is due to uncertainties about the duration of infectiousness for patients with more severe illness or immunosuppression which may

increase the time of viral shedding.

Transferring patients in an emergency scenario

If a patient has an emergency clinical need for transfer the patient's current infectious status and a risk assessment of the patient's **current infectious status** should be shared with the ambulance service and the receiving unit.

5.5 Community Outbreak in LPT tenant buildings

The actions identified below should be carried out when a confirmed increased incident/outbreak or cluster of Covid-19 has occurred within a community health building delivering care during daytime (no overnight stays).

- LPT representative to advise the Landlord there are staff/patient positive Covid-19
- LPT to request a deep clean via the facilities help desk (various depending on which building staff occupy).
- IPCT to review space/risk and advise if the building can be accessed and/or areas that LPT staff should avoid.
- Landlord to confirm to LPT representative if building access is affected, and to advise once the clean is complete.
- LPT representative to advise services to re-instate use/access.

References

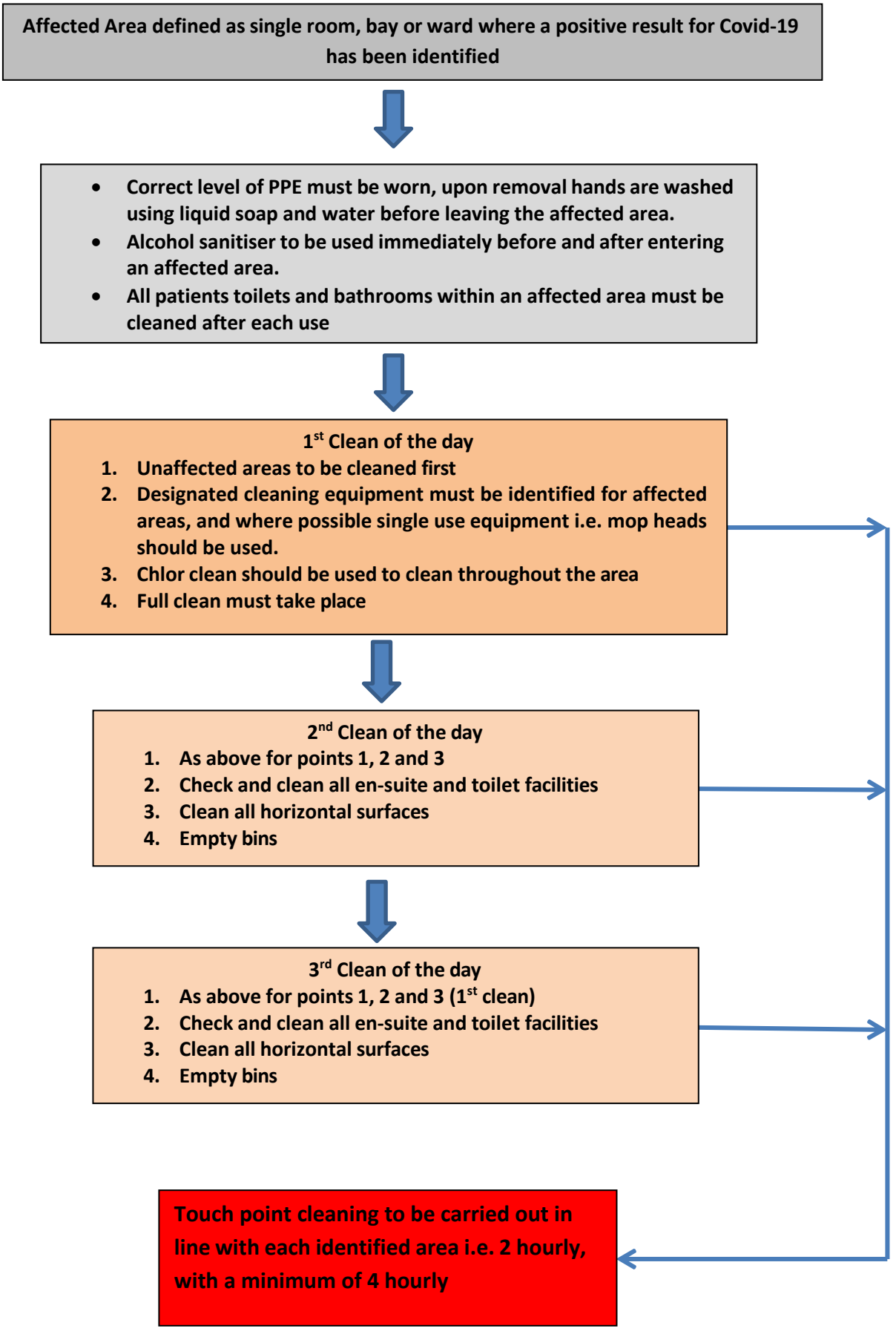
Management of an increased incident/outbreak policy 2018, Leicestershire Partnership Trust

www.gov.uk/coronavirus

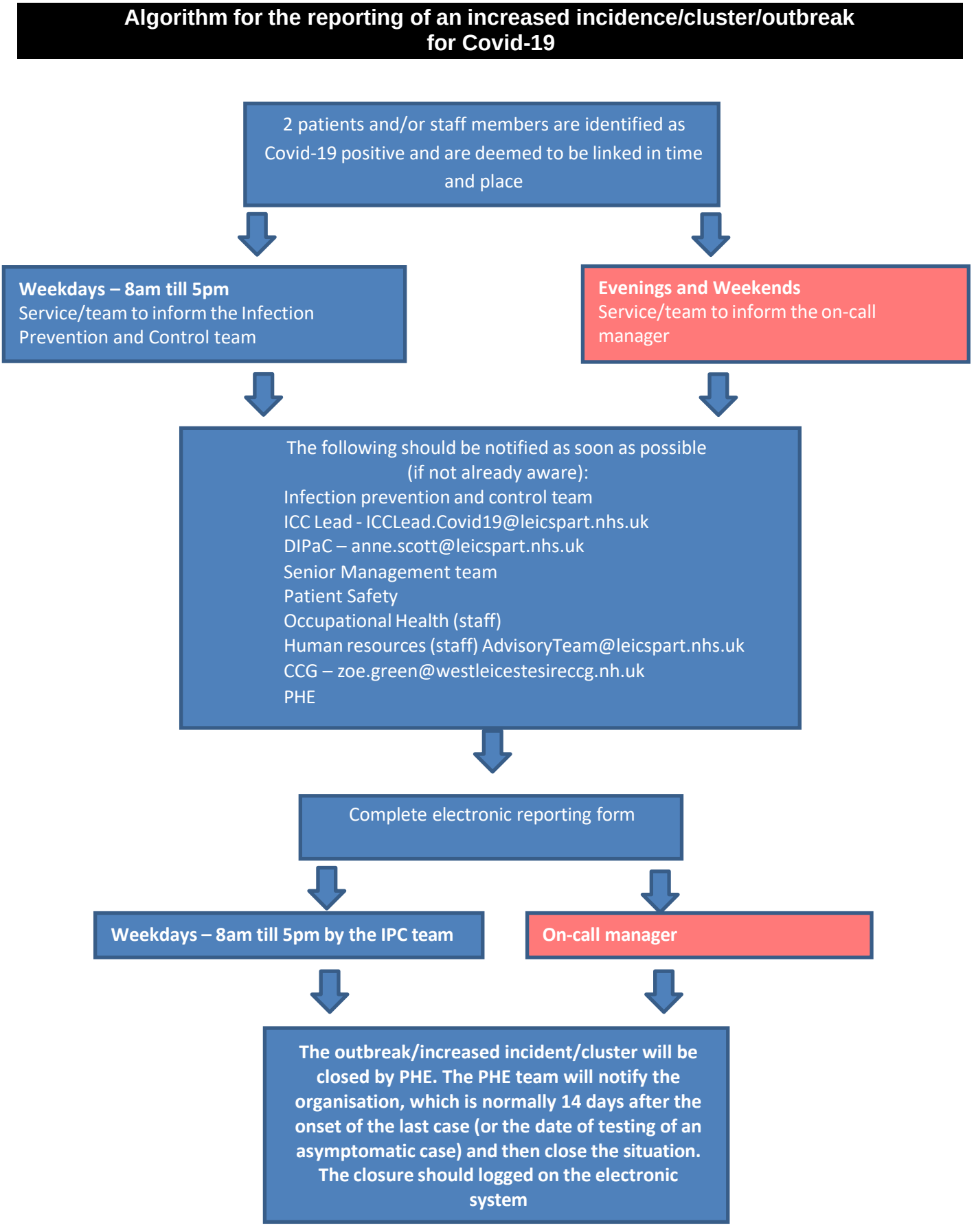
www.nhsimprovement.nhs.uk

Appendix 1

Cleaning Algorithm for an increased incidence, cluster or outbreak of infection for environmental cleaning



Appendix 2


Algorithm for the reporting of an increased incidence/cluster/outbreak for Covid-19
2 patients and/or staff members are identified as Covid-19 positive and are deemed to be linked in time and place
Weekdays – 8am till 5pm
Service/team to inform the Infection Prevention and Control team
Evenings and Weekends
Service/team to inform the on-call manager
The following should be notified as soon as possible (if not already aware):
Infection prevention and control team
ICC Lead - ICCLead.Covid19@leicspart.nhs.uk
DIPaC – anne.scott@leicspart.nhs.uk
Senior Management team
Patient Safety
Occupational Health (staff)
Human resources (staff) AdvisoryTeam@leicspart.nhs.uk
CCG – zoe.green@westleicestesireccg.nh.uk
PHE
Complete electronic reporting form
Weekdays – 8am till 5pm by the IPC team
On-call manager
The outbreak/increased incident/cluster will be closed by PHE. The PHE team will notify the organisation, which is normally 14 days after the onset of the last case (or the date of testing of an asymptomatic case) and then close the situation. The closure should logged on the electronic system

Appendix 3

HR Process following notification that a staff member had tested positive for Covid-19

Notification from manager that a member of staff has tested Positive for Covid-19 (Manager should include COVID-19 positive in subject line) If not on isolation spreadsheet, do not delay in taking action but ask manager to complete.

1. Reporting to Health and Safety Team

Transfer relevant information on to the Health and Safety Spreadsheet *(Send to H&S, IPC, Occupational Health and Helen Walton when new cases added)*

2. Reporting to IPC Team

Send IPC spreadsheet to line manager with covering email for completion.

Email to read: '**COVID-19 Positive – IPC Reporting – URGENT ACTION REQUIRED** Thank you for letting us know that a member of your team has had a positive Covid-19 swab test result. In order for the IPC team to identify any potential linkages between positive staff and patients and also to take the necessary actions in relation to a potential outbreak, please fully complete the attached spreadsheet and return it to - **LPT-IPCTeam@leicspart.nhs.uk** on the same day you have been notified of the test result or as soon as is practically possible thereafter.'

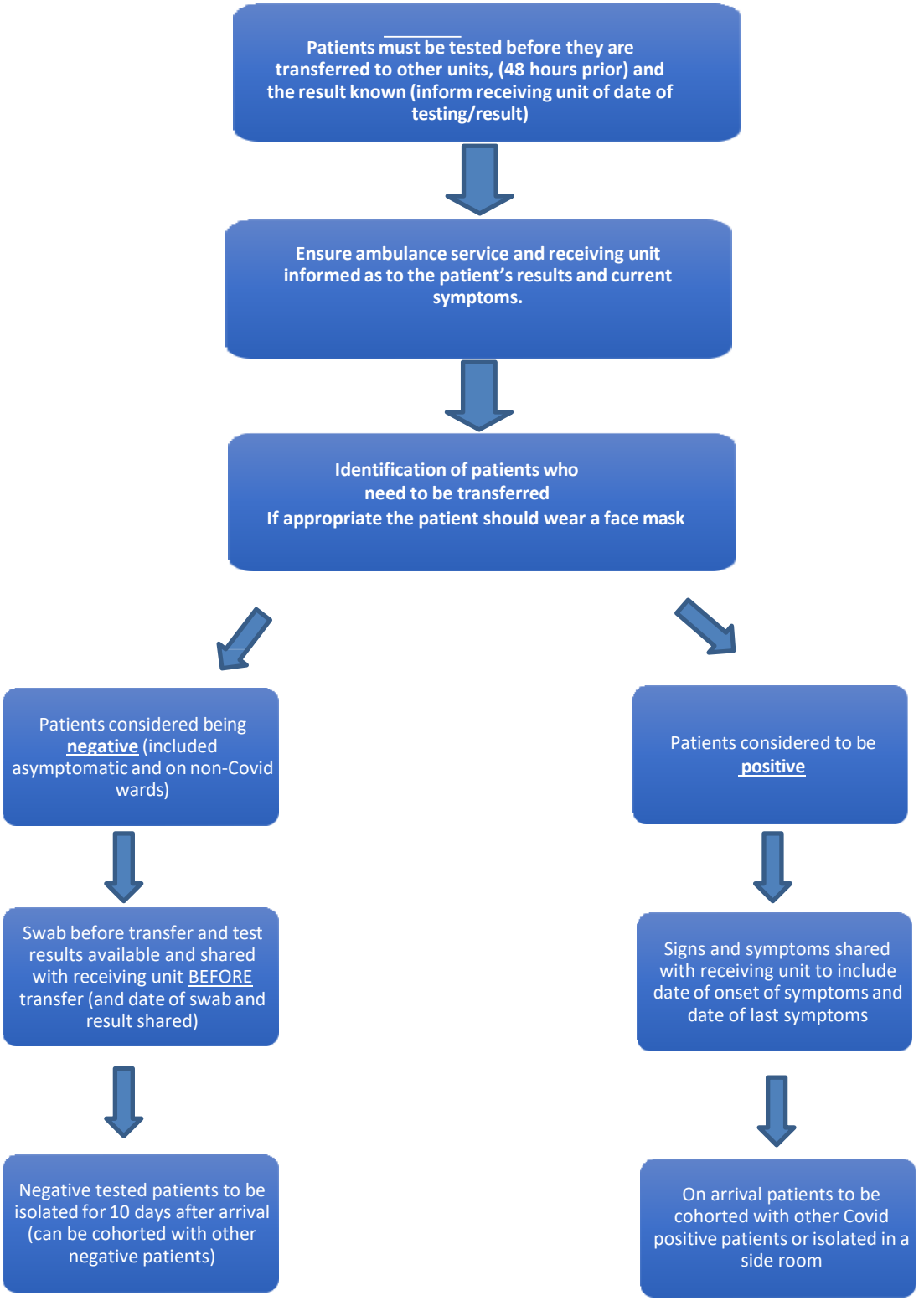
(IPC to follow up any information they require which is missing directly with managers)

3. Reporting to Occupational Health

HR to notify Occupational Health as soon as possible following notification of a positive staff member

Appendix 4

Algorithm for safe inter-facility transfer of patients



Appendix 5

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	Yes
Respond to different needs of different sectors of the population	Yes
Work continuously to improve quality services and to minimise errors	yes
Support and value its staff	Yes
Work together with others to ensure a seamless service for patients	Yes
Help keep people healthy and work to reduce health inequalities	Yes
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	Yes

Appendix 6

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there is any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Management of a cluster/increased incident/outbreak for Covid-19 Patients and Staff**	
Completed by:	**Amanda Hemsley**	
Job title	**Lead Infection Prevention and Control Nurse**	**Date** 17 June 2021

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	no	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	no	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	no	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**no**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	no	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	no	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	no	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**no**	

If the answerto any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	Emma Wallis - Associate Director of Nursing and Professional Practice
Date of approval	E L Wallis

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 7

Due Regard Screening Template

Section 1	
Name of activity/proposal	Policy for the management of Covid-19 clusters/increased incidents/outbreaks for patients and staff
Date Screening commenced	20 August 2020
Directorate / Service carrying out the assessment	Infection Prevention and Control
Name and role of person undertaking this Due Regard (Equality Analysis)	Amanda Hemsley Lead Infection Prevention and Control Nurse
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: **The aim of the policy is support staff within LPT to identify, manage and report any increased incidences of Covid-19 in line with national requirements and direction**	
OBJECTIVES: To maintain patient and staff safety and prevent the increase of infection of Covid-19	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	n/a
Disability	n/a
Gender reassignment	n/a
Marriage & Civil Partnership	n/a
Pregnancy & Maternity	n/a
Race	n/a
Religion and Belief	n/a
Sex	n/a
Sexual Orientation	n/a
Other equality groups?	n/a

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This policy is in line with national requirements and direction. It identifies reporting processes and management to maintain and promote patient and staff safety			
Signed by reviewer/assessor	E L Wallis	**Date**	10 June 2021
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

7.0 Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Amanda Hemsley, Mel Hutchings	Lead Infection Prevention and Control Nurse Infection Prevention and Control Nurse

Circulated to the following individuals for consultation

Name	Designation
Andy Knock	Infection Prevention and Control Nurse
Antonia Garfoot	Infection Prevention and Control Nurse
Laura Brown	Infection Prevention and Control Nurse
Emma Wallis	Associate Director of Nursing and Professional Practice
Anne Scott	Director of Nursing, AHP's and Quality
Sarah Latham	Deputy Head of Nursing, CHS inpatients
Helen Walton	Estates and Facilities Property manager
Laura Belshaw	Head of Nursing, FYPC
Louise Evans	Deputy Head of Nursing, FYPC
Jude Smith	Head of Nursing, CHS
Michelle Churchard-Smith	Head of Nursing, AMH and MHSOP
Claire Armitage	Deputy Head of Nursing, AMH Community
ICC Clinical leads	LPT
Tracy Ward	Head of Patient Safety
Sue Arnold	Lead Nurse, Patient Safety