

Joint High Consequence Infectious Disease (HCID) Policy

V2.0

Cornwall Partnership NHS Foundation Trust document reference code: IC/024/26

Purpose: To provide guidance on the assessment and management of patient with suspected or confirmed HCIDs.

Target audience: Trust staff, visitors, contractors and volunteers.

Document sponsor and role: Joanne Taylor, Director of Infection Prevention and Control (DIPC).

Document sponsors contact details: 01872 254969.

Document definition: Policy.

Freedom of information: Can be released under the Freedom of Information Act 2000. This document will be published on the internet and intranet.

Key words: HCID, Viral Haemorrhagic Fever (VHF).

Royal Cornwall Hospitals NHS Trust approval process

General manager confirming approval processes: Joanne Taylor.

Governance lead confirming approval process: Liam Button.

Supporting committee: Infection Prevention and Control Committee/group.

Supporting chairperson: Joanne Taylor, DIPC.

Executive director responsible for the policy: Chief Nursing Officer.

Approved at: Infection Prevention and Control Committee.

Date approved: 26 August 2026.

Executive approval: Louise Dickinson.

Date approved by: 26 August 2026.

Approved at: Royal Cornwall Hospitals NHS Trust Policy Ratification Group

Date approved: 16 September 2026

Document library folder and sub-folder: Clinical / Infection Prevention and Control

Cornwall Partnership NHS Foundation Trust approval process

Accountable Executive: Chief Nursing Officer

Supporting committee: Infection Prevention and Control Subcommittee

Supporting chairperson: Louise Dickinson, Chief Nursing Officer

Accountable Executive approved: Chief Nursing Officer

Date: 29 September 2026

Document library section: Safety and risk, infection control

Ratification

Start date: 29 September 2026

Review date: 1 March 2029 (6 months prior to the expiry date).

Expiry date: 1 September 2029 (3 years after ratification unless there are any changes in legislation or changes in NICE guidance or national standards).

Version control summary:

Version	Date	Sponsor and / or reviewer	Summary of recent updates / changes (key points). Please specify Section Numbers.
2.0	July 2026	G. Marquez and L. Button	Full review of existing policy. Updated the role of the IPAC team. Mpox specific guidance removed. Added Chapare virus infection under Contact HCID. Removed all Mpox-specific information. Updated link for VHF. Added the updated VHF risk assessment link. Updated the questions and links for the VHF endemic countries and additional question. Added Pathway for Managing Patients with Suspected High Consequence Infectious Disease (HCID) in acute and community settings. HCID treatment centres added to appendix 1. Updated visiting guidance. Updated contact logs,

Version	Date	Sponsor and / or reviewer	Summary of recent updates / changes (key points). Please specify Section Numbers.
			exposure management, and occupational health surveillance. Red clean added to environmental decontamination and glossary.

This document replaces: IC/024/24 High Consequence Infectious Disease (HCID) Policy V1.1.

This version supersedes any previous versions of this document.

Contents

Summary	7
1. Rationale	10
2. Scope	10
3. Roles and responsibilities	10
3.1 Role of the consultant Microbiologist/Infectious Disease consultant	10
3.2 Role of the Medical Staff	10
3.3 Role of the Infection Prevention and Control Team	10
3.4 Role of the Director of Infection Prevention and Control	10
3.5 Role of the Outbreak Control Group	11
3.6 Infection Prevention and Control Committee	11
4. Standards and practice	11
4.1 Key Screening Criteria	11
4.2 Clinical Symptom Checklists	12
4.3 Risk Assessment	12
4.4 Isolate	12
4.5 Unified HCID PPE Ensemble	13
4.6 Visiting	14
4.7 The Imported Fever Service (IFS) and Health Protection Team (HPT)	14
5. Specimen Collection and Management	15
5.1 Minimal risk of VHF	15
5.2 At risk of VHF or confirmed VHF	15
6. Contact Logs and Exposure Management	17
6.1 Occupational Health and Surveillance Procedures	18
7. Environmental Decontamination	18
7.1 Safe Management of Waste	18
7.2 Safe Management of Linen	19
8. Transfer Arrangements	19
9. Definitions and glossary	19
Appendix 1: HCID Specialist and Treatment Centres	22
Governance requirements	24
Associated Trust policies and documents	24
NICE guidance	24

Other related legislation and guidance.....	24
Training requirements	25
Trust Approved Publication (TAP) application/implementation	26
Monitoring arrangements	27
Environmental sustainability.....	27
Updating and review	27
Version control history	27
Data Protection Act 2018 (UK General Data Protection Regulation legislation).....	28
Equality and diversity	29
Equality impact assessment form	30

Summary

List of High Consequence Infectious Diseases (HCID)

Contact HCIDs

- Argentine haemorrhagic fever (Junin virus).
- Bolivian haemorrhagic fever (Machupo virus).
- Chapare virus infection.
- Crimean Congo haemorrhagic fever (CCHF).
- Ebola virus disease (EBOD).
- Lassa fever.
- Lujo virus disease.
- Marburg virus disease (MVD).
- Severe fever with thrombocytopaenia syndrome (SFTS).

Airborne HCIDs

- Andes virus infection (hantavirus).
- Avian influenza A H7N9 and H5N1*.
- Avian influenza A H5N6 and H7N7*.
- Middle East respiratory syndrome (MERS)*.
- Nipah virus infection.
- Pneumonic plague (Yersinia pestis).
- Severe acute respiratory syndrome (SARS)*.

*See Suspected Cases of Severe Imported Respiratory Virus Infections Policy.

Note: Not all VHF are HCID. For list of VHF [click here](#).

To access the most recent VHF Risk Assessment, please visit this link: [VHF risk assessment algorithm](#).

Pathway for Managing Symptomatic Contacts and/or Suspected Cases of High Consequence Infectious Disease (HCID) in the Acute Setting

Patient fits basic clinical criteria including recent travel history, exposure history, and compatible symptoms such as sudden fever and/or specific symptoms.



- Isolate and don the [unified HCID PPE ensemble](#) following [donning, doffing, and buddy requirements](#).
- Complete appropriate HCID assessment. Where possible all assessments should be completed remotely: **Viral Haemorrhagic Fever:** [VHF risk assessment algorithm](#) or the Suspected Cases of Severe Imported Respiratory Virus Infections Policy
- Contact a microbiologist or infectious disease consultant to discuss outcome of assessment and appropriate laboratory investigations.
- Consider alternative diagnoses and seek additional specialist advice as appropriate through established clinical pathways.
- Notify Infection Prevention and Control team.
- Contact Imported Fever Services (08447788990) and/or Rare and Imported Pathogens Laboratory (01980612348) if applicable.
- Discuss with UK Health Security Agency (UKHSA) Southwest Health Protection Team to agree next steps.
- Begin symptomatic treatment.



If able to isolate and manage symptoms at home, discharge the patient, and request a red clean. Waste managed as Category A.

If patient requires admission and is a probable case of HCID:

- On presentation to ED direct patient to cubicle 20 in Majors 2, using the rear entrance. Or direct admission to Wheal Prosper side room 6 or 7 using rear entrance
- Patients already in ED should remain in isolation or transfer to Wheal Prosper side room 6 or 7 using rear entrance
- If critically unwell, discuss with ICU consultant and microbiologist / infectious diseases.

If patient is for admission **but** is not a probable case of HCID:

- Consider alternative diagnosis, seeking advice as required as part of normal clinical pathways.
- Liaise with local Infectious Disease specialist/Clinical Microbiology consultant if clinical suspicion remains, to agree next steps as required.

Pathway for Managing Symptomatic Contacts and/or Suspected Case of High Consequence Infectious Disease (HCID) in the Community Setting

Patient fits basic clinical criteria including recent travel history, exposure history, and compatible symptoms such as sudden fever and/or specific symptoms.

- Isolate and don the [unified HCID PPE ensemble](#) following [donning, doffing, and buddy requirements](#).
- Complete appropriate HCID assessment. Where possible all assessments should be completed remotely: **Viral Haemorrhagic Fever:** [VHF risk assessment algorithm](#) or the Suspected Cases of Severe Imported Respiratory Virus Infections Policy
- Contact a microbiologist or infectious disease consultant to discuss outcome of assessment and next steps.
- Consider alternative diagnoses and seek additional specialist advice as appropriate through established clinical pathways.
- Notify Infection Prevention and Control team.
- Contact Imported Fever Services (08447788990) and/or Rare and Imported Pathogens Laboratory (01980612348) if applicable.
- Discuss with UK Health Security Agency (UKHSA) Southwest Health Protection Team to agree next steps.

If able to isolate and manage symptoms at home, discharge the patient, and request for a red clean, manage waste as Category A.

If patient requires admission and is a probable case of HCID:

- Contact the nearest acute hospital provider clinical site management. Do not direct patient to the provider until there is an admission plan whenever possible.
- Call '999', confirming a suspected HCID to arrange ambulance transfer if patient unable to utilise own private transport.
- Red clean all affected areas of the unit and treat waste as Category A.

If patient is for admission **but** is not a probable case of HCID:

- Consider alternative diagnosis, seeking advice as required as part of normal clinical pathways.
- Liaise with local Infectious Disease specialist/Clinical Microbiology consultant if clinical suspicion remains to agree next steps as required.

1. Rationale

To provide a framework for recognising and managing patients with suspected or confirmed High Consequence Infectious Disease (HCID).

2. Scope

This policy applies to all staff working in the Royal Cornwall Hospital's Trust (RCHT) and Cornwall Partnership NHS foundation trust (CFT).

3. Roles and responsibilities

3.1 Role of the consultant Microbiologist/Infectious Disease consultant

- Advise GP's and where relevant the admitting medical staff on the suitability of admission to the Trust or to a Regional Centre.
- Inform UK Health Security Agency (UKSHA) and the Director of IPAC (DIPC) of any patient who is either diagnosed/or suspected of having a HCID.
- Lead in the initial management of any patient with suspected/diagnosed HCID.

3.2 Role of the Medical Staff

- Alert and liaise with the Consultant Microbiologist/IPAC Doctor regarding the continuing management of a patient suspected of having a HCID.
- Communicate with the IPAC team to ensure that all relevant staff are informed regarding the infection control precautions to be undertaken.

3.3 Role of the Infection Prevention and Control Team

- Advise all relevant groups of staff on infection control precautions.
- Work closely with the Consultant Microbiologist/IPAC doctor/DIPC.
- To assess and consider the implementation of pathogen specific guidance in relation to this policy in response to an emerging HCID in the United Kingdom.

3.4 Role of the Director of Infection Prevention and Control

Instigate an Outbreak Control Group/Major Outbreak Control Group as required and update the Executive Team, as necessary.

3.5 Role of the Outbreak Control Group

- Initiate risk assessment and agree the management of the patient/ staff and contacts.
- Implement the Major Outbreak Procedure as outlined in the Management of Outbreaks Policy and develop a major outbreak plan where relevant.
- Ensure that relevant reports are communicated as outlined in the Management of Outbreaks Policy.

3.6 Infection Prevention and Control Committee

Responsible for approval and overseeing the implementation of this policy.

4. Standards and practice

Identifying a suspected High Consequence Infectious Disease (HCID) case requires evaluating clinical symptoms against travel, contact, or exposure history within the past 21 days. For suspected cases clinicians must immediately isolate the patient, implement the [unified HCID PPE ensemble](#), and contact the local Microbiologist or Infectious Disease consultant. In most circumstances the Microbiologist or the Infectious Disease consultant will contact the [Imported Fever Service](#) for an urgent risk assessment. On request, the clinical team may be asked to contact the Imported Fever Service.

4.1 Key Screening Criteria

Assessments for HCID are triggered if the patient presents with an acute, unexplained illness and has one or more of the following risk factors:

- **Travel or Residence:** Recent travel or coming from an area with active outbreaks or endemic HClDs (such as VHF-endemic countries, or areas with MERS-CoV).
- **Exposure History:** Direct contact with bodily fluids, clinical specimens, or laboratory cultures from a known or strongly suspected HCID case.
- **High-Risk Activities:** Contact with infected animals, animal reservoirs (e.g., wild rodents, primates, or ticks), or consumption of bushmeat.

HClDs including VHFs are rare in the UK. When cases occur, they tend to be sporadic and are typically associated with recent travel to an area where the infection is known to be endemic or where an outbreak is occurring.

For health professionals wishing to determine the HCID risk in any country, an A-to-Z list of countries and their respective HCID risk is available.

See [High consequence infectious disease: country specific risk - GOV.UK](#).

4.2 Clinical Symptom Checklists

The clinical presentation depends on the category of the pathogen:

- **Airborne / Contact HCIDs:** Presents with fever $\geq 38^{\circ}\text{C}$, muscle aches, headaches, swollen lymph nodes, and new unexplained rashes or respiratory distress.
- **Viral Haemorrhagic Fevers (VHF):** Characterised by unexplained acute fever $\geq 38^{\circ}\text{C}$ plus one or more signs of coagulopathy, such as extensive bruising, active bleeding, or severe gastrointestinal/neurological deterioration.

4.3 Risk Assessment

Patients should not present to the Emergency Department un-announced. Primary care, community services, ambulance services, and '111' / out of hours should, whenever possible, notify the acute trust that there is a potential HCID that may require admission. Preferably, all patients should be assessed with a microbiologist or infectious disease consultant before arrival to the acute trust. It is recognised that un-announced presentations may occur in any of the services provided in Cornwall.

Use the [VHF risk assessment algorithm](#) to determine whether an acutely unwell patient with a travel or exposure history within 21 days may have a VHF infection. The patient's risk assessment determines the level of staff protection and the management of the patient.

Airborne HCIDs can be more difficult to detect as initial symptoms may not vary much from seasonal illnesses such as influenza. Thorough assessment utilising the screening criteria is crucial in developing the clinical picture. See the Suspected Cases of Severe Imported Respiratory Virus Infections Policy for further information.

The risk to staff may change over time, depending on the patient's symptoms, the results of diagnostic tests and/or information from other sources.

If a patient meets the initial criteria, healthcare professionals must take the following mandatory steps.

4.4 Isolate

If a patient presents in ED or is referred by a General Practitioner (GP) and is clinically stable, isolate patient on Wheal Prosper side room 6 or 7 using the backdoor entryway. This needs discussion with the clinical site team and the IPAC team to ensure that the room is made available for use as soon as possible.

If a patient presents in ED and is not suitable for transfer to Wheal Prosper, direct patient to cubicle 20 in Majors 2 using the backdoor entryway. Ensure that all other cubicles in Majors 2 are empty if accordion door is to be used and opened by ED staff members.

If a patient is critically unwell this will require discussion with the critical care doctor and the duty microbiologist or infectious disease consultant.

For symptomatic contacts, probable or confirmed HCID in acute inpatient settings, isolation in a negative pressure isolation room with ensuite facilities is optimal in accordance with established local arrangements and activation of the HCID network.

If a patient presents in the community setting i.e. Urgent Treatment Centres (UTC), Community Assessment Treatment Unit (CATUs), and Minor Injury Unit (MIU), direct patient to the appropriate single room.

The specific isolation standards include:

- **Airflow and Ventilation:** Where pressure differentials exist, patient rooms must be under negative pressure relative to the surrounding area, with HEPA filtration of exhaust air. Positive pressure rooms are strictly prohibited.
- **Environment:** Rooms should be en-suite. Surfaces must be impervious to liquid, easy to clean, and can be cleaned with Trust-approved disinfectant.
- **Containment:** There must be no through-flow of staff or patients. All waste and laundry must be handled as category A or high-risk clinical waste according to local NHS guidelines.
- **Specialized Units:** Depending on the exact pathogen, patients may need transfer to dedicated specialist centres, such as the High-Level Isolation Units (HLIU) at the Royal Free London or the Royal Victoria Infirmary in Newcastle.

4.5 Unified HCID PPE Ensemble

The unified HCID PPE ensemble can be found [here](#).

Documents such as the donning and doffing of PPE and 'buddy' requirements can be found [here](#).

Only clinical staff who are trained and competent in the use of this PPE (donning and doffing) should enter the at-risk clinical environment. They may be required to undertake additional tasks or procedures that would routinely be done by other staff groups, such as environmental cleaning. Entry is strictly controlled with only pre-approved, minimal team of highly trained HCID clinical specialists, and the space must feature clearly separated donning and doffing zones for putting on and safely removing personal protective equipment (PPE).

Staff must not enter the at-risk environment without a trained observer (buddy) present in the designated clean or amber zone to visually verify the PPE and assist with safe donning and doffing procedures.

Inpatients are not required to wear a non-valved FFP3 respirator while in a single or isolation room. However, patients with probable or confirmed airborne HCID and contacts moving between care areas should wear a non-valved FFP3 respirator, unless contraindicated.

4.6 Visiting

A strict "no visitors" policy for the entire duration of the patient's HCID isolation should be in place. However, visitation for people who are at or near to the end of life will require approval from the nurse in charge and/ or matron. Approved exceptional circumstance visitors must always be supervised, and they must undergo training in donning and doffing. They must be informed of and understand the risks that they are subject to. The visitor will be subject to the same rigorous contact-tracing log and post-exposure monitoring as clinical staff.

In paediatrics a parent / guardian may accompany the young person, it is likely that they are already considered to be a high-risk contact. It remains important that the parent / guardian is aware of the risks.

4.7 The Imported Fever Service (IFS) and Health Protection Team (HPT)

Following the initial VHF assessment between the clinical team and the local Microbiologist / Infectious Disease consultant, the Microbiologist or Infectious Disease consultant will contact the Imported Fever Service (IFS) to coordinate assessment, testing, and potential transfer to a designated HCID Treatment Centre. In some circumstances the clinical team may be tasked with contacting the IFS.

The IFS can be contacted on 0844 778 8990.

For suspected cases of severe imported respiratory viruses, discuss the case with the Southwest HPT, they can be contacted on 0300 303 8162 and for urgent out of hours notification 0300 303 8162.

5. Specimen Collection and Management

5.1 Minimal risk of VHF

If a patient is assessed as 'minimal risk of VHF' according to the [VHF risk assessment algorithm](#), only standard infection prevention precautions apply.

To ensure timeliness of results clinical teams must notify the laboratory that specimens are to be delivered and that the outcome of the risk assessment is 'minimal risk of VHF'.

All samples from patients in the 'minimal risk of VHF' category can be handled as standard samples and laboratories are not required to take additional precautions. Investigations required will include **urgent malaria investigations**. Waste is disposed of as category B infectious waste.

5.2 At risk of VHF or confirmed VHF

5.2.1 Safe Collection

Sampling should be restricted to the absolute minimum necessary for immediate diagnostic confirmation. Routine baseline testing should only be done with consultant authorization.

No sample is drawn until the local Microbiology and/or Infectious Disease Consultant has discussed the case with the UKHSA Imported Fever Service (IFS) or relevant national reference laboratory.

A two-person team is required for sample collection:

- Red Zone Operator. Deployed inside the isolation room wearing Unified HCID PPE to draw the sample.
- Green Zone Buddy. Stationed at the clean threshold wearing gloves to verbally guide the operator, verify steps, and handle outer containment.

Sampling is executed using a segregated layout with two-bowl technique:

- Place newly drawn tubes into an upper "dirty" cardboard bowl inside the patient zone.
- Change outer gloves, sanitize the primary tube with an alcohol/chlorine wipe, and transfer it to a clean lower "clean" bowl.

Point-of-Care Testing (POCT) and any ward-based centrifugation is strictly prohibited due to the severe risk of aerosol generation.

5.2.2 Packaging

Triple-layer packaging in absolute accordance with Dangerous Goods Regulations Packing Instruction P650 (Category B) or P620 (Category A), depending on specific IFS instruction.

- **Primary Layer Containment.** Place the sample tube into a leak-proof primary container. Wrap it with sufficient absorbent material to completely absorb the entire liquid contents in the event of a rupture.
- **Secondary Layer Isolation.** Seal the wrapped primary container into a leak-proof secondary bag containing an integral sealing strip (do not staple or puncture). Multiple samples destined for the same laboratory may share a single secondary bag.
- **Tertiary Outer Box.** Enclose the secondary layer in a rigid outer transport box. For airborne or contact HCID diagnostic routing, ensure it is a certified UN 2814 (Infectious Substance, Category A) or UN 3373 (Biological Substance, Category B) container as directed by UKHSA. This must be labelled 'danger of infection'.

5.2.3 Transport

The use of pneumatic air tube (POD) systems is strictly prohibited for any suspected or confirmed HCID specimens.

Hand-deliver the sealed rigid transport box directly to the appropriate pathology department via a designated, trained porter or courier. The sample must never be left unattended in public corridors or reception spaces.

If required, the microbiology laboratory will arrange off-site transport to UKHSA reference laboratories via a specialized, ADR-compliant courier service certified to carry dangerous goods. Ensuring the transport route or vehicle is equipped with a dedicated hazardous chemical/biological spill kit capable of handling high-concentration chlorine surface decontamination (10,000 ppm for blood spillages).

5.2.4 Laboratory Notification

It is the responsibility of the clinical team to notify the receiving laboratory that at risk or confirmed HCID specimens are being collected. It is the responsibility of the clinical team to clearly communicate the result of the risk assessment to the receiving laboratory, which will either be 'at risk' or 'confirmed'. Laboratory staff will be supported in a decision to delay sample processing until this information is made available to them. All laboratory request forms should be placed in the outer dedicated pocket of the secondary containment bag or affix them securely to the outside of the tertiary box. Never place paperwork in the same compartment as the primary specimen tube.

"Danger of Infection" labels should be applied to both the request paperwork and the outermost tertiary packaging layer.

All laboratory staff should visually inspect the box integrity at a designated BSL-3/4 entry hatch, sign a formal chain-of-custody transfer log.

Malaria screening for cases assessed as 'at risk of VHF' can be carried out in containment level 2 within the haematology laboratory. When preparing blood film slides for malaria testing, consideration should be given to the potential for splash and therefore should be carried out in the filtration safety cabinet and facial protection to include face mask, goggles and double gloves should be used. Blood film slides should be disposed of in a dedicated sharps bin, which should be retained and processed as category A waste if VHF is subsequently confirmed in any of the samples. After use, the work surfaces should be treated with disinfectant cleaning solution.

Cases of confirmed VHF are unlikely; all specimen collection and laboratory processes are to be agreed by the microbiologist or infectious disease consultant. The laboratory's must be notified in advance to arrange the appropriate measures for safe testing processes.

6. Contact Logs and Exposure Management

A strict, contemporaneous contact log for every suspected or confirmed HCID case, including caregiver names, duration of contact, and PPE worn, should be maintained.

If the patient is deemed 'at risk' of a HCID, the Southwest Health Protection Team should be notified as soon as possible, they can be contacted on 0300 303 8162 and for urgent out of hours notification 0300 303 8162. Community contacts will be followed up, and advice will be given by the health protection team.

For healthcare contacts, each case or event must be immediately discussed with the local Microbiologist or Infectious Disease consultant for risk assessment. The Microbiologist or Infectious Disease consultant must contact the duty Rare Imported Fevers Physician by calling the IFS on 0844 778 8990 for those patients who are deemed 'at risk' but testing is not complete.

In cases of confirmed VHF or HCID the Microbiologist or Infectious Disease consultant the incident was reported to must immediately contact the duty Infectious Diseases consultant at the Royal Free Hospital on 020 7794 0500.

A contact or exposure incident would be classified as any unprotected contact with the symptomatic patient, their bodily fluids, or the environment (including contaminated sample containers).

6.1 Occupational Health and Surveillance Procedures

Guidance regarding surveillance, isolation, and exclusion from the workplace will be provided by the UKHSA in conjunction with the local Microbiologist or Infectious Disease consultant dependent on the level of risk. In general, the incubation period would be 21 days for those who are deemed to be 'at risk' contacts.

7. Environmental Decontamination

Domestic Services staff are prohibited from entering isolation areas. All daily and terminal cleaning must be performed exclusively by clinical staff who are fully trained and competent in the unified UK HCID PPE ensemble.

A designated buddy is required to visually supervise the decontamination of any reusable equipment and the subsequent PPE removal process.

It is mandatory to use a chlorine-releasing agent at a minimum concentration of 10,000 ppm available chlorine or a UKHSA/IPAC-approved equivalent effective against specific viral/bacterial HCID pathogens. All physical cleaning equipment (mops, buckets, cloths) must be strictly single use, dedicated entirely to the isolation room, and immediately disposed of as clinical waste.

It is necessary to clean from highest to lowest points and from the least to most contaminated areas, ensuring all equipment and surfaces (including floors) are decontaminated.

The frequency of cleaning in areas prone to higher contamination such as toilets and commodes, and frequently touched surfaces such as door/toilet handles, locker tops, over bed tables and bed rails, should be increased.

After a patient is transferred, discharged, or deemed no longer infectious a 'red' clean must be carried out. If it is not possible to use hydrogen peroxide vapour in the environment this must be discussed with the IPAC team.

7.1 Safe Management of Waste

Confirmed, probable, and symptomatic contacts

Waste generated in the care of patients with confirmed HCID infection, including laboratory waste and used PPE, is considered Category A waste.

Waste generated during assessment of a symptomatic contact or probable case may be quarantined in Category A compliant conditions pending the results of HCID diagnostic testing. If results are negative, quarantined waste may be disposed of per the appropriate

clinical waste category. If waste cannot be securely quarantined while awaiting results of diagnostic testing, it must be disposed of as Category A waste.

If the waste contains chemical or pharmaceutical contaminants, it must be placed in a yellow container (or purple if cytotoxic or cytostatic), and either incinerated or sent to a permitted site for disposal as per national regulation.

7.2 Safe Management of Linen

Confirmed, probable, and symptomatic contacts

Linen from a symptomatic contact, probable or confirmed HCID case must not be returned to the laundry.

Infectious linen should be stored securely until diagnostic results are available. If HCID is confirmed, the linen must be disposed of as Category A waste as outlined in section 8.1. If storing infectious linen while awaiting diagnostic test results is not feasible, it should be disposed of as Category A waste as a precautionary measure.

When handling linen from symptomatic contacts, probable or confirmed HCID cases, ensure a waste receptacle is placed as close as possible to the point of use for immediate deposit.

8. Transfer Arrangements

Once a HCID has been confirmed by appropriate laboratory testing, cases should be transferred to a designated HCID Treatment Centre. Occasionally, highly probable cases may be moved to a HCID Treatment Centre before laboratory results are available. A list of designated HCID Treatment Centres can be found in appendix 1.

Transfer to a designated HCID treatment centre is a clinical decision. Once the decision is made, the local emergency planning, resilience and recovery (EPRR) lead must be informed so that they can liaise with the system EPRR lead to arrange specialist transport to the designated hospital. Out of hours the request needs to be made through the on-call management arrangement.

During larger airborne HCID outbreaks, confirmed adult cases may also receive care in specialist regional infectious disease centres, if this has been agreed at a national level.

9. Definitions and glossary

Airborne precautions: Transmission-based measures used to prevent the spread of infectious agents via aerosols or droplet nuclei (NHS England, 2026).

Amber zone: A designated transitional buffer area located just outside the patient's room. It poses a potential risk of indirect exposure due to infectious particles on environmental surfaces or discarded Personal Protective Equipment (PPE) (NHS, 2026).

Buddy: A trained, dedicated healthcare worker who safely observes and assists a colleague wearing specialized Personal Protective Equipment (PPE). They act as a critical safety net by helping don and carefully doff to prevent contamination (NHS, 2026).

Confirmed HCID case: This refers to an individual with clinical symptoms whose infection is laboratory-confirmed by a specialist reference laboratory, such as the UKHSA Rare and Imported Fever Service (UKHSA, 2026).

Contact precautions: Enhanced transmission-based precautions designed to prevent direct/indirect transmission of pathogens via infected body fluids, tissues, or contaminated surfaces (NHS England, 2026).

Doffing: The careful, step-by-step process of removing contaminated personal protective equipment (NHS England, 2026).

Donning: The step-by-step process of safely putting on the personal protective equipment (NHS England, 2026).

Endemic: A high-risk infectious disease that is native, constantly circulating, and maintained at a steady baseline level within a specific geographic region or animal population (UKHSA, 2026).

Green zone: A designated, completely clean safe area where no clinical care or dangerous procedures take place. It is strictly separated from infectious hazards, so healthcare workers do not need to wear Personal Protective Equipment (PPE) while inside it (NHS, 2026).

High Consequence Infectious Disease (HCID): An acute infection characterized by a high fatality rate, limited treatment options, challenging detection, significant transmission potential, and the need for a robust, coordinated response (UKHSA, 2026).

High-Level isolation Unit (HLIU): Specialised, medically secure facility designed for the containment and treatment of patients with suspected or confirmed High Consequence Infectious Diseases (HCIDs). These units are used to safely isolate patients, protect staff, and prevent community outbreaks (UKHSA, 2026).

Personal Protective Equipment (PPE): Specialised, unified clothing and gear that healthcare workers must wear to safely assess and treat patients who have or are suspected of having highly dangerous, easily transmissible pathogens (NHS England, 2026).

Probable HCID case: Any person presenting with a clinical syndrome compatible with a known HCID pathogen, and who meets the operational criteria for risk (e.g., specific travel history or contact with a confirmed case within the incubation period), which requires the immediate implementation of transmission-based precautions and emergency clinical discussion with local infection specialists (UKHSA, 2026).

Red clean: Local term for the level of environmental disinfection required following the transfer, death, or discharge of a patient. This level requires a manual clean of the environment using an appropriate disinfectant product followed by hydrogen peroxide vapour (HPV) disinfection. When it is not possible to use HPV the area requires manual cleansing with 10,000ppm chlorine or equivalent product twice.

Red zone: The designated patient care area where contamination is confirmed or highly suspected. It is the room or enclosed space where direct, hands-on care is provided to a probable or confirmed HCID patient (NHS, 2026).

Symptomatic contact: Anyone who has a known epidemiological link with a confirmed or probable HCID case **and** with acute (or history of) symptoms compatible with specific HCID infection (UKHSA, 2026).

Viral haemorrhagic fevers (VHFs): A group of severe, life-threatening viral illnesses caused by five distinct virus families (Arenaviruses, Filoviruses, Bunyaviruses, Flaviviruses). They are characterized by fever, malaise, and internal or external bleeding (DOHS, 2026).

Appendix 1: HCID Specialist and Treatment Centres

Specialist Regional Infectious Disease Centre's in Southwest – Adults:

- Royal Devon University Healthcare NHS Foundation Trust.
- North Bristol NHS Trust; Southmead Hospital is the dedicated Regional Infectious and Tropical Diseases Unit.

Specialist Regional Infectious Disease Centre in Southwest – Children:

- University Hospitals Bristol and Weston NHS Foundation Trust.

Contact HCID Treatment Centres – Adults:

- Royal Free Hospital High Level Isolation Unit (HLIU), London.
- Royal Victoria Infirmary HLIU, Newcastle-upon-Tyne.

Further support for managing additional confirmed adult contact HCID cases can be provided by the Royal Liverpool University Hospital, Liverpool and the Royal Hallamshire Hospital, Sheffield, if necessary.

Contact HCID Treatment Centres – Children:

- Royal Victoria Infirmary HLIU, Newcastle-upon-Tyne.
- Paediatric HCID Treatment Centre, St Mary's Hospital, London.

Airborne HCID Treatment Centres – Adult:

- St Thomas' Hospital, London.
- Royal Free Hospital, London NHS.
- Royal Liverpool University Hospital, Liverpool.
- Royal Victoria Infirmary, Newcastle-upon-Tyne.
- Royal Hallamshire Hospital, Sheffield.
- John Radcliffe Hospital, Oxford.
- Southmead Hospital, Bristol.

Airborne HCID Treatment Centres – Children:

- St Mary's Hospital, London; paediatric service.
- Evelina London Children's Hospital, London.
- Great North Children's Hospital; adult and paediatric services).
- Alder Hey Children's Hospital Trust (paediatric service only).

- John Radcliffe Hospital, Oxford.

Governance requirements

Associated Trust policies and documents

Cornwall Partnership NHS Foundation Trust

- HS/024/25 High consequence infectious disease (incorporating pandemic) plan.
- IC/037/24 Suspected cases of severe imported respiratory virus infection policy (CFT and RCHT).
- IC/042/25 Joint management of outbreaks policy.

Royal Cornwall Hospitals NHS Trust

Pandemic Plan [RCHT Pandemic Plan Policy](#) 2024.

Joint management of outbreaks policy 2025.

NICE guidance

None.

Other related legislation and guidance

Advisory Committee on Dangerous Pathogens (2015) Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence. London: Department of Health.

Centres for Disease Control and Prevention (2021) [Viral haemorrhagic fevers \(VHFs\) | CDC](#)

CQC Regulation 12.

Department of Health and Health and Safety Executive. (2015) [Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence \(publishing.service.gov.uk\)](#)

Department of Health and Social Care (2026). Risk assessment and immediate management of viral haemorrhagic fevers (contact high consequence infectious diseases) in acute hospitals. Available at: <https://www.gov.uk/government/publications/viral-haemorrhagic-fever-acdp-algorithm-and-guidance-on-management-of-patients/risk-assessment-and-immediate-management-of-viral-haemorrhagic-fevers-contact-high-consequence-infectious-diseases-in-acute-hospitals>

NHS (2026). High Consequence Infectious Diseases Training, Networks: Training. Available at: [HCID Training Videos - \(hcid-training.co.uk\)](https://hcid-training.co.uk)

NHS England (2024). Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste. Available at: [Health Technical Memorandum 07:01 'Safe Management of Healthcare Waste'](#)

NHS England (2024a). Health Technical Memorandum 01-04: Decontamination of linen for health and social care. Available at: [Health Technical Memorandum 01-04: Decontamination of linen for health and social care.](#)

NHS England (2026) National infection prevention and control manual for England, addendum on high consequence infectious disease (HCID) personal protective equipment. Available at: [NHS England » Addendum on high consequence infectious disease \(HCID\) personal protective equipment \(PPE\)](#)

NHS England (2026). National infection prevention and control manual for England. Available at: [NHS England » National infection prevention and control manual \(NIPCM\) for England](#)

UKHSA (2025). Principles for managing cases of suspected high consequence infectious diseases in adult social care. Available at: <https://www.gov.uk/government/publications/managing-cases-of-suspected-high-consequence-infectious-diseases-in-adult-social-care/principles-for-managing-cases-of-suspected-high-consequence-infectious-diseases-in-adult-social-care>

UKHSA (2026). High consequence infectious diseases (HCID). Available at: [High consequence infectious diseases \(HCID\) - GOV.UK](#)

Training requirements

HCID PPE training must be completed by staff working in healthcare settings where assessment or admission of suspected HCID may take place. These settings are the following:

- Admission Areas in acute care settings (Emergency Department).
- Isolation ward (Wheal Prosper).
- Intensive Care Unit.
- Community Assessment and Treatment Unit (CATU).
- Minor Injury Unit (MIU).
- Urgent Treatment Centre (UTC).
- St Mary's Hospital in the Isles of Scilly.

It is essential that senior clinical medical and nursing staff who may be required to wear PPE for the assessment and care of suspected or confirmed HCID cases are trained, practised, and competent in the unified HCID ensemble. This includes staff who will act as buddies.

Clinical staff must be trained and assessed as competent in putting on the PPE ensemble, removing the PPE ensemble, and in the procedures to follow in the event of a PPE breach. This training and confirmation of competence must be completed before using the ensemble to care for a patient for the first time. Competence is described as independently donning and doffing the PPE without prompts when observed.

Once competence is achieved HCWs should attend a refresher training session a minimum of yearly, but ideally 6 monthly, where confirmation of competence will be re-assessed. A minimum 2 yearly FFP3 fit testing is mandatory for all clinical staff.

Training and educational resources for the unified HCID PPE ensemble are available at [HCID-training UK](#). This also includes access to a simulation based HCID train the trainer course.

The HCID networks have developed an online learning theory module on the NHS learning hub, and it is advised that any staff caring for HCIDs should complete this annually.

Providers can undertake training on donning and doffing and the assessment of HCID using the unified HCID PPE ensemble locally including competency assessments, providing that this meets the learning outcomes.

Additional training advice and support can be provided by regional HCID treatment centres.

Trust Approved Publication (TAP) application/implementation

As a minimum the sponsor needs to describe how the document will be applied/implemented with the production of an approved action plan if needed.

Monitoring arrangements

Information category	Detail of process and methodology for monitoring compliance
Element to be monitored	In the event of any suspected case each case will be monitored against the policy and reported to the IPAC Committee.
Lead	Infection Prevention and Control Team.
Tool	Risk Assessment in this document.
Frequency	As cases occur.
Reporting arrangements	Information will be reported to the Infection Prevention and Control Committee.
Acting on recommendations and lead(s)	Required actions will be identified and completed within a month.
Change in practice and lessons to be shared	Via the Infection Prevention and Control Steering Group.

Will the monitoring arrangements result in a clinical audit: No.

Environmental sustainability

The Trust is committed and obligated to reduce its environmental impacts. Healthier outcomes can be achieved for people, the planet, and pounds by conducting our activities in a more environmentally sustainable manner.

More information and guidance is available by contacting cft.sustainability@nhs.net

Updating and review

This policy will be reviewed within 3 years.

Version control history

Version	Date	Sponsor and / or reviewer	Previous updates and key changes.
V1.0	08/2024	Graham Kaye, Senior IPAC Specialist Practitioner.	Merged RCHT and CFT Policies and updated to joint template. Title changed to incorporate all HCID's. Pathway added. Summary Mpox classification added. 1.4 added. 7 added specific to Mpox. Appendix 1 related documents updated. Added List of HCID Summary,

Version	Date	Sponsor and / or reviewer	Previous updates and key changes.
		Rashima Hamdan, Senior IPAC Specialist Practitioner.	Pathway for managing patient with Mpox infection summary, updated introduction, added HCID definition, added training requirements and updated all hyperlinks. Added mental health and ACS in the mpox pathway.
V1.1	09/2024	Rashima Hamdan, Senior IPAC Specialist Practitioner.	Page 7 Algorithm chart removed and link to VHF risk assessment added instead. Updated policy based on the updated guidance released 17.09.2024 NHS England » Infection prevention and control measures for clinically suspected and confirmed cases of mpox in healthcare settings . Mpox flowchart on page 7 amended and added the link to the updated guidance. Added updated PPE guidance and advice for patient to wear a mask and cover lesions on the flowchart in page 9. Updated section 1.5 on page 16. Added the link of the update guidance to section 6.4 on page 29.

Data Protection Act 2018 (UK General Data Protection Regulation legislation)

The Trusts have a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out; it must be opted in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679, contact the Information Governance Team.

- Cornwall Partnership NHS Foundation Trust: Email cpn-tr.infogov@nhs.net
- Royal Cornwall Hospitals NHS Trust: Email rch-tr.infogov@nhs.net

Equality and diversity

This document complies with the Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust equality and diversity statements. The statements can be found in the [Royal Cornwall Hospitals NHS Trust equality diversity and inclusion policy](#) and [Cornwall Partnership NHS Foundation Trust equality, diversity and inclusion statement](#).

Equality impact assessment form

Title of policy or document for assessment: Joint High Consequence Infectious Disease Policy V2.0

Who is affected by the document?

☒ Staff ☒ Patients ☒ Visitors ☒ Carers ☐ Other

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Concerns

Are there concerns that the procedural document could have a differential impact on the following areas?

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Age	☐ Yes ☒ No	
Disability	☐ Yes ☒ No	
Sex	☐ Yes ☒ No	
Gender reassignment	☐ Yes ☒ No	
Pregnancy and maternity	☐ Yes ☒ No	
Race	☐ Yes ☒ No	
Religion and belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Marriage and civil partnership	☐ Yes ☒ No	
Groups at risk of stigma or social exclusion such as offenders or homeless people	☐ Yes ☒ No	
Human rights	☐ Yes ☒ No	
Are there any other associated objectives of the document	☐ Yes ☒ No	

Name: IPAC Lead Practitioner.

Date: 18 August 2026.