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London Memorandum of Understanding

For managing complex infectious disease incidents and outbreaks that require a multi-agency response

Final September 2025

SIGNATORIES TO THE MOU

UK Health Security Agency (London Region)	**Signature:** **Name: Dr J. Yimmy Chow** **Designation: Regional Deputy Director- UKHSA London region** **Date: 11th July 2025**

NHS England London	**Signature:** **Name:** **Designation:** **Date:**

SWL **Integrated Care Board**	**Signature:** J Byrne **Name:** John Byrne **Designation:** Chief Medical Officer **Date:** 21/05/2025

[INSERT REGION] **Integrated Care Board**	**Signature:** **Name:** **Designation:** **Date:**

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[SIGNATORIES CONTINUED ON NEXT PAGE]

Directors of Public Health on behalf of Local Authorities			
Local Authority	**Signature**	**Name**	**Date**
Barking and Dagenham	signed	**Matthew Cole**	**02.06.2025**
Barnet	signed	**Janet Djomba**	**30.05.2025**
Bexley	signed	**Nicole Klynman**	**03.07.2025**
Brent	signed	**Dr. Melanie Smith**	**01.07.2025**
Bromley	signed	**Nada Lemic**	**09.06.2025**
Camden	signed	**Kirsten Watters**	**30.05.2025**
City of London	signed	**Sandra Husbands**	**23.05.2025**
Croydon	signed	**Ruth Hutchison**	**08.09.2025**
Ealing	signed	**Anna Bryden**	**06.05.2025**
Enfield	signed	**Dudu Sher-Arami**	**30.05.2025**
Greenwich	signed	**Samatha Bennett**	**26.06.2025**
Hackney	signed	**Sandra Husbands**	**23.05.2025**
Hammersmith and Fulham	signed	**Nicola Lang**	**30.06.2025**
Haringey	signed	**Will Maimaris**	**30.05.2025**
Harrow	signed	**Laurence Gibson**	**27.06.2025**
Havering	Agreed to use as guidance	**Mark Ansell**	**03.07.2025**
Hillingdon	signed	**Kelly O'Neill**	**07.05.2025**
Hounslow	signed	**Kelly O'Neill**	**01.05.2025**
Islington	signed	**Jonathan O'Sullivan**	**30.05.2025**
Kensington and Chelsea	signed	**Anna Raleigh**	**31.07.2025**
Kingston upon Thames	signed	**Sarah Ireland (CEO)**	**10.06.2025**
Lambeth	signed	**Ruth Hutt**	**26.06.2025**
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Merton	signed	**Russell Styles**	**08.07.2025**
Newham	signed	**Jason Strelitz**	**02.06.2025**
Redbridge	signed	**Gladys Xavier**	**02.06.2025**
Richmond upon Thames	signed	**Shannon Katiyo**	**02.07.2025**
Southwark	signed	**Sangeeta Leahy**	**26.06.2025**
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Tower Hamlets	signed	**Somen Banerjee**	**02.06.2025**

Waltham Forest	signed	**Joe McDonnell**	**10.07.2025**
Wandsworth	signed	**Shannon Katiyo**	**02.07.2025**
Westminster	signed	**Anna Raleigh**	**31.07.2025**

GOVERNANCE TABLE

Title	Memorandum of Understanding for complex outbreaks and single case/exposure that require a multi-agency response
Version	Version 1.0 (DRAFT TEMPLATE) – October 2024
Author	UKHSA on behalf of all signatory organisations
Document status	Draft template
Review date	This MoU will be reviewed annually, incorporating lessons learned from incident responses, debriefs, and exercises. The review will align with the London Resilience Implementation Group (LRIG), with lessons fed through LRIG for oversight. The MOU may be reviewed sooner when organisational responsibilities change significant issues are identified via incident debrief A tabletop/live exercise will be conducted as agreed by the partnership. The MoU will also be informed by other relevant exercises to ensure continuous I improvement.

Version Control	**Details**	**Amended**	**Date**
V1.0	Authors: Otibho Edeke-Agbareh, Sarah Robinson, Sam Perkins and Tania Misra		**16.09.2025**

Contents

1. INTRODUCTION

1.1 This MoU covers the stages of managing complex infectious disease incidents and outbreaks including surveillance, prevention, response, and recovery. It covers all settings in the community.

1.2 The MoU is between:

- Integrated Care Boards in London
- Directors of Public Health on behalf of their Local Authority
- NHS England London
- UKHSA (London Region)

1.3 For the purposes of this document, an infectious disease outbreak is defined as:

- An incident in which two or more people with the same infectious disease are linked by time, place, or common exposure.
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.

1.4 Other situations may not fit into the above outbreak definition but nonetheless require a rapid and comprehensive response. For the purposes of this document, such are referred to as infectious disease incidents and include:

- A single case of certain rare or high-consequence infectious disease.
- A single exposure to a suspected or confirmed high consequence infectious disease.
- A suspected, anticipated, or actual event involving microbial contamination of food or water.

1.5 A complex infectious disease incident (clusters, exposures and/or HCID) or outbreak has been defined as one that requires a multi-agency response which is covered by this MOU, recognising that not all incidents and outbreaks will be complex. This definition could apply to complex incidents or outbreaks of any size, from a single case of a high consequence infectious disease to a large outbreak across multiple geographies. Annex A outlines some examples of the type of outbreaks or incidents that may be covered by this MoU. This list is not exhaustive. The principles, roles and responsibilities outlined in this MOU should apply and should be used as the starting point for a multi-agency response.

1.6 Health protection outbreaks and incidents occur regularly and may require the rapid deployment of significant resources to deliver investigations and interventions to control them. Managing infections across different settings / local Health Protection systems may vary significantly therefore it must be acknowledged that the latest available guidance and Standard Operating Procedures (SOPs) should be followed.

2. OVERVIEW OF COMMITMENTS

2.1 This MoU is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from the provisions of this MoU. The parties enter into this MoU intending to honour their obligations.

2.2 All parties to this MoU have a statutory duty to cooperate with responding to outbreaks and incidents under the Civil Contingencies Act 2004.

2.3 All parties should adhere to the Health Overview and Scrutiny Committee principles[1] to ensure oversight and scrutiny across the health protection system to enable better outcomes for patients and residents and ensure accountability to local communities.

2.4 All parties agree that if a situation warrants mutual aid and coordinated support to ensure an effective response this will be discussed and agreed by the relevant organisations. This includes, but is not limited to, the sharing of resources, personnel, expertise, and logistical assistance as required. All support shall be provided in accordance with established public health protocols, emergency response frameworks, and applicable regulatory requirements. This agreement is made in the spirit of collaboration, resilience, and collective preparedness to safeguard London's communities.

2.5 Each party shall comply with data protection legislation at all times during the term of this MOU (https://www.gov.uk/data-protection).

2.6 The signatory parties agree to the commitments outlined in Table 1.

Table 1: MoU commitments

No	Organisation agree to these commitments:	Relevant section in the MoU
1	Adherence to the principles contained throughout the MoU for supporting incident and outbreak response	Section 2 and whole document
2	Agreement of the roles and responsibilities of each organisation at each stage of a multi-agency response	Section 6
3	To deliver the required actions within existing resources where feasible	Section 7
4	Funding of outbreaks and incident response according to existing commissioning / contracting arrangements where possible and always in discussion with local commissioners	Section 7
5	Ensuring that budgetary or contractual issues will not delay a necessary response, with issues resolved after the incident	Section 7
6	Adherence to the communications guidance described in the MoU	Section 8

[1] www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles

3. AIMS, OBJECTIVES AND SCOPE

3.1 The aim of this MoU is to ensure that there is an integrated streamlined system that delivers effective protection for the population of London from health threats based on clear accountabilities, collaboration and co-ordination at every level of the system, and robust and locally sensitive arrangements for planning and response.

3.2 Key objectives include:

3.2.1 Identification of the key roles and responsibilities of each organisation.
3.2.2 Development of a collaborative framework to support the rapid deployment of resources and action across London's healthcare and public health networks.
3.2.3 To ensure the coordinated deployment of personnel, expertise, and resources to contain and manage infectious disease incidents and outbreaks.
3.2.4 Clarification of funding mechanisms and commissioning responsibilities where possible.

3.3 The MoU will cover various stages of managing infectious disease outbreaks and incidents including surveillance, prevention, response, and recovery.

3.4 The illustrations table in Annex A outline some examples of the type of outbreaks or incidents that may be covered by this MoU. This list is not exhaustive, and the principles, roles and responsibilities will apply for any size outbreak or incident and should be used as the starting point.

3.5 Some health protection incidents are outside the scope for this MoU:

3.5.1 CBRNE terrorism incidents (deliberate chemical, radiological, biological, nuclear or explosive
3.5.2 HAZMAT incidents, which include accidental incidents involving hazardous materials
3.5.3 Pandemic response measures. If the outbreak begins to show pandemic potential – the MoU should be used in collaboration with Pandemic specific plans and guidance available for the London health system.

4. HEALTH EQUITY PRINCIPLES

4.1 To promote equitable outcomes in managing infectious disease outbreaks, all parties to this MoU commit to systematically identifying and addressing health inequalities during surveillance, planning, response and recovery phases.

4.2 By embedding the health equity commitments (section 4.4) into all stages of outbreak management, this MoU aligns with statutory obligations under the Public

Sector Equality Duty (Equality Act 2010) and supports the objectives of the Health and Social Care Act 2012.

4.3 Additional guidance in relation to migrant settings has been produced "UKHSA London Health Protection: Roles and Responsibilities for Supporting the Acute Response and Prevention of Outbreaks in Migrant Settings".

4.4 The following commitments aim to advance health equity and reduce preventable disparities in health outcomes:

- **Applying the CORE20PLUS Framework -** parties will identify populations at heightened risk, including those in deprived socio-economic settings, individuals with protected characteristics, and those within inclusion health groups. This ensures that no vulnerable group is overlooked in the response process.

- Ensuring Equitable Distribution of Resources - control measures, resources, and communication strategies will be allocated in a manner that minimises avoidable harm and prevents the exacerbation of existing inequalities. Decision-making will prioritise equity to address the specific needs of disadvantaged populations.

- Conducting Comprehensive Assessments – health disparities brought to light during a response will be captured via the IMT who will assign the follow-up for these issues to the appropriate teams/ partners. It will be the responsibility of those allocated to assess disparities brought to light e.g. in health outcomes, access to preventative measures, and any disproportionate impacts of response measures. These assessments will guide targeted interventions and resource allocation. The outcomes of these assessments and interventions will be captured within an In Action Review - Lessons Learned meeting before being agreed and provided to the London Resilience Partnership Learning and Implementation Review Group (LIRG).

5. TERM AND TERMINATION

5.1 This MoU shall commence on 16 September 2025 and will be reviewed in September 2026, unless required earlier due to notice of termination by one or more parties.

5.2 This MoU may be terminated by any party at any time by giving written notice to the other parties' signatories.

5.3 A party terminating this MoU shall give a minimum of three months' notice, and shall offer all reasonable assistance to ensure:

- An effective handover of activities, if the activities are not concluded at the time of termination.

- To mitigate the effect of termination on the other parties by fully co-operating with the other parties to achieve an effective transition without disruption to operational requirements.

5.4 The MoU will be reviewed annually, embedding lessons identified throughout the year. The UKHSA will facilitate this review via the London Health Resilience Partnership.

5.5 All organisations are expected to run familiarisation sessions within their organisation to ensure their provisions are well understood and effectively implemented. These activities will enhance preparedness and ensure a coordinated response to complex outbreaks and incidents that require a multi-agency response.

6. ROLES AND RESPONSIBILITIES

6.1 The primary roles of partner organisations relating to health protection incidents and outbreaks are described below.

6.2 The specific roles of signatory organisations at each stage of an outbreak or incident are outlined in Table 2.

6.3 Primary role of UKHSA:

6.3.1 Provision of specialist health protection advice: Provide management and leadership, supported by UKHSA national and regional epidemiological services, surveillance, specialist laboratory services and subject matter experts/ networks.

6.3.2 Co-ordination of multi-agency response efforts: The agency actively facilitates collaboration between local, regional and national public health bodies, emergency services and other key partners, ensuring a unified and coherent response during infectious disease outbreaks.

6.3.3 Maintenance of continuous operational readiness: Through an integrated 24/7, 365 days health security service, UKHSA underpins rapid risk assessment, early incident escalation and timely mobilisation of critical resources to mitigate emerging threats.

6.3.4 Strategic preparedness and resilience building: UKHSA drives the development, validation and continuous improvement of multi-agency emergency plans, training programmes and exercises, thereby enhancing collective capacity to respond to and recover from public health emergencies.

6.4 Primary role of Integrated Care Boards:

6.4.1 ICBs are the local commissioners of NHS-funded community and secondary care services, and are best placed to lead the NHS's preparation for and response to local infectious disease incidents. This applies to all community settings within the ICB footprint, including sites managed by the Ministry of

Defense for Afghan entitled persons, and by the Home Office for people seeking asylum.

6.4.2 ICBs are responsible for planning and funding NHS community and secondary care services, enabling them to integrate resources, align priorities, and address gaps across providers.

6.4.3 ICBs are also responsible for developing integration and collaboration within the local system, ensuring a coordinated response which combines clinical expertise, infection prevention, testing, vaccination, and treatment capabilities.

6.4.4 As Category 1 responders under the Civil Contingencies Act 2004, ICBs must assess the risk of emergencies and use this to inform contingency plans, put in place emergency plans and business continuity arrangements, and share information and co-operate with other local responders to enhance coordination and efficiency.(https://www.legislation.gov.uk/ukpga/2004/36/contents)

6.5 Primary role of Local Authorities:

6.5.1 Local Authorities have defined health protection functions and statutory powers in respect of environmental health, animal health, licensing and health & safety and defined functions and statutory powers in respect of housing and safeguarding vulnerable people.

6.5.2 The Director of Public Health (DPH) is responsible for the local authority's contribution to health protection matters, including the local authority's roles in planning for, and responding to incidents that present a threat to the public's health

6.5.3 In practice, this means that the DPH will provide information, advice, challenge and advocacy on behalf of their local authority, and promote the preparation of health protection arrangements by relevant organisations operating in their local authority area. The DPH, on behalf of their local authority, should be absolutely assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not being fully meet. In addition, the local authority provides and/or commissions services that will play a direct part in the response to incidents.

6.5.4 Local knowledge on Place and their communities including inequalities. Operational and strategic links that may be beneficial to responses e.g., education, care homes etc.

6.5.5 Advice on local comms and engagement and escalation if required e.g. Borough Resilience Forum (BRF).

6.6 Primary role of Environmental Health:

6.6.1 EHOs exercise Statutory responsibilities contained in various Acts and Regulations including Food law, Health & Safety, Public Health, Health Protection, Environmental Protection, Housing and others.

6.6.2 To ensure that Food Safety is adequately regulated in the borough.

6.6.3 To provide competent food safety advice and information.

6.6.4 To manage the food safety risks, arising from work activities, sporting, and other public events.
6.6.5 To prevent, control and investigate infectious disease incidents, food alerts, food poisoning outbreaks and complaints, if necessary, via the provisions of the three sets of Health Protection Regulations 2010.
6.6.6 Registered Medical Practitioners have a Statutory duty to inform the Proper Officer of the Local Authority (L/A) of cases of Notifiable diseases and associated incidents.
6.6.7 The majority of London L/As appoint UKHSA Consultants as Proper Officers for the receipt of Notifiable diseases and associated threats to Public Health.
6.6.8 To promote public health nutrition priorities to reduce the risk of rising obesity.
6.6.9 To deliver a food inspection and food sampling programme.

6.7 Primary role of NHS England:

6.7.1 NHS England has a role when community outbreaks are impacting on NHS service provision.
6.7.2 NHSE commissions all healthcare in prisons and places of detention
6.7.3 Commissions s7A immunisation services and some other health services.
6.7.4 Responsible for advising what NHS England commissioned services can support during an outbreak. Ensuring contracted providers will deliver an appropriate vaccination response to any vaccine-preventable incident or outbreak that threatens the public's health.

6.8 Primary role of Acute Trusts:

6.8.1 Acute Trust IPC team should lead or participate in an IMT depending on the incident or outbreak.
6.8.2 Taking samples, testing samples, clinical assessment and diagnosis, hospital infection prevention and control, including contact tracing of people exposed within health care settings (including staff, patients, and visitors).
6.8.3 Delivery of treatment and prophylaxis as appropriate.
6.8.4 Provision of High Consequence Infectious Disease (HCID) response through the NHS England HCID network.
6.8.5 Provide infectious disease/microbiology advice to support local incident management where needed.

6.9 Primary role of Primary Care (general practice, out of hours, community pharmacy):

6.9.1 Taking samples and sending for testing, clinical assessment and diagnosis, contact tracing of people exposed within the health setting (staff and patients).
6.9.2 Delivery of treatment and prophylaxis.
6.9.3 Responding to and supporting an outbreak as per contractual requirements.

6.10 Primary role of London Ambulance Service:

6.10.1 Provide emergency response to those who have life threatening health needs and to major incidents.
6.10.2 Specialist vehicles for transferring high risk patients (e.g., suspected HCID).

Table 2: Responsibilities of MoU signatory organisations

Stage	Roles and responsibilities of MoU partners
Preparation and surveillance	**1. <u>The UKHSA agrees to:</u>** a) Conduct health protection surveillance and disseminate to partners (including ICBs and LAs) b) Inform DPH of any significant health protection issues, advise of actions being taken (including outbreaks, incidents and cases of HCID occurring in their area.) and discuss actions required of DPH c) To respond to local authority DPH assurance requests around outbreak and incident management arrangements **2. <u>The ICB agrees to:</u>** a) develop pathways and ensure that services are in place for the diagnosis of infectious diseases in the community, including timely clinical assessment and collection, storage and transport of clinical specimens b) develop pathways and ensure that services are in place for prescribing and dispensing post-exposure chemoprophylaxis to contacts of infectious disease, including out-of-hours c) arrange for timely provision of post-exposure vaccination of contacts of infectious disease, and reactive vaccination of individuals and groups in response to an unfolding outbreak across a range of local settings d) develop local immunoglobulin pathways which are clearly defined and available to treat contacts of infectious disease when recommended by the Health Protection or National Immunisation teams, including for immunocompromised patients and children e) develop local pathways for the assessment and management of patients with suspected high consequence infectious diseases up to the point of diagnosis f) develop policies for decontamination of premises and homes as appropriate g) develop internal escalation and accountability pathways for health protection to ensure that issues reported by partners can be escalated appropriately h) consider the needs of different populations in relation to infectious diseases and making appropriate plans to meet these needs in the event of an incident or outbreak i) Disseminate information as required by UKHSA, NHS England or the Local Authority regarding the response to and prevention or control of health protection incidents and outbreaks across the local system

	j) To have in place a nominated point of contact/post and liaison to support with delivery of the above role and responsibilities. k) To respond to local authority DPH assurance requests around outbreak and incident management arrangements. **3. <u>The Local Authority agrees to:</u>** a) Have in place a way of understanding local health protection risks through local fora e.g. a health protection forum/board b) Act as a link to other settings for example, education, asylum seeker, care settings etc. c) Exercise powers under the health protection regulations to prevent or limit the spread of an infectious disease d) Support local preventative action to protect residents and communities from a range of threats, including but not limited to: ▪ supporting NHS led vaccination and immunisation programmes ▪ supporting outreach work with under-represented groups ▪ action to reduce inequalities and support those most in need ▪ Support local awareness and interpretation of health protection guidance and contribute to emergency planning training events in collaboration with local partners e.g. winter planning and training done through local resilience forums ▪ facilitating local partnerships (to support both preventative action and a health protection response), including through local forums ▪ As appropriate providing initial health protection advice and where specialist support is required signpost to UKHSA ▪ communicating risks and threats to local partners and the population., in partnership with ICB and UKHSA colleagues **4. <u>NHS England London agrees to:</u>** a) Support the development of incident and outbreak specific frameworks b) In the context of VPD outbreaks: Ensure vaccination provider organisations they commission are prepared to respond adequately to VPD incidents/outbreaks in the settings they serve, e.g., vaccination providers in school settings c) To respond to local authority DPH assurance requests around outbreak and incident management arrangement
Response	**1. <u>The UKHSA agrees to:</u>** a) Lead the health protection response to incidents / outbreaks b) Contribute to negotiations surrounding funding decisions as outlined in section 5 of this MoU and ensure mobilisation of vaccines through ImmForm where appropriate c) Ensure decisions taken regionally involving locally commissioned services are discussed with commissioners of that service d) Receive and investigate notifications (in line with Health Protection (Notification) Regulations 2010) e) Provide timely epidemiological reports to system partners including information about local incidents and outbreaks

	f) Provide expert epidemiological advice through field epidemiology teams to support incident / outbreak investigation g) Share information concerning incidents / outbreaks with the Local Authority through the Director of Public Health h) Convene an incident management team (IMT) for a regional or local response and participate in hospital or LA chaired IMTs and provide updates to IMT members until the incident / outbreak is declared over i) Provide advice and direction to NHS providers for: ▪ Swabbing/ sampling ▪ Post exposure vaccination ▪ Prophylaxis (e.g. antibiotics or antivirals) j) Coordinate regional behavioural insight led public communications / media response in collaboration with the Local Authority, ICBs and NHSE **2. <u>The ICB agrees to:</u>** a) Participate (as required) in IMTs to help inform decisions about the appropriate level of NHS response from providers and any ICB resources that might be needed b) Contribute to negotiations and agreements surrounding funding decisions as outlined in section 5 of this MoU c) Co-ordinate the primary care response to the incident or outbreak d) Commission clinical support for the prescribing and administration of medication and specialist infection control advice where required, depending on the nature of the incident, and as determined by the IMT. It is noted that specialist infection control resources vary across the ICB/ICS. Each ICB will respond as appropriate to requests for specialist advice and any challenges in securing this will be raised at the IMT **3. <u>The Local Authority agrees to:</u>** a) With the UK Health Security Agency, provide local leadership in responding to infectious disease incidents and outbreaks b) Participate (as required) in IMTs to help inform decisions about the appropriate level of all partners response from providers and any LA resources that might be needed c) Contribute to negotiations and agreements surrounding funding decisions as outlined in section 6 of this MoU and ensure relevant services commissioned by local authority are mobilised as appropriate (e.g., sexual health, drug and alcohol, school nursing, health visiting) d) Support the development and dissemination of general communications to/with their local population to reduce risk e) Being the conduit across the Local Authority and to local communities and settings, establishing and maintaining relationships at a local level (e.g. Businesses, Community Groups, Asylum Seeker Accommodation Hotels) f) With the Food Standard Agency and the UKHSA, investigate clusters and outbreaks of foodborne infectious diseases

	g) Provide specialist help and advice on the environmental aspects of the incident or outbreak h) When required, undertake timely inspections, collection of specimens and investigations of implicated premises via Environmental Health and/ or Health and Safety in the LA for example food-related sampling, legionella incident, lead sampling etc. i) As an H&S enforcement authority, execute the statutory duty to investigate infectious disease and non-infectious environmental hazards linked to some workplace and other high-risk settings (those not enforced by HSE), regulate workplace risk assessment processes and exercise powers under the Health and Safety at Work Act 1974. j) Prepare and deliver briefings to Local Authority colleagues and Elected Members. **4. <u>NHS England London agrees to:</u>** a) Participate (as required) in IMTs to help inform decisions about the appropriate level of NHS response from providers and any ICB/NHSE resources that might be needed b) Contribute to negotiations surrounding funding decisions as outlined in section 5 of this MoU and ensure relevant services commissioned by NHS England are mobilised as appropriate (e.g., vaccinations, prison health). c) Ensure decisions taken regionally involving locally commissioned services are discussed with commissioners of that service. d) Support ICBs to coordinate any response required from provider organisations such as Community Trusts and/or Acute Trusts. e) Support regional coordination of NHS resources, where required (note not all cases of infectious disease will require a regional response, regional involvement must be proportionate and follow the principle of subsidiarity)
Recovery	The recovery phase is critical in restoring public health, community well-being, and system functionality following a complex outbreak or incident. Recovery actions should commence as early as practicable during the response phase, with an emphasis on multi-agency collaboration, sustainability, and resilience. **Key Objectives:** ▪ **Community and System Recovery**: Ensure health, social, and economic recovery for affected populations while restoring essential services. ▪ **Learning and Adaptation**: Incorporate lessons learned into future preparedness and response plans. ▪ **Equity in Recovery**: Assess health inequalities and ensure the inclusion of vulnerable and underserved populations.

	Multi-Agency Roles and Responsibilities: ▪ **UKHSA**: Lead the health protection aspects of recovery, including ongoing surveillance, public health messaging, and post-incident reviews. Provide technical support for health equity initiatives identified during recovery. ▪ **Local Authorities**: Support community recovery, coordinating with local stakeholders. Provide leadership in rebuilding trust and resilience within communities. Lessons learned reports to go through appropriate structures e.g., health protection forums and/or Resilience Boards. ▪ **NHS England and Integrated Care Boards (ICBs)**: Ensure healthcare services are restored and enhanced to manage ongoing or delayed health needs. This includes follow-up care for affected individuals and integration of lessons learned into clinical commissioning strategies. ▪ **Other Partners**: Collaborate to provide logistical support, communication strategies, and psychosocial services to communities, including the voluntary, community and faith sector. **Best Practice Principles:** ▪ **Early Engagement**: Recovery planning should involve stakeholders from the onset of the incident, ensuring alignment with response efforts and clear role definitions. ▪ **Comprehensive Debriefing**: Conduct post-incident debriefs to capture actionable insights, involving all relevant agencies. These findings should be shared with the London Resilience Implementation Group (LRIG) and incorporated into updated policies and protocols. As well as being utilised to provide updated versions of this MoU. ▪ **Transparent Communication**: Provide regular updates to the public and stakeholders about recovery progress, addressing concerns and managing expectations effectively. ▪ **Resource Allocation**: Ensure resources are equitably distributed to address identified disparities and enhance the resilience of at-risk groups. ▪ **Continuous Monitoring**: Maintain active surveillance to identify delayed health impacts or new outbreaks, ensuring swift intervention if needed. **Implementation Framework:** ▪ **Incident Management Team (IMT)**: Transition responsibilities to a Recovery Coordination Group with representatives from all signatory agencies. ▪ **Health Equity Assessments**: Evaluate the recovery process's impact on vulnerable populations, applying frameworks such as CORE20PLUS. ▪ **Performance Monitoring**: Develop metrics to assess recovery progress and outcomes, reporting findings to stakeholders

	▪ National guidance has been published to support this process [Lessons Management Best Practice Guidance]

7. FUNDING OUTBREAK AND INCIDENT RESPONSE

7.1 For many outbreaks / incidents, a coordinated response can be achieved through usual commissioning / contracting authorities (Table 3).

7.2 Commissioners should ensure, through contractual arrangements with provider organisations, that resources are made available to respond to the level required, and the financial cost of that response is covered within contracts, or where not covered the healthcare provider, will still respond and take part in the process for recouping monies once the incident or outbreak is over.

7.3 This is not necessarily an automatic contribution and agreement might need to be reached following discussion with the relevant commissioner of the service required.

7.4 Decisions required for any regional response must always be made in collaboration with local commissioners.

7.5 All commissioning/ contracting authorities and healthcare providers of services are responsible for working in partnership to ensure any action needed to respond to an outbreak / incident is effective and timely.

7.6 If the responsibility is not clear, the parties will need to agree which organisation is best placed to provide funding (in terms of legal responsibilities) or to agree to a cost sharing agreement. This should be agreed in a timely manner so as to not disrupt providing an effective response.

7.7 The NHS Standard Contract 2024/252 states that: The Provider must provide whatever support and assistance may reasonably be required by the Commissioners and/or NHS England and/or the UK Health Security Agency in response to any national, regional or local public health emergency or incident.

7.8 The OHID/UKHSA Integrated sexual health service specification (March 2023) contains a section that states that the provider and sub-contracted providers (including laboratories) should comply with all requests from relevant national bodies (including, but not limited to NHSE, MHRA and UKHSA) relating to the management of national and local incidents and outbreaks. Depending on findings of initial analysis, further investigation and public health action may be indicated; this will usually be led by the local public health or health protection team. Actions may include case finding, enhanced surveillance or public health control measures such as vaccination or testing.
(https://assets.publishing.service.gov.uk/media/6412fa41d3bf7f79d7b78f5d/Integrated-sexual-health-service-specification-2023.pdf)

7.9 The principle of immediate action should apply. To ensure timely responses, commissioning or funding issues should not delay immediate public health action. All partners agree to a "respond first, resolve cost" approach, allowing rapid response to health emergencies with financial details addressed subsequently. This principle ensures London's health services can act swiftly in the face of urgent threats, protecting the public without procedural delay.

Table 3: Commissioning or contracting authority for services relevant to outbreak or incident management

Organisation	Services
ICBs ***This includes the treatment of infectious diseases and immunisation outside routine s7A programmes***	▪ Planned hospital care ▪ Urgent and emergency care ▪ Rehabilitation care ▪ Community health services ▪ Infection Prevention Control (IPC) Advice ▪ Mental health ▪ Learning disability ▪ GP primary care services ▪ Locally commissioned services ▪ Extended GP hours over and above the national contract ▪ Out of Hours GP services ▪ NHSE Delegated Pharmacy and Optometry contracts ▪ NHSE Delegated Dental services (primary and secondary)
NHS England	▪ Routine population immunisation programmes included in s7A ▪ Services falling under the new CYPCIS service (Children and Young People's Community Immunisation Service). Note that while NHS England includes in the contract with the provider of CYPCIS that the provider needs to contribute to outbreak response, NHS England does not fund immunisations provided in outbreak response ▪ Routine population screening programmes included in s7A ▪ Child health information systems (part of Section 7A) ▪ Specialised commissioned services which includes HIV treatment ▪ Health Services in Prisons and Places of Detention ▪ Health Services for Armed Forces personnel
Local Authorities ***Most are delivered by NHS providers, although funded by Public Health***	▪ Drug and alcohol treatment services ▪ Sexual health services ▪ Some services for children aged 0-19 in the community (e.g., health visitors and school nurses) ▪ Other public health services e.g. health improvement and community engagement networks.

8. COMMUNICATIONS AND ENGAGEMENT

8.1 Comms will be agreed for each incident / IMT and signatory organisations should then cascade as appropriate.

8.2 Health Equity Principles in Communications:

8.2.1 Prioritising Accessible Communication - guidance and communication materials will be tailored to diverse populations, ensuring accessibility through translations, easy-read formats, and inclusive dissemination strategies. This approach will reduce barriers to understanding and will support effective engagement across different communities.

8.2.2 Collaborating with Trusted Partners - parties will actively engage with trusted partners, including community organisations and local networks, to co-develop and deliver public health messages. This collaborative approach will ensure messages are effectively disseminated and culturally sensitive.

8.2.3 Clear and effective communication to the public, stakeholders and partners is important in the management of outbreaks and incidents. WHO guidelines consist of five principles to guide communication during outbreaks and other emergencies: building trust, announcing early, being transparent, respecting public concerns and planning in advance.

8.3 Communication and engagement pathways will vary depending on the type of outbreak or incident.

8.4 UKHSA

8.4.1 If an IMT has been established, and unless otherwise agreed upon within the IMT, UKHSA will set the communications strategy and lead the development of public communications and media statements. These messages will be prepared in collaboration with all involved partners to ensure consistent, clear, and accurate public messaging.

8.4.2 They have a specific role to keep the DPH informed of incidents and outbreaks occurring in their area.

8.4.3 They may develop communications guidance for partners for large scale incidents and outbreaks affecting a large region.

8.4.4 They will communicate to the public via the media and regional or national campaigns.

8.5 Local authorities and ICBs will play a key role in sharing insights on the community and then disseminating general messages out to local populations. These communications will align with national or regional messaging.

8.6 Local authorities

8.6.1 The DPH will communicate to partners through existing groups, e.g. the Health Protection Forum / Local Health Resilience Partnership and will provide updates to elected members.

8.6.2 They may coordinate local campaigns in conjunction with ICBs or immunisation teams, for example to improve vaccination coverage.

8.6.3 They will communicate to a range of community settings such as schools and asylum seeker hotels and will utilize existing communication channels to communicate with communities.

8.6.4 They will support communication to a number of professionals and settings such as schools, nurseries, health visitors, Special Education Need (SEN) Schools and nurseries, children centres, local businesses and wider workforce as needed.

8.6.5 Amplify and widen the reach of communications being led by other partners.

8.7 ICBs

8.7.1 Will communicate to partners through existing groups, e.g. IPC Boards, and will communicate with primary care including relaying relevant feedback and concerns from primary care and other providers.

8.7.2 They will coordinate local campaigns in conjunction with Public Health teams and will utilise existing communication channels to communication with local patients.

8.8 NHS England

8.8.1 Will ensure appropriate regional and national communications, in partnership with UKHSA and ICBs, as appropriate to the situation

Annex A – Illustrative Case Studies

NOTE 1. This is not an exhaustive list, but one based on our current experience of outbreak and incident management and will be kept under review.

NOTE 2. These are illustrative and the principles would apply to other infections that present with similar scenarios.

NOTE 3. The timescale for response is likely to be urgent, based on the pathogen concerned.

NOTE 4. Due to variation in how ICBs are structured, it should be left to ICBs internally to decide on the most appropriate structures and roles in terms of accountability for the commissioning and delivery of clinical outbreak and incident response. Each ICB may consider having a named person who is accountable for the outbreak response.

Scenario 1: Avian influenza

1.1 Background

Since October 2021, there has been an unprecedented outbreak of highly pathogenic avian influenza (HPAI) of the subtype H5N1 in wild birds within the UK and internationally. In addition to affecting wild bird populations, the virus has passed into farmed and captive flocks leading to a large number of infected premises (IP).

Within Europe, a small number of people have tested positive for H5N1 over the past year, all of whom were living with or working with H5N1-infected poultry. All cases were asymptomatic when tested.

Health Protection teams (HPTs) lead the local human public health response to HPAI incidents involving large-scale commercial poultry establishments, smaller backyard premises or wild birds. Responding to these incidents requires close collaboration with the Department for Environment, Food and Rural Affairs (Defra), the Animal and Plant Health Agency (APHA), local authority and the local NHS.

This scenario discusses the response to human exposure to Avian influenza (in captive or wild birds or to human cases). Contacts of infected birds are likely to include those individuals who were exposed prior to the identification of an incident, such as: farm workers, owners of backyard flocks or other people resident at the premises who have had exposure to birds or infected materials, veterinary staff, members of the public who have had direct contact with a probable or confirmed wild bird case. The scope and size of the response i.e. the number of people exposed and settings of exposure, is not possible to predict. A similar response will be required for contacts of human avian flu cases and will include the likelihood of exposure in hospital, with healthcare workers exposed.

1.2 Cases and contacts

A flock of dead swans found near a lake in a public park. Following this, a member of the public contacted the environmental health department of the borough. The birds were collected by a member of staff who did not wear appropriate PPE. The member of the public tried to move close to the birds to try to collect them together but had not touched them and had been less than a metre from the dead flock.
Or
Detection of bird flu in a farm just outside London where most of the workers are residents of London.

1.3 Actions Required

Contacts of a probable wild bird case or confirmed H5N1 in any birds who were not wearing appropriate PPE or had a breach in PPE at the time of exposure should:

- receive antiviral prophylaxis if within 7 days of exposure
- receive active follow-up if within 10 days of exposure
- be tested (swabbing) if symptomatic or for asymptomatic surveillance

1.4 Organisations involved and their roles

UKHSA

- Provide evidence-based advice, guidance, and support on health protection measures
- Instigate a multiagency teleconference
- Categorisecontacts based on type of exposure
- Active/passive monitoring of exposed persons
- Surveilance (by swabbing) for asymptomatic contacts
- Identify any symptomatic contacts
- Arrange courier for swabs/samples from case and contacts tested in the community, to reference laboratory
- Work with APHA/DEFRA who lead on non-human aspects of incident and undertake risk assessment to identify exposed persons
- Draft communications for contacts and for healthcare providers for management of the contacts

NHS England (under guidance from the IMT or UKHSA)

- Manage interface with NHS England National

ICB (under guidance from the IMT or UKHSA)

- Mobilise workforce for
    - clinical assessment and testing of any contacts, keeping in mind PPE requirments
    - prescribing and dispensing of antivirals. Antivirals may need to be delivered to the contacts, as they contacts may be instructed to isolate
    - Conveying symptomatic contacts to hospital for assessment and swabbing, if not able to manage or isolate in the community
    - Support Trusts with exposures in healthcare settings which will also need consideration of testing, prophylaxis, monitoring and possibly, isolation

Local Authority

- DPH assurance role on health protection arrangements
- EHOs to support with the implementation of control measures, such as leaving signage where infected birds were found.
- Liaison with LA housing team if additional isolation needed for contacts to explore possibilities within existing statutory housing duties
- Manage public messaging, media, and communication

1.5 Additional organisations involved in this scenario

Employers at the setting (e.g., farm / poultry business)

- Employers / contracting organisations are responsible for ensuring that staff have access to PPE, are trained in PPE donning, doffing and disposal, and appropriate biosecurity and infection prevention and control. They should have appropriate assurance in place for their policies and procedures
- Employers and contracting organisations are responsible for ensuring that employees have access to an occupational health service who can provide management, including pathways to allow access to clinical care for diagnostic testing and prescription of treatment-dose antivirals, if symptomatic with avian influenza symptoms

Representation from the Animal and Plant Health Agency (APHA)

- If it is a farm or premises they will coordinate the response and ensure Occupational Health (OH) provision for the responders
- They will also lead on general public facing communication on the incident

1.6 Health equity concerns

- Language barriers that impede engagement with exposed members of staff will require the use of interpreters, language line, translated information resources
- Exposed people not registered with a GP will need to fast-track their GP registration or provide temporary registration

1.7 Key discussion points

To consider for discussion and inclusion in ICB and LA outbreak / incident management plan or operational plan – who holds accountability for stated actions within each organisation listed in Section 1.4 above.

Scenario 2: High Consequence Infectious Disease – e.g. Middle East Respiratory Syndrome (MERS)

2.1 Background

Definition of a High Consequence Infection Disease (HCID)
In the UK, a high consequence infectious disease (HCID) - High consequence infectious diseases (HCID) - GOV.UK) is defined according to the following criteria:

- acute infectious disease
- typically has a high case-fatality rate
- may not have effective prophylaxis or treatment
- often difficult to recognise and detect rapidly
- ability to spread in the community and within healthcare settings
- requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely

List of high consequence infectious diseases
A list of HCIDs has been agreed by the UK 4 nations public health agencies, with advisory committee input as required.
MERS-CoV is a HCID. It is a zoonotic respiratory virus and the causative agent of Middle East respiratory syndrome (MERS). MERS-CoV is a coronavirus, first identified in Saudi Arabia in 2012.

2.2 Case

A confirmed case of MERS is reported in a 70 y old man who has returned from Saudi Arabia, which is one of the high-risk countries. The risk assessment carried out with the case has revealed that the case has been to the theatre with his family while infectious. He was also seen in person at a walk-in health centre before he reported to a hospital ED during his infectious period. He lives with his family, which includes his wife, son, daughter-in-law, and two grandchildren aged 2-½ y and 2 months respectively. His son and daughter-in-law are healthcare workers. He is now isolated in a specialist ID unit in a hospital in London.

2.3 Actions Required

Actions (MERS-CoV: public health investigation and management of close contacts of confirmed cases - GOV.UK) related to control measures to mitigate the spread of this infection include identification of close contacts and their follow up:

Close contact is defined as (from date of illness onset in index case and throughout their symptomatic period) MERS-CoV: public health investigation and management of close contacts of confirmed cases - GOV.UK

- Any person who had prolonged face-to-face contact (>15 minutes) with a symptomatic confirmed case of MERS CoV in a household or other closed setting
- Health or social care worker who provided direct clinical or personal care or examination of a symptomatic confirmed case of MERS-CoV, or was within 2m of a symptomatic case or had direct contacts with body fluids from a symptomatic case, for any length of time:

- advising self-isolation of contacts
- active monitoring for 14 days post exposure
- travel restrictions for 14 days
- risk assessment for work, education, other settings and possible exclusion advice
- information and advice to contacts and wider communications on exposure

2.4 Organisations involved and their roles

UKHSA

- Provide evidence-based advice, guidance, and support on health protection measures
- Instigate multiagency teleconference
- Identification of contacts based on risk of exposure
- Advising on minimising further exposure and reducing the likelihood of infection spread
- Follow up of high-risk contacts 14 days post exposure
- Border health considerations if the case has travelled during their infectious period
- Draft communications
    - for case
    - for contacts
    - for healthcare providers for management of the case and contacts

ICB (under guidance from the IMT or UKHSA)

- Fund isolation of high-risk contacts if deemed necessary
- Fund clinical assessment of paediatric contacts

Local Authority

- Support outreach to affected sectors
- Facilitate public health messaging as directed

2.5 Additional organisations involved in this scenario

EHOs of the LA where the theatre is located to risk assess the theatre on exposed people there, and to liaise with the theatre owner to identify contacts and ensure dissemination of messages.

Occupational health provider, IPCT representative, manager for the providers / organisations that runs the Walk-in Centre and the ED respectively, to ensure that any staff or patients exposed are identified, risk assessed and followed up based on their exposure risk.

Occupational health providers for the two household contacts who are healthcare workers may also need to be involved, based on their clinical status.

2.6.1 Other similar scenarios

Additional partners who would be part of the OCT / ICT if this case had attended any of the following settings during his infectious period and exposed others who would need to be risk assessed and followed up as contacts:

- University or college - university or college health and safety (H&S), university or college HR
- School - headteacher, LEA representative
- Workplace - HR and H&S representative
- Care Home - Adult Social Care, IPC (if available), Care Home Manager, EHO
- Healthcare setting Hospitals - Hospital IPCT, Infection Control Doctor, Occupational health

- Healthcare setting GP - GP or manager / representative from GP surgery, Primary Care QA team
- Community setting (e.g., faith centre) - representative from the faith centre or community group / venue, EHO
- Asylum seeker accommodation - representative from Home Office, manager of the accommodation
- Detention centre (e.g., prison) - there are different pathways for prison health issues, would involve NHSE (as the commissioner of prison healthcare services), prison healthcare provider, prison doctor or nurse or both, prison manager
- Sexual networks - sexual health commissioners, representative from a setting if it was a particular venue e.g., a nightclub, or a healthcare representative if seen by a GUM physician or nurse

2.7 Health equity concerns

- Some contacts may not be registered with a GP and the response needs to consider arrangements to fast-track their GP registration or source an alternative provider and to agree who would pay for this?
- If there are symptomatic children contacts, we would consider involving paediatric nurses and doctors for their clinical assessment and this would entail a commissioning discussion as their time would need to be paid for
- Consideration of strict confidentiality for the case and their contacts and sensitivity in informing the HCW contacts' workplace
- Welfare checks and / or financial assistance for contacts who may lose wages due to isolation requirements.

2.8 Key discussion points

To consider for discussion and inclusion in ICB and LA outbreak / incident management plan or operational plan – who holds accountability for stated actions within each organisation listed in Section 2.4 above.

Scenario 3: Diphtheria in Asylum Accommodation

3.1 Background

Diphtheria, although rare in the UK, can result in significant morbidity and mortality when untreated. For most single cases of confirmed or probable diphtheria, an IMT is convened. Close contacts include household type contacts, kissing/sexual contacts, and healthcare workers with direct exposure to respiratory droplets or undressed wounds (in cutaneous cases) where there has been splash/droplet contamination.

3.2 Case

A case of diphtheria is reported in a young male asylum seeker. He is living in shared asylum accommodation with several other people, some of whom are registered with a GP practice and some who are not. There is a shared kitchen and living space, with mixing of contacts which would classify them as close contacts.

3.3 Actions required

Actions related to clinical investigation and control measures include:

- Swabbing (of the nose, throat, as well as skin swabs if appropriate)
- Antibiotic chemoprophylaxis
- Immunisations as appropriate
- Antibiotic regime and post-antibiotic follow up swabbing of contacts identified as asymptomatic carriers, to ensure eradication

3.4 Organisations involved and their roles

The different organisations involved would need to be part of the IMT that will be convened and expected to deliver as per their roles (as outlined in Section 5 of the main document).

<u>UKHSA</u>

- Provide evidence-based advice, guidance and support on health protection measures
- Instigate multiagency teleconference
- Source Diphtheria anti-toxin as required (from national stocks)
- Draft communications for
    - case, contacts, and healthcare providers
    - wider inform and advise communications for others at the setting.

<u>NHS England (under guidance from the IMT or UKHSA)</u>

<u>ICB (under guidance from the IMT or UKHSA)</u>

- Mobilise primary care staff for:
    - Clinical assessment (in primary and secondary care)
    - Swabbing
    - Antibiotic chemoprophylaxis
    - Antibiotic regime and post-antibiotic follow-up swabbing of contacts identified as carriers
- Ensure stocks of DTP vaccine are available

- If outside contract, commission any extra capacity as required in discussion with other commissioners

Local Authority

- DPH assurance role over the risks to public health in the wider community
- Facilitate dissemination of communications to wider public if required
- Facilitate partner understanding of national guidance on migrant health
- facilitate liaison with the community and voluntary sector where appropriate

3.5 Additional organisations involved in this scenario

Home Office contracted provider

Actions as per guidance for short term asylum seeker (AS) settings

- Operationalise actions related to dissemination of communications
- Facilitate access to cases and contacts
- Support implementation of IPC measures in accommodation where outbreaks are reported as per recommendations made
- Ensure staff have access to appropriate PPE and are trained in its use
- Encourage staff to be up to date with their vaccinations

AS Setting

Actions as per guidance for short term AS settings

- support residents to seek urgent healthcare if unwell, including arranging transport when necessary
- Ensure IPC measures are put in place as advised by the HPT/ OCT/ ICT
- Provide a safe working environment for staff

3.6 Other similar scenarios

Additional partners who would be part of the OCT / ICT if this case of Diphtheria was in the following settings:

- University or college - university or college health and safety (H&S), university or college HR
- School - headteacher, LEA representative
- Workplace - HR and H&S representative
- Care Home - Adult Social Care, IPC (if available), Care Home Manager
- Healthcare setting Hospitals - Hospital IPCT, Infection Control Doctor, Occupational health, Clinician
- Healthcare setting GP - GP or manager / representative from GP surgery, Primary Care QA team
- Community setting (e.g., faith centre) - representative from the faith centre or community group / venue
- Detention centre (e.g., prison) - there are different pathways for prison health issues, would involve NHSE (as the commissioner of prison healthcare services), prison healthcare provider, prison doctor or nurse or both, prison manager

3.7 Health Equity Concerns

- It is likely that a large proportion of asylum seekers are not registered with a GP and the response needs to consider arrangements to fast-track their registration or source alternative provider and who would pay for this?

- If there are a large number of children contacts, we would consider involving paediatric nurses and doctors for their clinical assessment and this would entail a commissioning discussion as their time would need to be paid for.
- Language barriers need to be addressed and attention paid to translated resources, access to interpreters or language line for the clinical response and communication with cases and contacts.
- Consideration to cultural perceptions and attitudes towards healthcare seeking and possible issues of trusting authority figures, as well as lack of understanding of healthcare systems and pathways.

3.8.1 Suggested discussion point

To consider for discussion and inclusion in ICB and LA outbreak / incident management plan or operational plan – who holds accountability for stated actions within each organisation listed in Section 3.4 above.

Scenario 4: iGAS in a nursery

4.1 Background

Group A Streptococcus infection can cause a range of clinical manifestations ranging from non-invasive conditions such as impetigo or scarlet feature to life-threatening invasive disease, such as necrotising fasciitis. Cases primarily are sporadic, however outbreaks (2 or more cases of confirmed or probable iGAS infection linked by place, person, and time) can occur.

4.2 Cases

Two cases of iGAS have been reported in two 3-year-old children who both attend the same nursery. The local HPT has conducted a risk assessment, and identified there is also co-circulating chickenpox, with 3 children in the last week reporting new cases of chickenpox.

An incident management team has been convened. Other control measures such as infection prevention control advice, cleaning of the environment have been actioned, and seeking expert advice have been actioned.

4.3 Actions required

The clinical interventions required include:

- Targeted swabbing of contacts (such as staff and children who have had contact with cases) for group A Strep
- Chemoprophylaxis (targeted or mass, depending on the risk assessment +/- guidance from the national teams) with antibiotics
- Varicella vaccination for (a) children and (b) staff with no history of chickenpox – 2 doses to be offered, 4-8 weeks apart

4.4 Organisations involved and their roles

The different organisations involved would need to be part of the OCT / ICT that will be convened and expected to deliver as per their roles (as outlined in Section 5 of the main document):

<u>UKHSA</u>

- Provide evidence-based advice, guidance and support on health protection measures
- Instigate multiagency teleconference
- Draft communications for sharing with parents / carers and staff at the school
- Draft communication for healthcare providers for management of cases and contacts

<u>NHS England (under guidance from the OCT / ICT or UKHSA)</u>

<u>ICB (under guidance from the OCT / ICT or UKHSA)</u>

- Mobilising of workforce for:
    - Clinical assessment (in primary and secondary care)
    - Swabbing (for group A Streptococcus)
    - Antibiotic chemoprophylaxis (for iGAS)

- Liaise with and support the relevant Community Immunisation Team (for children and young people = 0-19) to ensure their timely response in an outbreak/incident (responsibility to mobilise staff, but funding sits with ICB colleagues)
- Fund and arrange collection and delivery and administration of the swabs, and antibiotics for chemoprophylaxis as listed above

Local Authority

- DPH assurance role on health protection arrangements.
- Support media and communications, as agreed at the IMT
- Support communication to schools, school nurses, health visitors, children's centres and wider workforce as required and applicable

4.5 Additional organisations involved in this scenario

School / Nursery

- Facilitate access to cases' and contacts' details if requested
- Operationalise actions related to IPC and exclusion measures
- dissemination of communications

4.6.1 Health Equity Concerns

- It is likely that there are language barriers, we would need to consider translation services and engagement with community leaders or representatives
- If there are a large number of children contacts, we would consider involving paediatric nurses and doctors for their clinical assessment and this would entail a commissioning discussion as their time would need to be paid for.

4.7 Suggested discussion point

To consider for discussion and inclusion in ICB and LA outbreak / incident management plan or operational plan – who holds accountability for stated actions within each organisation listed in Section 4.4 above.

Scenario 5: Hepatitis A in community settings

5.1 Background

In developed countries, hepatitis A viral infection is transmitted commonly through person-to-person spread, through the faecal-oral route. It can also be spread through contaminated food and water, through sexual intercourse, and through injecting drug use.

The clinical course of hepatitis A infection can vary, with complications including the rare occurrence of fulminant hepatitis and maternal complications when infected during pregnancy.

Examples of outbreaks of Hepatitis A include two or more cases in a care home, two or more cases in different year groups of a primary school (who are not close contacts outside of the school), a number of cases linked to a single event/location/food item, two or more cases in different households but within the same social/community network or two or more cases within a certain group, e.g., sexual networks.

5.2 Cases

Hepatitis A cases in an educational setting (day care, nursery or school), in a care home, or in relation to sexual transmission in high-risk groups - where there is spread in the community.

5.3 Actions required

The clinical interventions related to control measures in a Hepatitis A outbreak include:

- Administration of monovalent Hepatitis A vaccination for unvaccinated contacts
- Administration of HNIG and the hepatitis A vaccine for vulnerable groups (contacts aged 60 years and over, contacts with chronic liver disease, contacts with pre-existing chronic hepatitis B or C infection, or immunosuppressed contacts)

5.4 Organisations involved and their roles

UKHSA

- Provide evidence-based advice, guidance and support on health protection measures.
- Instigate multiagency teleconference.
- Source immunoglobulin (HNIG) for vulnerable contacts from national stocks if not available locally.
- Draft communications
    - for parents / carers and staff - if at the school
    - for residents and staff – if at a care home
    - on preventative messages for high-risk sexual networks
    - for healthcare providers for management of cases and contacts

NHS England (under guidance from the IMT or UKHSA)

- Liaise with and support the relevant Community Immunisation Team (for children and young people 0-19) to ensure their timely response in an outbreak/incident (responsibility to mobilise staff, but funding responsibility sits with ICB colleagues).
- Work with provider and ICB to ensure stocks of hepatitis A vaccine are adequate.

ICB (under guidance from the IMT or UKHSA)

- Fund and mobilise appropriate workforce, working with NHSE and commissioners, to provide hepatitis A vaccine or administer immunoglobulin (HNIG), as required to those identified at risk (except if outbreak in relation to sexual health).
- Liaise with and support primary care staff (for adults/children) to ensure their timely response in an outbreak/incident.
- Fund and arrange couriers for collection and delivery of hepatitis A vaccines or immunoglobulin (HNIG) from community/hospital pharmacies to appropriate setting.

Local Authority

- If an outbreak is related to sexual health (SH), fund and mobilise appropriate workforce, working with ICB and NHSE, to provide hepatitis A vaccine, as required, in discussion with SH commissioning team.
- Liaise with and support the Community Immunisation Team (for children and young people as part of 0-19 team) to ensure their timely response in an incident/outbreak, within capacity as agreed with providers.
- Manage public messaging, media, and communication.
- Support communication to schools, school nurses, health visitors, special school nurses, children's centres and wider workforce as required.

5.5 Other similar scenarios

Additional partners who would be part of the OCT / ICT if this outbreak of Hepatitis A, based on possible settings:

- University or college - university or college health and safety (H&S), university or college HR
- School - headteacher, LEA representative
- Workplace - HR and H&S representative
- Care Home - Adult Social Care, IPC (if available), Care Home Manager, EHO
- Healthcare setting Hospitals - Hospital IPCT, Infection Control Doctor, Occupational health
- Healthcare setting GP - GP or manager / representative from GP surgery, Primary Care QA team
- Community setting (e.g., faith centre) - representative from the faith centre or community group / venue, EHO
- Asylum seeker accommodation – representative from Home Office, manager of the accommodation
- Detention centre (e.g., prison) - there are different pathways for prison health issues, would involve NHSE (as the commissioner of prison healthcare services), prison healthcare provider, prison doctor or nurse or both, prison manager
- Sexual networks - sexual health commissioners (already mentioned previously), representative from a setting if it was a particular venue e.g., a nightclub, GUM physician or nurse

5.6 Health Equity Concerns

- It is likely that there are language barriers for contacts in the care home (workers from overseas) and possibly in schools as well. We would need to consider translation services and engagement with community leaders or representatives.
- If there are a large number of children contacts, we would consider involving paediatric nurses and doctors for their clinical assessment and this would entail a commissioning discussion as their time would need to be paid for.

- Sensitivity and stigma as well as access issues related to sexual health, e.g., limited routes to disseminate information to sexual contacts.

5.7 Suggested discussion point

To consider for discussion and inclusion in ICB and LA outbreak / incident management plan or operational plan – who holds accountability for stated actions within each organisation listed in Section 5.4 above.

Annex B – Glossary

Term	Definition
MoU	Memorandum of Understanding – a formal agreement between parties outlining roles and responsibilities in responding to outbreaks.
UKHSA	UK Health Security Agency – responsible for public health protection, infectious disease control, and health emergency preparedness.
ICB	Integrated Care Board – local commissioners responsible for planning, funding, and integrating NHS services for outbreak response.
LHRP	London Health Resilience Partnership – a strategic group overseeing resilience and emergency planning in the London health system.
LRIG	London Resilience Implementation Group – ensures implementation of resilience strategies and lessons learned from incidents.
HCID	High Consequence Infectious Disease – a disease with high mortality and transmissibility requiring specialised response and treatment.
IMT	Incident Management Team – a multi-agency team assembled to manage infectious disease outbreaks and responses. This is interchangeable with Outbreak Control Team (OCT) and Incident Control Team (ICT)
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
HAZMAT	Hazardous Materials – substances posing risks to health, safety, and the environment requiring specialist response
Public Sector Equality	Legal duty requiring public bodies to consider eliminating discrimination and advancing equality in their decision-making
CORE20PLUS	A NHS framework identifying populations at high health risk due to socio-economic deprivation and inequalities
Category 1 Responders	Designated emergency response organisations legally required to assess risks and prepare emergency
Civil Contingencies Act	Legislation outlining emergency response requirements for public bodies, ensuring coordinated crisis management.
Incident Management Team	A coordinated group of experts and agencies responding to infectious disease outbreaks.
Epidemiology	Study of disease patterns, causes, and effects in populations to inform public health action.
Health Equity	Fair distribution of health resources and tailored responses to reduce disparities in health outcomes.
Contact Tracing	Identification and monitoring of individuals exposed to an infectious disease to prevent further spread.
Environmental Health Officer	A professional responsible for enforcing environmental and public health laws.
Health Overview and Scrutiny	A committee ensuring oversight and accountability in public health decision-making.

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