

West Midlands Guidance for the coordination and management of the health sector response to Ebola Virus Disease

A. Background, purpose, case definitions and principles of leadership and coordination of management

1. Background and purpose

This guidance has been developed with respect to the health economy wide management of cases of Ebola Virus Disease (EVD) as defined in the national Advisory Committee for Dangerous Pathogens (ACDP) algorithm and guidance for Viral Haemorrhagic Fevers (updated September 2014) at: <https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients>

It supplements the organisational principles already agreed for supporting the health response to significant public health incidents and situations outlined in the Memorandum of Understanding (MOU) for the Mobilisation of NHS Resources in the event of a significant Health Protection Incident, April 2014,

It describes the responsibilities of Public Health England (PHE), NHS England Area Team (NHS AT) and Director of Public Health (DPH) in the context of a shared decision to activate a health led Incident Control Team (ICT). For a full description of how these arrangements would normally be activated refer to the MOU.

2. Presentation of a suspected case of Ebola Virus Disease

A case of EVD could present in the UK:

- In travellers returning from the affected area in W Africa within the last 21 days:
 - In humanitarian workers and military responders
 - In West Africans and others returning from visiting family and friends or removing themselves from the outbreak situation
- In a person who has not travelled to West Africa, but had an unrecognised or undeclared contact with a case in UK

Patients may present:

- *At ports*
- *In primary care* - primary care reception staff and clinicians need to be able to identify those who are unwell and have visited an EVD affected area in the preceding 21 days, isolate them, and deal with the case appropriately in line with published guidance

- *In hospital* – by referral from 111 or primary care, self presentation directly to A&E, or transfer in by ambulance. Triage mechanisms need to be able to quickly identify patients at risk so that they can be isolated and a risk assessment completed
- *In other community or institutional settings*

The ACDP guidance sets out the arrangements for the management of suspected and confirmed cases (according to how far through the diagnostic process cases have travelled) – this includes guidance both for clinical management and for the notification to the PHE-commissioned Imported Fever Service and local HP teams. Relevant nationally PHE operational guidance has also been published and disseminated to primary, secondary care and other institutional settings.

3. Case definitions from the ACDP guidance for Viral Haemorrhagic Fever (VHF)

The following case definitions are determined by the initial shared clinical risk assessment between the receiving primary or secondary care doctor and the local Microbiologist or Infectious Disease Specialist as per the ACDP guidance and algorithm. This risk assessment should determine the further clinical assessment and management of the case and any necessary infection control precautions.

Patients with a fever >38°C are highly unlikely to have a VHF infection if:

- They have **not** visited a VHF endemic area within 21 days of becoming ill;
- They have not become unwell within 21 days of caring for or coming into contact with the bodily fluids of / handling clinical specimens from a live or dead individual or animal known or strongly suspected to have a VHF;
- If their UK malaria screen is negative and they are subsequently afebrile for >24 hours;
- If their UK malaria screen is positive and they respond appropriately to malaria treatment;
- If they have a confirmed alternative diagnosis and are responding appropriately.

Low Possibility of VHF

The patient has a fever [**>38C**] or history of fever in past 24 hours **AND** has returned from (or is currently residing in) a VHF endemic country within 21 days

High Possibility of VHF

The patient has a fever [**>38C**] or history of fever in past 24 hours **AND** has cared for/come into contact with body fluids of /handled clinical specimens (blood, urine, faeces, tissues, laboratory cultures) from an individual or laboratory animal known or strongly suspected to have VHF.

Or

The patient fits the case definition above for Low Possibility of VHF **AND**

- The patient travelled to any area where there is a current VHF outbreak, or
- The patient lived or worked in basic rural conditions in an area where Lassa Fever is endemic, or
- The patient visited caves OR mines, or had contact with primates, antelopes or bats in a Marburg / Ebola endemic area, Or, or
- The patient travelled in an area where Crimean-Congo Haemorrhagic Fever is endemic **AND** sustained a tick bite or crushed a tick with their bare hands OR had close involvement with animal slaughter.

Or

The patient fits the case definition above for Low Possibility of VHF **AND** has extensive bruising or active bleeding.

These case definitions will change as the patient progresses through the diagnostic process and VHF is either excluded or confirmed.

4. Local Incident Control Teams (ICT)

In line with the ACDP guidance and upon notification of a high possibility or confirmed Ebola case a local ICT will always be convened to oversee local infection control issues, undertake any necessary contact tracing and manage the local logistics and communications relating to the incident.

For a confirmed case of EVD a national ICT will be also be established to provide national co-ordination of situation and media handling.

There will be an early need to coordinate and manage communications both locally with multiagency partners, and upwards through PHE to COBR, and so the local ICT will need to involve NHS England, the DPH and PHE Centre as well as representatives from the local hospital trust where the case is located. This group will also need to manage communications and input as necessary to a local police-led SCG, if called.

Within this arrangement, PHE Centres will identify a named, experienced and confident Incident Director (Dr Sue Ibbotson and Dr Rob Carr in the West Midlands) to contribute to the local strategic management of the incident alongside NHS England, local DPH (and SCG as appropriate), and be part of the national ICT and input to COBR as necessary.

The local PHE CCDC will lead the local contact tracing task and oversee community infection control arrangements.

Involvement of the PHE Lead Microbiologist is also crucial to ensure that appropriate communications with NHS microbiologists are in place.

The PHE Centre communications manager should also be part of the ICT, working with NHS and Local Government communications colleagues.

The arrangements described above are entirely consistent with those already in place in PHE Centres for the management of an infectious disease incident in the context of a complex situation, rather than requiring a new set of arrangements.

5. The importance of good communication

The greatest challenge for agencies in managing an EVD scenario will be in maintaining the confidence of patients, the wider public and their staff. Effective communication between partners is therefore a crucial part of the effective management of a suspected or confirmed case of EVD, and forms an essential part of the assurance process alongside clinical management.

Poor communications is far more likely to occur than poor clinical care.

There needs to be a 'single version of the truth' shared between agencies, and all agencies need to be able to shape and be kept informed of this. Good coordination between communications officers will help facilitate this.

The local DPH has a critical role in providing assurance to both their elected members and the communities that they serve, and should therefore play a major part in helping to shape the public communications strategy and content.

During major outbreaks and other health protection incidents, the PHE Centre would normally coordinate the local public and media communications for the multiagency partnership, and EVD related incidents should not be an exception to this.

All agencies will also need to keep their own staff up to date with the necessary guidance and situation as it develops.

B. Responsibilities for convening and leading an Incident Control Team (ICT)

1. Incident control arrangements for low possibility cases of EVD

In this situation there should be an early conversation and risk assessment between the receiving clinician and a microbiologist or specialist in infectious diseases regarding the likelihood of Ebola infection and the need for any further Ebola, or indeed other, clinical investigations.

For all patient categorised as ‘low possibility of VHF’

- A senior member of the medical team should be responsible for the acute care of the patient and should be the lead clinician;
- Infection control measures appropriate to the patient’s risk category and clinical care procedures should be put in place (including isolation of the patient in a side room);
- Urgent malaria screening and local diagnostic investigations should be carried out urgently.

This would normally require the patient to be transported to hospital.

There is no need for any contact tracing for this scenario (unless case becomes confirmed).

The receiving hospital (or primary care physician) should contact their local PHE Health Protection Team (HPT) and a decision will be made, in consultation with the Local DPH and NHS AT Director on call, as to whether a local Incident Control Team (ICT) might be helpful to coordinate the further management and investigation of the patient and consider any wider communication issues.

The IMT if activated would normally be chaired by the PHE Centre Incident Director.

The NHS AT would provide any support required in mobilising the NHS response and manage and NHS related communications issues as necessary.

The DPH will be fully briefed and provide assurance to their local authority that the situation is being managed by partners appropriately and will brief their local authority members and others as appropriate.

2. Incident control arrangements for ‘high possibility and confirmed cases of VHF’

For high possibility cases, the patient will normally already be an inpatient in the local hospital, isolated in a side room, and waiting for results of Ebola tests. There will need to be an early conversation with the HPT about possible close contacts who may need to be followed up and put under surveillance should the case become confirmed.

In this situation there should be an early conversation and risk assessment between the PHE CCDC, the NHS AT and the DPH to consider the activation arrangements for a local health led Incident Control Team (ICT) and appropriate membership (unless this has already been activated).

The CCDC will escalate this situation to the PHE Centre Director or the PHE Centre Deputy Director for Health Protection (who have both been designated as local PHE Centre Incident Directors in the situation).

The LHRP Co- Chair (NHS AT or Lead DPH by agreement) would agree any necessary coordination arrangements with other multiagency partners through an early discussion with the LRF Chair (e.g. where it has been suggested that an SCG should be established).

3. Strategic responsibilities for the Incident Control Team (for highly probable and confirmed cases)

PHE responsibilities

The Incident Control Team (ICT) would normally be chaired by the PHE Centre Incident Director (or their Deputy)

The PHE Centre would coordinate the public health risk assessment for the case and any close contacts and advise the IMT of any necessary further investigations and control measures required.

The PHE Centre coordinate the public and media Communications Strategy as directed by the ICT (e.g. through liaison with other comms officers, provision of public health advice to inform messaging and provision of public health talking heads as required).

The PHE Centre would brief their own team and upwards within PHE as necessary.

The PHE Centre would provide onward briefing of the local DPH (and any adjoining DsPH as necessary).

NHS England Area Team responsibilities

The NHS AT would host the ICT in their Incident Coordination Centre (unless this was done through teleconferencing arrangements or by agreement through another local NHS organisation), maintain the incident log, and provide logistics support to this arrangement (with assistance from other partners as necessary).

The NHS AT would coordinate the NHS response to the case, and any NHS support to the further public health investigations and control measures for close contacts (as directed by PHE Centre).

The NHS AT would brief their own team, local NHS Commissioners and Providers, Private Health Providers, and upwards within NHS as necessary.

The NHS AT would provide ongoing briefing of the local DPH and any adjoining NHS partners in another NHS ATs as necessary.

Director of Public Health responsibilities

The DPH Co-Chair of the LHRP may be asked by the NHS AT to lead aspects of the response on behalf of the LHRP.

The local DPH will provide assurance to their local population that the incident is being appropriately managed to reduce any risks.

The local DPH will brief local authority officers and members as necessary.

The local DPH will activate any necessary local authority resources and staff (e.g. Environmental Health Officers, Public Health Staff, School Staff or Communications Officers) to support the local ICT led response

Clinical Commissioning Groups

The NHS AT may seek operational support from their local Clinical Commissioning Groups for any of the NHS AT responsibilities identified above,