Novel coronavirus (COVID-19) Guidance for health protection teams

Version 8.6

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Before use check the HPS COVID-19 page to verify this is the latest publication.
## Version history

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of changes</th>
</tr>
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<tbody>
<tr>
<td>V1.0</td>
<td>23/01/20</td>
<td>First publication</td>
</tr>
<tr>
<td>V2.0</td>
<td>24/01/20</td>
<td>revised contact details in Appendix 1</td>
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<tr>
<td>V3.0</td>
<td>31/01/20</td>
<td>revised with updated case definition and new nomenclature</td>
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<tr>
<td>V4.0</td>
<td>02/02/20</td>
<td>Revised definition of contact with a case</td>
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<tr>
<td>V5.0</td>
<td>07/02/20</td>
<td>Amended to align with updated case definition and contact definition issued by PHE on 06/02/20</td>
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<tr>
<td>V5.1</td>
<td>07/02/20</td>
<td>Small amendment to contact definition</td>
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| V6.0    | 13/02/20   | Amendment to epidemiological criteria of case definition to clarify that travel includes transit through a country Update to  
`- actions to take when informed of a case presenting in primary care`  
`- actions to take when informed of a case presenting in secondary care`  
Addition of  
`- actions to take when informed of asymptomatic contacts of possible or confirmed cases`  
`- actions to take when informed of symptomatic contacts of possible cases`  
`- section on isolation while awaiting test results`  
`- section on test results`  
`- section on clinical and public health management of confirmed cases`  
`- section on further information`  
`- appendix on safe forms of transport to hospital`  
V6.1    | 24/02/2020 | 2019-nCoV changed to COVID-19                                                       |
| V6.2    | 28/02/2020 | Corrected phone numbers in appendix 2                                              |
| V6.3    | 02/03/2020 | Revised with updated risk area                                                     |
| V6.4    | 05/03/2020 | Revision in Actions for Local HPTs section for possible case data collection Corrected phone numbers in appendix 2 |
| V6.5    | 12/03/2020 | Update to  
`- Case definition`  
`- Investigation and initial clinical management of possible cases`  
`- Actions for local HPTs`  
`- Clinical management of confirmed cases`  
`- Appendix 1`  |
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of changes</th>
</tr>
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<tr>
<td>V7.0</td>
<td>16/03/2020</td>
<td>Update to reflect change from containment to delay phase “Stay at home” advice</td>
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<tr>
<td>v7.4</td>
<td>24/03/2020</td>
<td>Updated recommendations on social distancing and “shielding” (to protect people, including children, who are extremely vulnerable to severe illness from COVID-19). Expanded advice for HCWs. Expanded advice for the management of an outbreak of respiratory illness in a residential care or other closed setting e.g. prison. Added flowchart for the management of COVID-19 by setting.</td>
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<tr>
<td>v7.5</td>
<td>27/03/2020</td>
<td>Clarification in page 6 that exposed patients discharged to residential care or other closed settings, should be isolated in their own room for 14 days following last exposure. Case definition update. Advice on testing key health and social care workers.</td>
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<tr>
<td>V7.8</td>
<td>02/04/2020</td>
<td>Cross reference to other documents added. Updated recommendations on PPE.</td>
</tr>
<tr>
<td>v8.0</td>
<td>12/04/2020</td>
<td>Updated recommendation to consider testing patients in hospitals. Updated recommendation on transports and signposting to relevant documents – appendix previously numbered as 1 has been removed and a link is provided to the appropriate appendix in the G for secondary care. Appendices numbers have consequently changed. Updated recommendation on private testing. Link to “Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings”</td>
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<tr>
<td>V8.1</td>
<td>16/04/20</td>
<td>Testing of symptomatic people in care home. Outbreak definition</td>
</tr>
<tr>
<td>V8.2</td>
<td>22/04/20</td>
<td>Outbreak definition updated</td>
</tr>
<tr>
<td>V8.3</td>
<td>29/04/20</td>
<td>Updated recommendations on the 28th April SG Testing Strategy and Delivery (SG letter to NHS Chief Exec). Updated terminology regarding physical (social) distancing. Updated recommendation on discharging to residential homes or own house via link to updated “guidance for stepdown (…) and discharging (…)”.</td>
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<tr>
<td>v. 8.4</td>
<td>01/05/20</td>
<td>Updated recommendations on enhanced outbreak investigation in all care homes where there are any cases of COVID (following First Minister announcement 1st May)</td>
</tr>
<tr>
<td>V8.5</td>
<td>01/05/20</td>
<td>Updated options appraisal notice</td>
</tr>
<tr>
<td>V8.6</td>
<td>19/05/20</td>
<td>Updated case definition</td>
</tr>
</tbody>
</table>
Contents

Contents ................................................................................................................................................. 3
1. Introduction ........................................................................................................................................ 4
2. Investigation and initial clinical management of possible cases ....................................................... 4
   2.1. Case definition for individuals in the community ............................................................................. 5
   2.2. Case definition for individuals requiring hospital admission ....................................................... 5
3. Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness ....... 6
4. Management of possible and confirmed cases ................................................................................... 7
   4.1. Triage ............................................................................................................................................... 7
   4.2. Possible or confirmed case presenting in secondary care ............................................................. 8
   4.3. Management of patients being discharged to residential settings or their own home .............. 8
5. HPT investigation and follow-up ........................................................................................................ 8
   5.1. Exposed HCW ................................................................................................................................. 8
   5.2. A confirmed case of COVID-19 has not been appropriately isolated on hospital admission ....... 9
   5.3. Discharge of COVID-19 patients from hospital to social or community care & residential settings ......................................................................................................................................................... 10
   5.4. A confirmed case of COVID-19 in a HCW ................................................................................... 10
   5.5. A confirmed case of COVID-19 in social or community care & residential settings ................. 10
   5.6. An outbreak of respiratory illness in social or community care & residential settings ............ 11
      5.6.1. Sampling .................................................................................................................................... 11
      5.6.2. Sample transport ....................................................................................................................... 12
      5.6.3. Notification of the testing laboratory ......................................................................................... 12
      5.6.4. Number of samples .................................................................................................................. 12
      5.6.5. Testing for pathogens other than SARS-CoV-2 (COVID-19) .................................................. 13
      5.6.6. Results reporting ...................................................................................................................... 13
      5.6.7. Measures .................................................................................................................................. 13
6. Sampling and testing .......................................................................................................................... 14
7. Reporting cases .................................................................................................................................... 14
8. Further information ............................................................................................................................ 15
Appendix 1: Health Protection Team management of COVID-19 outbreak by settings ....................... 16
Appendix 2: Contact details for local Health Protection teams ............................................................. 17
1. Introduction

Novel coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan, China. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. COVID-19 was declared a pandemic by the World Health Organisation on 12/3/2020. We now have spread of COVID-19 within communities in the UK.

2. Investigation and initial clinical management of possible cases

The case definition being used across the UK reflects our current understanding from the epidemiology available and will likely be subject to change as new information emerges. For most people COVID-19 will be a mild, self-limiting infection and will not require admission to hospital. People in the community who fit the definition should self-isolate. Clinicians should be alert to the possibility of atypical and non-specific presentations in older people with frailty, those with pre-existing conditions and patients who are immunocompromised. Inpatients must be assessed for bacterial sepsis or other causes of symptoms as appropriate.

Clinicians should test patients who meet the case definition for individuals requiring hospital admission (see section 2.2).

Clinicians should also consider testing any patient in hospital (whether a new admission or existing patient) with new respiratory symptoms, fever or worsening of a pre-existing respiratory condition.

From 29th April, for a 4 week pilot period, all individuals aged over 70 should be tested for COVID-19 on admission to hospital. Those with a negative test result should then be tested every 4 days until they are discharged.

Care home setting: Currently all care home residents who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19. The First Minister announced changes to testing of residents and staff in care homes on 1/5/20:

“We now intend to undertake enhanced outbreak investigation in all care homes where there are any cases of COVID - this will involve testing, subject to individuals’ consent, all residents and staff, whether or not they have symptoms. In addition, where a care home with an outbreak is part of a group or chain and staff might still be moving between homes, we will also carry out urgent testing in any linked homes.
We will also begin sampling testing in care homes where there are no cases. By definition this will also include testing residents and staff who are not symptomatic. This is a significant expansion and we do not underestimate the logistical and workforce requirements. Now we have the increasing testing capacity, we will make it happen as swiftly as practicable."

An urgent options appraisal is currently underway to guide development of detailed guidance to allow for implementation of these changes. The resulting revised care homes and health protection guidance will be published on this website as soon as it is available.

**Key workers** can access testing if they meet certain criteria as outlined on [NHS Inform](https://www.nhsinform.scot). Arrangements vary by NHS Board.

### 2.1. Case definition for individuals in the community

People with the following symptoms are advised to self-isolate for 7 days and COVID-19 testing is not usually required unless it is clinically indicated:

**Recent onset:**
- New continuous cough
  - or
- Fever
  - or
- Loss of/ change in sense of smell or taste

### 2.2. Case definition for individuals requiring hospital admission

- Clinical or radiological evidence of pneumonia
  - or
- Acute respiratory distress syndrome
  - or
- Influenza like illness (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).
3. Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness

There is currently no vaccine to prevent COVID-19.

The following measures are recommended to help reduce the spread of COVID-19 and to protect people at increased risk of severe illness:

**Physical (social) distancing** measures should be followed by everyone, including children, in line with the government advice to stay at home. The aim of physical (social) distancing measures is to reduce the transmission of COVID-19. Up to date information can be found on the NHS Inform website. Note that shielding advice should be followed by individuals at risk of severe infection.

**Shielding** is a measure to protect people, including children, who are extremely vulnerable to severe illness from COVID-19 because of certain underlying health conditions. The aim of shielding is to minimise interaction between these individuals and others to protect them from coming into contact with the virus that causes COVID-19. People with these serious underlying health conditions are strongly advised to rigorously follow shielding measures in order to keep themselves safe. Further information, including the list of underlying health conditions that make people extremely vulnerable, is available on the NHS Inform website.

**Stay at home guidance for households with possible COVID-19** should be followed by people with symptoms and their household contacts to reduce the community spread of COVID-19. This means that anyone who has symptoms of COVID-19 and anyone else living in the same household should follow ‘stay at home’ advice on NHS Inform.

**Staff (such as health care workers)** with underlying health conditions that put them at increased risk of severe illness from COVID-19, including those who are immunosuppressed, should not provide direct care to patients with possible or confirmed COVID-19. Staff who think they may be at increased risk should seek advice from their line manager or local Occupational Health service. Pregnant staff should also seek advice from their line manager or local Occupational Health service. Guidance on COVID-19 and pregnancy is available on the Guidance for NHS Scotland workforce Staff and Managers on Coronavirus.
4. Management of possible and confirmed cases

4.1. Triage

Public messaging directs people who are unwell and worried about COVID-19 to consult NHS inform and phone NHS 24 (111) as the first point of contact, not their GP. **NHS Inform** and NHS 24 (111) is the first point of contact for all COVID-19 related symptoms during the in-hours period.

Calls will be triaged through NHS24 (111) to a local (non-patient facing) hub staffed with clinicians drawn from across both primary and secondary care. People who need to be seen will be offered appointments at dedicated local assessment centres, staffed and equipped to deal with COVID-19 related presentation. Transport to and from local assessment centres should follow local protocol.

Cases in community are **not required to be reported to local HPTs**.

Care providers should **discuss suspected clusters or outbreaks in facilities with local HPTs**. They should also discuss single cases where it is suspected that this is due to transmission within the facility.

If you are contacted for advice about cases in the community:

- If the patient does not require referral to secondary care then ensure they and members of their household have been given appropriate ‘stay at home’ advice and signpost the GP to follow the **primary care guidance** in the **HPS COVID-19 page**. Testing for COVID-19 is not usually required for this group of patients.

- If the patient is to be brought into the hospital (see sections 2 and 4.2) or other healthcare setting for assessment, advise the GP of the need to ensure the patient is **transported appropriately** to the hospital following the principles in **appendix 1** of the **Novel coronavirus (COVID-19) Guidance for secondary care**. Note travel to dedicated local assessment centres should follow local protocol.

Currently all care home residents who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19. See further details in the paragraph for care home settings in **section 2**.
4.2. Possible or confirmed case presenting in secondary care

If you are contacted for advice:

- Confirm that the patient has been isolated and appropriate PPE is being used in line with COVID-19 Guidance for infection prevention and control in healthcare settings.
- Advise the secondary care physician to arrange testing for COVID-19 and to follow the secondary care guidance in the HPS COVID-19 page.
- From 29th April, for a 4 week pilot period, all individuals aged over 70 should be tested for COVID-19 on admission to hospital. Those with a negative test result should then be tested every 4 days until they are discharged.

4.3. Management of patients being discharged to residential settings or their own home

Guidance on appropriate discontinuation of infection prevention and control (IPC) precautions for patients recovering or recovered from COVID-19, being discharged to their own home or to residential care can be found at the Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.

See section 5.2. for advice on the discharge of patients who have been exposed to COVID-19 during their admission.

5. HPT investigation and follow-up

HPT action (including contact tracing for confirmed cases) is no longer routinely required. However, there are certain circumstances where investigation and follow-up may still be indicated. These include:

5.1. Exposed HCW

The following advice should be provided:

When the exposure was household:

- Asymptomatic HCW living in the same household as possible COVID-19 cases should follow the “stay at home advice” in NHS Inform.
- Symptomatic HCW living in the same household as possible COVID-19 cases should follow the “stay at home advice” in NHS Inform.
When the exposure was not household (e.g. travel or occupational) *

- **Asymptomatic HCW** should self-monitor for symptoms for 14 days. They should continue working as long as they remain asymptomatic.

- **Symptomatic HCW** who develop symptoms of COVID-19 should follow “stay at home” advice as in [NHS Inform](https://www.nhsinform.scot/).  

*For exposure to confirmed cases in hospital settings see additional measures in the section 5.2.

These are guiding principles and there may require further risk assessment based on individual staff circumstances – i.e. immunocompromised individuals.

The Scottish Government have produced guidance for NHS Boards in relation to the testing of symptomatic key health and social care workers for COVID-19 infection to enable them to return to work. Further information can be found [here](https://www.gov.scot/).  

**5.2. A confirmed case of COVID-19 has not been appropriately isolated on hospital admission**

It is expected that providers of secondary care will follow recommendations on identifying possible cases of COVID-19, isolate patients with respiratory illness and follow appropriate [COVID-19 Guidance for infection prevention and control in healthcare settings](https://www.gov.scot) from the outset.

However, there may be occasions when COVID-19 was not considered to be a possible diagnosis initially. Investigation and management of such a scenario will usually be led by the NHS board IPCT with involvement of the local HPT and Occupational Health where appropriate. Actions may include:

- Identifying exposed HCWs and ensuring they are aware of the need to self-isolate if they develop any respiratory symptoms. They can continue to work if they are asymptomatic.

- Identifying exposed patients and ensuring:
  
  - those who are inpatients are appropriately isolated / co-horted where possible for 14 days following last exposure;
  
  - those who have been discharged should follow the “stay at home” guidance if they develop respiratory symptoms. If they require ongoing outpatient treatment e.g. dialysis, chemotherapy etc. then they should be advised to report any symptoms before attending so that they can be appropriately isolated if required;
where exposed patients have been discharged to residential care or other closed settings then they should be isolated in their own room for 14 days following last exposure to minimise the risk of a subsequent outbreak within this setting. Follow Information and guidance for non-healthcare settings and Information and guidance for social or community care & residential settings.

- Advice to visitors:
  - Visitors of patients in neighbouring bays of a confirmed COVID-19 patient are unlikely to meet the required contact time or distance of <2 metres for 15 minutes. They should be informed that a COVID-19 diagnosed patient was present on the ward when they visited their relatives, and be given advice about what to do if they develop symptoms and advised to refer to NHS Inform.

5.3. Discharge of COVID-19 patients from hospital to social or community care & residential settings.

Please refer to the Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.

5.4. A confirmed case of COVID-19 in a HCW

Where the HPT is informed of a confirmed case of COVID-19 in a HCW who was working whilst symptomatic, then a risk assessment should be carried out (in partnership with the IPCT and Occupational Health where appropriate) and HCW / patient contacts managed as per above. This may require a PAG or IMT depending on the situation.

5.5. A confirmed case of COVID-19 in social or community care & residential settings

No further action is needed unless there is a particular concern. If so then the local HPT may wish to consider a PAG or IMT

Points for consideration will include:

- if the confirmed case is a staff member, were they working whilst symptomatic?
- If there is any evidence of an outbreak of respiratory illness within the facility setting see section 5.6.
Possible actions include:

- ensuring staff are aware of and are following appropriate infection prevention and control advice, including use of appropriate PPE when managing symptomatic individuals (for HCW by secondary care inpatient clinical setting or for primary, outpatient and community care by setting);
- ensuring staff are aware of the need to self-isolate if they develop any symptoms;
- isolating / cohorting individuals who are contacts of the confirmed case;
- ensuring individuals are informed of symptoms to be aware of and know how to report symptoms quickly to staff.

5.6. An outbreak of respiratory illness in social or community care & residential settings

If a cluster or an outbreak of COVID-19 is suspected within the care home, care providers should discuss this with local HPTs.

An outbreak is NORMALLY defined as two linked cases of a disease. However, with respect to COVID-19, an outbreak should be suspected when there is a single new case with symptoms consistent with COVID-19 infection arising in the care home, likely to be due to spread of the virus within the care home. Assessment of resident cases when considering any potential outbreak should also include symptomatic cases who have either been transferred from the facility to hospital as a result of infection or a suspected COVID-19 individual who has died within the same time period.

A control measure tool for the control of incidents and outbreaks in Social or Community Care & Residential Settings, specific for COVID-19, is available here.

On identification of a new suspect COVID-19 case, the local HPT will advise on the need for testing of residents and staff as well as other IPC measures to help limit further spread of the virus and control the outbreak.

Currently all care home residents who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19. See further details in the paragraph for care home settings in section 2.

5.6.1. Sampling

Sampling should be discussed and agreed with the local HPT and should be taken by trained staff in the local setting using appropriate PPE (for HCW by secondary care inpatient clinical setting or for primary, outpatient and community care by setting).

A combined nose and throat swab (taken throat first then nose) is the sample of choice; where this is not possible, please collect a viral nose swab and a viral throat swab in one collection tube.
5.6.2. Sample transport

Samples should be packaged and transported in accordance with Category B transportation regulations. UN 3373 packaging must be used for sample transport. Samples should be sent to the local laboratory using established means of transport, for example via courier.

5.6.3. Notification of the testing laboratory

The local testing laboratory must be notified of the outbreak using established channels. This is to ensure that a sufficient number of samples is tested to determine whether there is an outbreak and the cause thereof.

The name of the facility/ward and the date of the first case must be added to the clinical details on the request in order to identify this as an outbreak sample when it is processed in the laboratory. The date is required in order to differentiate between potential sequential outbreaks.

For samples taken for occupational reasons e.g. from a healthcare worker at the facility, please also add “OCH” to the clinical details.

5.6.4. Number of samples

In large outbreaks, it is not feasible to test all samples. The number of samples should be agreed between the local HPT and the laboratory. Any further testing within the outbreak would be by discussion with the duty virologist at the laboratory only.

Clinical and epidemiological factors will need to be taken into account when deciding to attribute all outbreak cases to SARS-CoV-2 (COVID-19) or not.

Currently all care home residents who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19. See further details in the paragraph for care home settings in section 2.

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1 On 11th Feb 2020, the International Committee on Taxonomy of Viruses (ICTV) announced “severe acute respiratory syndrome coronavirus 2 (SARS-CoV02) as the name of the new virus responsible for COVID-19 (previously known as “2019 novel coronavirus”) and the disease it causes. Source: WHO.
5.6.5. Testing for pathogens other than SARS-CoV-2 (COVID-19)

Consider where testing for pathogens other than SARS-CoV-2 such as influenza A and B, human metapneumovirus (hMPV) and adenovirus should be undertaken in discussion with the local virologist as necessary. Discussion may also be needed with the local laboratory whether a single swab will be sufficient if pathogens other than SARS-CoV-2 are to be tested for.

5.6.6. Results reporting

Positive SARS-CoV-2 results should be communicated urgently to HPTs via established electronic or telephone communication. Negative results will be reported using the established routes.

5.6.7. Measures

- Guidance on IPC measures can be found in the following documents
  - Information and guidance for non-healthcare setting.
  - Information and guidance for social or community care & residential settings.

- Guidance for PPE for different settings can be found in
  - The Infection Prevention and Control Guidance for Pandemic Coronavirus – COVID-19 personal protective equipment (PPE) Guidance – and note the relevant PPE table (for HCW by secondary care inpatient clinical setting or for primary, outpatient and community care by setting).

- Enhanced surveillance
  - Monitoring arrangements should be discussed and agreed locally.
  - It is important to identify infected individuals as early as possible in order to implement IPC measures and care pathways to reduce the further spread in the facility.
• Closing the facility
  o Careful risk assessment is required to determine whether the facility should remain open to admissions, transfers and hospital outpatient appointments.
  o Closure of part or all of the facility should be based on a joint risk assessment between the facility and the local HPT. This will depend on a number of factors including, the number of individuals and/or staff affected and their location within the facility.
  o If appointments or transfers are essential, inform the clinic/hospital that this is a possible or confirmed COVID-19 case so appropriate infection control plans can be made for the individual (inform the local Hospital Infection Prevention and Control Team).

6. Sampling and testing

See separate Guidance for sampling and laboratory investigations.

Some private laboratories and manufacturers are offering products for the diagnosis of COVID-19 infection in community settings. All tests that are used in the NHS are assessed (validated) to ensure that they are sensitive (detect a high proportion of those with the disease) and specific (a high proportion of people with a positive result actually have the disease) and supporting quality control systems are in place as part of the delivery of test results. These tests have not yet undergone this assessment.

There is the potential for harm if action is taken on the basis of such non-validated test results; they may provide false reassurance if falsely negative (e.g. household isolation lifted in someone affected by COVID-19) or a wrong diagnosis of COVID-19 if falsely positive (e.g. unnecessary anxiety and interventions). Therefore, HPS cannot recommend the use of tests that have not been validated.

7. Reporting cases

• Health Protection Teams are no longer required to report possible or confirmed cases to HPS; data for national surveillance is taken from laboratory reports in ECOSS.
• Deaths associated with COVID-19 are known to HPS by using NRS death data linked to ECOSS data for laboratory confirmed cases. HPT therefore no longer require to report this to HPS.
• **Outbreaks in social or community care and residential settings.**

As per the routine reporting of outbreaks of acute respiratory illness in social or community care and residential settings, the local HPT is requested to complete the modified surveillance form *(available on SHPIR).*

HPS can be contacted for specific advice as required:

  o Office hours:
    
    HPS COVID-19 IMT: 0141 300 1414
  
  o Out of hours:
    
    HPS On Call: 0141 211 3600.

8. **Further information**

Further Information for health professionals can be found on the [HPS COVID-19 page](#) and on [SHPIR](#).

Information for the general public including self-isolation advice can be found on [NHS Inform](#).

Pre-travel guidance can be found on [fitfortravel](#) for the public, and on [TRAVAX](#) for health professionals.

Further information on COVID-19 and pregnancy can be found on the [ccc](#) website.
Appendix 1: Health Protection Team management of COVID-19 outbreak by settings

<table>
<thead>
<tr>
<th>High risk settings</th>
<th>High risk settings</th>
<th>Low risk settings</th>
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<tbody>
<tr>
<td>High risk individuals</td>
<td>Low / Moderate risk individuals</td>
<td>Low risk individuals</td>
</tr>
<tr>
<td>Non-acute healthcare*</td>
<td>Prison</td>
<td>School</td>
</tr>
<tr>
<td>Care home</td>
<td>Asylum seeker shared residence</td>
<td>University</td>
</tr>
<tr>
<td>Special education needs school</td>
<td>Boarding school</td>
<td>Hotel</td>
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</tbody>
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Outbreak definition: Two or more cases where nosocomial infection and ongoing transmission is suspected. However, with respect to COVID-19, an outbreak should be suspected when there is a single new case with symptoms consistent with COVID-19 infection arising in the care home, likely to be due to spread of the virus within the care home.

(This does not include cases admitted with possible/confirmed COVID-19 and applies only to cases which have been acquired within the healthcare setting via onward transmission).

- **Acute hospital outbreaks where transmission is suspected among staff or patients** will be led by NHS Boards with support from HPTs.
- **Upper respiratory tract sample** (combined nose and throat swab). Samples must be labelled with HPzone incident number for processing by laboratory; and state the name of the care home / prison / or institution, label as an outbreak and the date of the first suspected case of this outbreak.
- **HPT to inform laboratory and to give HPzone incident number. To request testing for COVID-19 plus seasonal respiratory viral panel plus pneumococcus where available.**
## Appendix 2: Contact details for local Health Protection teams

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number</th>
<th>Ask for Public Health On Call</th>
</tr>
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<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>01292 885 858</td>
<td>01563 521 133</td>
<td>Crosshouse Hospital switchboard</td>
</tr>
<tr>
<td>Borders</td>
<td>01896 825 560</td>
<td>01896 826 000</td>
<td>Borders General switchboard</td>
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<tr>
<td>Dumfries and Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
<td></td>
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<tr>
<td>Fife</td>
<td>01592 226 435 /798</td>
<td>01592 643355</td>
<td>Victoria Hospital switchboard</td>
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<tr>
<td>Forth Valley</td>
<td>01786 457 283 Ask for CPHM on call</td>
<td>01324 566000</td>
<td>Ask for CPHM on call</td>
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<tr>
<td>Grampian</td>
<td>01224 558 520</td>
<td>0345 456 600</td>
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<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600</td>
<td>Gartnavel switchboard</td>
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<td>Highland</td>
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