UK Health Security Agency

UKHSA London Health Protection: Roles and Responsibilities for Supporting the Acute Response and Prevention of Outbreaks in Migrant Settings

November 2023

To note roles and responsibilities are accurate as of this date but are subject to change.

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Amendment history

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The amendments that have occurred since the **original** version of this document are shown below:

Version	Section(s) amended	Date	Details of amendment

Contents

Executive Summary

1. Introduction

Background:

- London is home to approximately half of the initial and contingency accommodation (ICA) in the UK. ICA will be used throughout this document. At the time of writing the majority of ICA is hotels but other types of accommodation are used. In recent years, there have been a number of infectious disease outbreaks across these settings, affecting this particularly vulnerable population. This document outlines the challenges and best practice when supporting infection control and outbreak management in migrant accommodation settings, with a focus on the roles and responsibilities of different partners.

Audience:

- This document is for all partners who contribute to the health protection response in these settings, including but not limited to local authorities (LAs), Integrated Care Boards (ICBs), the Home Office, Home Office contracted operators (Clearsprings), primary care colleagues, and other partners working in this space

Guidance Aims:

- This document aims to ensure that: best practice is shared; partner expectations are outlined so that we can achieve consistency in provision across London; and roles and responsibilities are explicitly stated and agreed upon by all partners. It is not intended that this work replaces previous guidance, but rather acts in conjunction with it
- Broad Aim**:** To support effective prevention and routine care, as well as response to notifiable diseases and outbreaks in migrant accommodation settings to preserve the dignity and safety of residents whilst reducing transmission of infectious disease

Methodology:

2. Key response for prevention, acute response, and regional or national incidents in Asylum and Migrant accommodation settings:

Prevention

Settings
Ensure that settings have: appropriate isolation facilities, sufficient Personal Protective Equipment (PPE) supplies, have an infection prevention and control (IPC) plan, keep sanitiser and soap full, and regular cleaning of common areas

Staff
Encourage staff to be up to date with vaccinations, ensure staff know how and when to notify the Health Protection Team (HPT), and staff are trained in donning and doffing PPE and responding to outbreaks

Residents
Offer new arrivals information packs; provide translated leaflets re protection from diseases; ensure all new arrivals receive an initial health assessment which screens for common infections including tuberculosis (TB), blood-borne viruses (BBVs), and sexually-transmitted infections (STIs); encourage primary care registration and ensure everyone is offered vaccinations in line with the UK vaccination schedule

Acute Response

Suspected/confirmed infection
Symptomatic individual: support isolation, provide cleaning equipment, undertake welfare checks and provide access to medical assessment and testing. [See Action Card 1 p13]
Carry out identification and follow up of close contacts. Liaise with medical professionals where relevant

Notification
Either in-reach services or the registered medical professional should notify their local HPT. Hotel staff may also contact HPTs directly [See Action Card 2 p14]
Public health advice will then be provided to the setting

Outbreak management
After notification, follow actions including isolation advice, and IPC and decontamination advice. Communications should take place between HPT and Clearsprings and ICA staff , the LA, the ICB SPOC and primary care partners. [See summary Action Card 3 p16]
Incident Management Team Meetings (IMTs) may be needed

Regional or national

Additional capacity may be needed due to:
- Additional vaccination, testing, or chemoprophylaxis at scale
- The urgent need for translated resources
- UKHSA may mobilise a national surge response to deal with the additional workload in exceptional circumstances
- National specialist teams may become involved in leading on national IMTs, development of guidance and briefings
- Information sharing between partners, accountability, and consistent guidance are key in these scenarios
- Response will vary depending on disease and setting. The above are potential components to the response

3. Concluding comments

The intention of this document is to support health and wider partners in London to work together to be able to swiftly react and work collaboratively to prevent, prepare, and respond to infections and outbreaks in these settings, placing the safety and dignity of residents at the core. Access to healthcare, safeguarding, and non-infectious health threats should also be considered in asylum and migrant settings in relation to health protection and the wider public health response for the capital.

1. Introduction

1.1 Scope and Aims

The scope of this document is on the health protection issues relating to migrant accommodation settings in London. Definitions are outlined in *Appendix A*. This document was developed in response to the challenges highlighted during the recent increase in diphtheria cases and other infectious diseases in asylum seekers, and also by the efforts of the system to respond to infections and outbreaks in migrant settings. There has been a clear ask from stakeholders in the London system to have support in clarifying organisational roles. The methodology behind the development of this document is outlined in *Appendix B*.

Broad aim: To support effective prevention and routine care, as well as response to notifiable diseases and outbreaks in migrant accommodation settings to preserve the dignity and safety of residents whilst reducing transmission of infectious disease

Objectives:

1. To outline the roles and responsibilities of UKHSA London Region, as well as other partners, to support health protection and advise on infection control
2. To set out and have partnership agreement as to what the processes should be for a health protection response in these settings
3. To provide clarity on health protection escalation criteria and pathways

Broader issues experienced, including mental ill health, poor access to healthcare, trauma, or long-term conditions are outside the scope of this piece of work. Other sources of guidance addressing these issues include OHID's Migrant Health Guide, the GLA's pages on Migration, and Migrant Help's website.

1.2 Audience

This document is for all partners who contribute to the health protection response in these settings, including but not limited to local authorities (LAs), Integrated Care Boards (ICBs), the Home Office, Home Office contracted operators (Clearsprings), primary care colleagues, and other partners working in this space. This document is not prescriptive but rather it aims to support evolving learning and practice in this space. It is not intended to replace previous guidance but should be used in conjunction with other relevant local and national guidance, for example, UKHSA's guide to managing infectious disease in asylum accommodation settings. See *Appendix C* for signposting to other guidance.

Further background on the health protection challenges in migrant accommodation in London and the suggested best practice by partners can be found in *Appendix D*.

Section 2 provides a summary of the roles and responsibilities of different partners in the health protection response in migrant accommodation settings in London.

1. Overview of roles and responsibilities of system partners in prevention, acute response to notifiable diseases and outbreaks, and broader health protection threats:

	UKHSA National	UKHSA HPTs	Home Office	Home Office Contracted Operator
General Role	Protects against infectious diseases and other health threats. Provides leadership, strategic oversight, coordination	Risk assesses notifiable disease notifications, outbreaks, and other health threats, and provides public health advice	Overall responsibility for asylum and refugee accommodation (including commissioning of accommodation) see national requirements [1]	Has oversight of accommodation settings, is responsible for signposting to health services, and cascades guidance and directives. They must take necessary action to protect the welfare of a service user with an infectious or contagious disease
Responsibilities regarding health protection in migrant accommodation	**Prevention** • Advise and work with other government departments and NHSE to improve access to healthcare to enable effective initial health checks • Promoting appropriate vaccination and screening policy, including directives for current issues **Acute Response** - Develop evidence-based guidance for how to respond to various health threats - Develops Patient Group Directions **Regional/National Incidents** - Liaise with other government departments - Lead on national incidents and provide National Command and Coordination through NICC meetings - Cascade information and national directives to partners	**Prevention** - Work locally with stakeholders to promote good comms, training, and networks - Provide guidance for local settings on IPC measures that should be put in place - Develop resources to assist in preventing and responding to public health threats **Acute Response** - Risk assess notifications of notifiable diseases/outbreaks - Provide advice to setting and residents - Manage local and regional outbreaks - Co-ordinate partners to respond to scenarios - Produce Standard Operating Procedures and guidance - Lead on Incident Management Team meetings and ensure all stakeholders have same situational awareness	**Prevention** - Embed training and IPC processes in contracts - Stay up to date with and cascade guidance to settings - Ensure adequate sanitation measures at initial arrival centres; this includes limiting overcrowding - Hold a quality assurance role: ensure contracted operators are maintaining IPC standards **Acute Response** - Assign representatives who attend meetings - Be aware of outbreaks and situations within settings **Regional/National Incidents** - Work with other national stakeholders to operationalise guidance and advice - Heightened involvement in outbreaks is needed when outbreaks cross regions, as contact tracing may be needed before transfers to other settings	**Prevention** - Work with Clearsprings/IA to ensure GP registration process and accessing healthcare is clear - Embed training and infection prevention and control processes in the ICA staff contracts - Ensure staff have adequate supply of PPE - Encourage all staff to be up to date with their vaccinations - Establish QA system to ensure all settings are at a minimum IPC standard **Acute Response** - Train staff on steps to take in an outbreak - Be aware of outbreaks within settings, and support ICA staff to manage these situations **Regional/National Incidents** - Attend meetings and act on guidance from partners - Provide accurate information to staff who are concerned about their own infection risk - Dissemination of comms to all settings when there are national or regional situations - Facilitation of mass vaccination in settings - Heightened involvement in outbreaks is needed when outbreaks cross regions, as contact tracing may be needed before transfers to other settings

	Clearsprings and IA staff and managers	Local Authority
General Role	Responsible for the assistance of residents and for rapid communication with UKHSA with regards to health protection incidents on the ground	Responsible for liaising with local partners (inc. being a member of ICB) and signposting into appropriate services
Responsibilities regarding health protection in migrant accommodation	**Prevention** - Include dedicated health question into welfare checks to determine a) whether resident is registered with GP and b) whether they are subsequently managing to access care - Residents should be told that if they have particular symptoms, that they should inform a member of ICA staff and will be assisted in accessing a clinical assessment - Support residents to register with the GP and to receive initial health assessments and any subsequent medical care (including vaccinations) - Implement IPC measures in settings: this should include keeping soap and sanitiser full, encouraging handwashing, cleaning high touchpoint areas, donning and doffing PPE correctly **Acute Response** - Support residents to seek healthcare and receive clinical assessments - Notify primary care provider and the Health Protection Team if setting may be experiencing an outbreak - Provide the HPT with names and contact details of cases and contacts - Follow SOPs and guidance (UKHSA guidance on Outbreak management in short term asylum seeker accommodation) - Follow the processes as laid out in *Action Cards 1, 2,* and *3*	**Prevention** - The Director of Public Health maintains an assurance role over the risks to public health - Responsible for providing oversight and public health guidance for settings in their footprint - Provide wrap-around support to bridging hotels *(now largely stood down)* - Environmental health teams have the authority to assess accommodation IPC standards in communal areas and hold providers to account. Assurance visits by the local authority provide an opportunity for accountability in the system - Local Authorities are responsible for enforcing food hygiene laws and can inspect business at any point in the food production and distribution process. This includes asylum accommodation where food is being prepared and/or distributed **Acute Response** - The Director of Public Health should be kept informed of outbreaks in settings in their area - If the setting is a bridging hotel *(now largely stood down),* local authorities are accountable for resident refugees in their borough - For larger incidents, LA can help with arrangements for epidemiological surveillance and arrangements for provision of medical supplies - Environmental Health at the LA will support with necessary checks and sampling at the setting **Regional/National Incidents** - Local Authorities hold the statutory responsibility for protecting the health of their local population. Therefore, when there are regional threats, the local authority may provide advice and support on: • The appropriate coordination of roles and responsibilities between any responsible or relevant bodies • Appropriate emergency provision for incidents which occur outside normal working hours • Arrangements for epidemiological surveillance or environmental hazard monitoring in their area The local authority is also key in bringing together partners across the system in their patch and signposting to the voluntary and community sector

	NHS Services		
	NHS England and NHS London [1]	**Integrated Care Board (ICB)**	**Primary Care**
General Role	Provision of commissioned services (inc. emergency and secondary care)	Responsible for commissioning healthcare for people seeking asylum who are accommodated within their area	Includes GPs and pharmacies. Responsible for treating residents, regardless of immigration status
Responsibilities regarding health protection in migrant accommodation	**Prevention** - Communications to commissioners and primary care colleagues regarding national funding arrangements and how to apply for reimbursement - Equitable vaccination commissioning, provision, and performance monitoring - Training and communications campaigns **Acute Response** - Support given from NHS microbiology laboratories - Mobilisation of clinical staff and resources when needed - Specialist screening and assessment services, such as RESPOND or Find and Treat, may also be commissioned **Regional/National Incidents** - Development of service specifications and guidance - Participate in NICC meetings (National Incident Coordination Centre) - Provide oversight and support to ensure that alerts from UKHSA are actioned - Responsible for health needs of detained migrant populations - NHS EPRR role: if a more complex response is needed, coordination and management of information sharing between government/GLA and local health systems ***Note:*** NHSE is currently carrying out some work clarifying legal roles and responsibilities at arrival centres such as Manston	**Prevention** - Take a leadership role on preventive interventions, working closely with one or more Director(s) of Public Health to ensure action is informed by public health expertise - Commission pathways to ensure residents receive a minimum standard of initial health assessment and preventive care - Assign a named SPOC migrant link - Responsible for communications re healthcare arrangements, funding, designated pharmacies **Acute Response** - Commission and co-ordinate response of any community, acute or primary care providers. This may include coordination of mass treatment, vaccination, and chemoprophylaxis - When mass treatment is required and residents do not yet have HC2 forms, ICBs need to establish a pathway via which treatment and prescriptions can be provided quickly at scale **Regional/National Incidents** - Each ICB has different local arrangements for how they might respond at scale, as the numbers involved can make it unfeasible for individual GPs to respond - ICBs may need to agree on the most appropriate and consistent approach to take when there are shared outbreaks in a region	**Prevention** - Provide an initial holistic health assessment to detect both symptomatic and asymptomatic infections - Provision of vaccinations - Assist settings in registering each new arrival with their link GP surgery - Refer to local bespoke specifications on initial assessments or refer to OHID's migrant health guide **Acute Response** - Support with clinical assessment and treatment of cases and contacts - Notify HPT of notifiable diseases and of outbreaks (2 or more cases) of other diseases of potential public health importance - Take forward actions as recommended by HPT and/or IMTs - When appropriate, primary care to proactively reach out to accommodations to enquire if other residents have similar symptoms

Considerations around roles and responsibilities

- Roles and responsibilities are also aligned to holding risk and having resource to coordinate the response
- ICBs highlighted that there needs to be more clarity on funding when additional vaccinations are required to be delivered via primary care, as not all of these vaccinations are covered by the Global Sum
- There needs to be sufficient skills and capacity in the system in order to stand up urgent responses for vulnerable groups such as people seeking asylum; these skills are reportedly scarce in many areas of the health service. Thus, several areas raised the suggestion that a hybrid model of pan-London outbreak response alongside ICS and borough capacity should be considered in order to enable successful delivery during incidents
- A range of stakeholders drew attention to the fact that it is impractical to delegate outbreak management to routine primary care settings, as this can easily consume a whole practice. In these scenarios, it has been strongly advised that it is critical that the response then moves to a PCN or ICS approach and that with this, there is an expectation that commissioners will need to support this larger-scale response
- All stakeholders made it clear that they would find it extremely valuable to have a named and responsible person for prevention of and response to outbreaks in asylum settings at each level and organisation e.g. at the different organisational levels in hotels, Clearsprings, and the NHS system. This would also mean having an understanding of which individual or team holds the responsibility and risk at each of the following: accommodation site, at borough level, at sub-regional level (ICB), and at regional level (London). By naming these individuals, it is felt that this would improve accountability, as if one partner does not fulfil their role or responsibility, it is possible to follow this up with the correct contact

Other notable system stakeholders

Specialised outreach services: With regards to prevention of infectious disease in migrant accommodation settings, specialised outreach services such as Find and Treat and RESPOND (and others) play a key role in the areas in which they are commissioned.

The Office for Health Improvement and Disparities (OHID) London: OHID London does not hold statutory responsibilities for health protection, since those functions moved to UKHSA on the dissolution of PHE and the creation of UKHSA and OHID. However, OHID London continues to play a supportive and complimentary role to UKHSA London, particularly by facilitating system convening at a pan-regional level, across central government, local government, the health and care system and the voluntary sector. This facilitation of collaboration contributes to improving the system response in these settings.

Note on the above tables: Further information on notifiable diseases is listed in *Appendix E* and HPT responsibilities and contact information are outlined in *Appendix F*.

[1] *Note that responsibilities for NHSE are subject to change pending future NHSE service specifications*

3. Prevention

By collectively strengthening response to routine care and prevention, less pressure is placed on partners when needing to respond urgently to broader outbreaks. Whilst this document does not focus specifically on primary care access, effective prevention of infectious disease cannot take place without supporting straightforward and timely access to primary care services for these populations. Appropriate identification of conditions, timely screening, and vaccinations can prevent cases and outbreaks of infectious disease, and can prevent infections being transferred between accommodations. A key priority for all partners should be on ensuring that people seeking asylum and refugees are linked into mainstream services. Further information on appropriate screening and vaccinations for new arrivals can be found in the Migrant Health Guide and in OHID's individual health assessment guidance for newly displaced populations. RCPCH guidance on assessment for refugee and asylum-seeking children and young people can be found here.

3.1 Initial assessment upon arrival

Asylum seekers or refugees may have been exposed to infectious diseases dependent on the routes which people have taken to the UK, but best practice (as outlined in the Migrant Health Guide) is to have a clear process for an initial health assessment that is consistent, regardless of which area of the country an individual is placed. Recommendations on planning commissioning services to meet the needs of residents and conducting initial health assessments can be found in the Doctors of the World Safe Surgeries Toolkit for ICB and PC commissioners: *Access to healthcare for people seeking asylum in initial and contingency accommodation*.

An initial holistic health screening upon arrival allows symptomatic and asymptomatic infections to be detected, allowing timely treatment and fewer transmissions. NICE guidance[2] suggests that unaccompanied asylum-seeking children should be offered 'tailored initial health assessments that address risks arising from their country of origin and journey to the UK'.

It is advised that these initial assessments should include:

- Tuberculosis screening (*UKHSA recommends, in line with international guidance (from the European Centre for Disease Control (ECDC) and guidance from (WHO), migrants who arrive from high TB incidence countries (more than 40 cases per 100,000 population), who are not covered by the pre-entry screening programme, should be offered screening for active TB disease and latent TB infection as soon as possible after arrival. LTBI screening for migrants arriving from countries where TB incidence is more than 150/100,000 should also be offered. The above should happen at the first point of contact with healthcare*)
- Sexual health (*including testing for sexually transmitted diseases*)
- Assessment for gastrointestinal symptoms and/or screening for parasites
- Assessment of other infectious and bloodborne infections, such as HIV and hepatitis testing
- Assessment of rashes or skin infections and/or itching

Common infectious diseases which particularly impact on these populations include:

- Scabies
- Tuberculosis (including latent TB)
- Hepatitis B and C
- Cutaneous diphtheria
- Sexually Transmitted Infections (STIs)
- Vaccine preventable diseases e.g. Measles
- Chickenpox

In addition to the recommended and/or existing screening programmes, practitioners may also be able to identify common rashes and skin infections like scabies, signs of liver failure, or signs of fever. These symptoms could indicate numerous infections depending on where the individual has travelled from and which countries they have travelled through, and could need treatment to reduce risk of spread. Initial health assessments should also be followed up by an onwards care planning package, as opposed to simply referring an individual on to a GP for next steps. A preventive model which relies only on GPs carrying out assessments cannot be scaled up to provide urgent in-reach vaccination in the event of an outbreak (or the risk of one).

3.2 Vaccinations

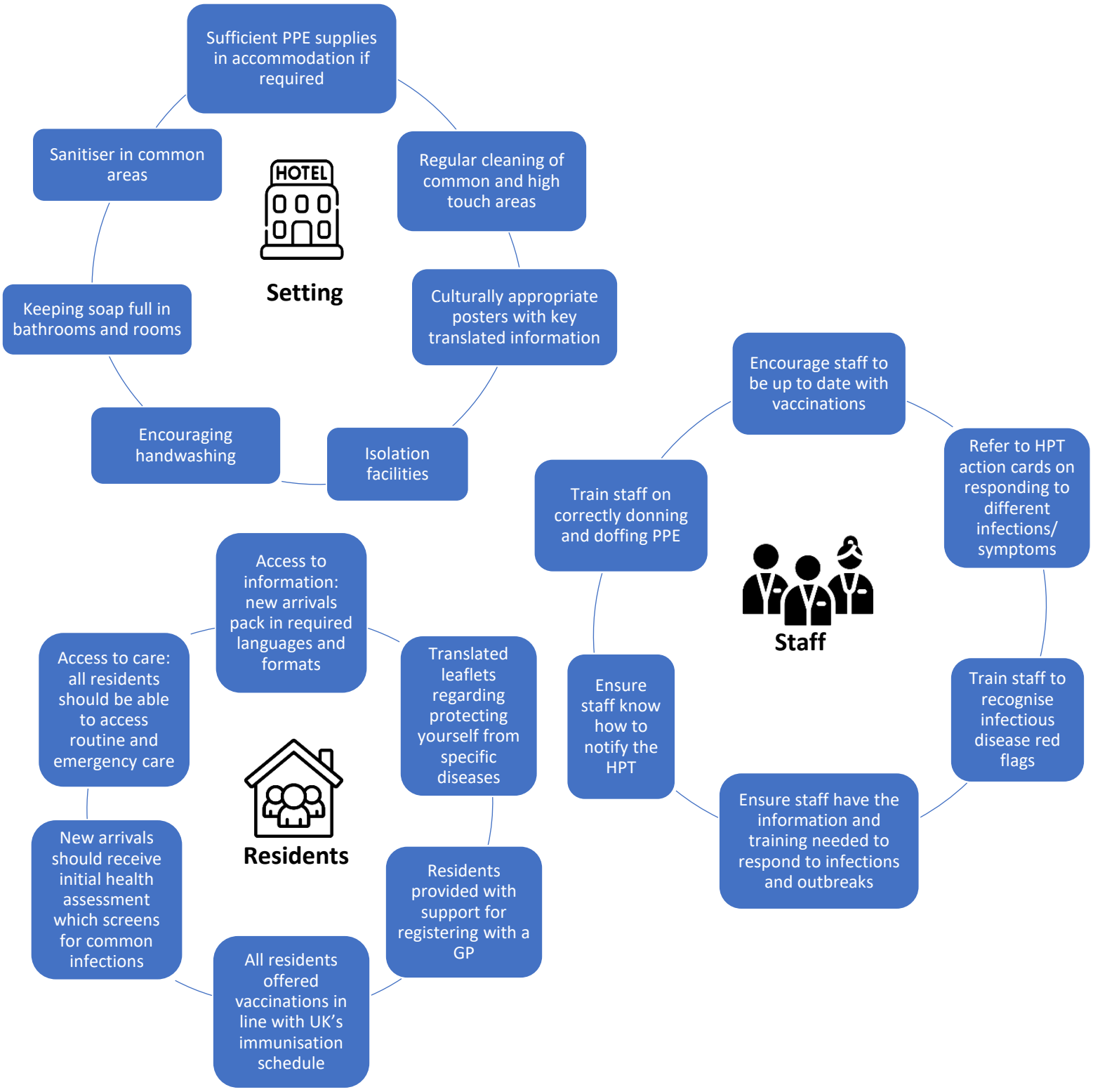
Immunisation for inclusion health groups is currently being developed as a separate workstream within London. As a general recommendation:

- All asylum seekers and refugees should be assessed for their immunisation history[3] and they should be offered the necessary vaccinations so that they are up to date with the UK's immunisation schedule
- Residents should be encouraged at all opportunities to register with a GP, as this is a critical entry point to the system
- At all points of transit, regardless of the predicted length of stay, that opportunity should be taken to offer vaccination
- Records on immunisation status may often be missing. UKHSA has developed a one-page summary on the approach to catching up patients who have an uncertain or incomplete immunisation status
- The standard childhood, adult and seasonal immunisations should be followed as well as Hepatitis A in an outbreak situation.

Responsible agencies should provide comprehensive access to primary care and vaccination services available to those seeking asylum or refuge. This includes through GP settings and outreach.

By offering vaccinations promptly to this population, both accommodation residents and other local citizens are better protected against infectious diseases. *Figure 1* summarises the prevention activity required across settings, staff, and residents.

Figure 1: Key actions for prevention of infections and outbreaks


Sufficient PPE supplies in accommodation if required
Regular cleaning of common and high touch areas
Culturally appropriate posters with key translated information
Isolation facilities
Encouraging handwashing
Keeping soap full in bathrooms and rooms
Sanitiser in common areas
HOTEL
Setting
Encourage staff to be up to date with vaccinations
Refer to HPT action cards on responding to different infections/ symptoms
Train staff to recognise infectious disease red flags
Ensure staff have the information and training needed to respond to infections and outbreaks
Ensure staff know how to notify the HPT
Train staff on correctly donning and doffing PPE
Staff
Access to information: new arrivals pack in required languages and formats
Translated leaflets regarding protecting yourself from specific diseases
Residents provided with support for registering with a GP
All residents offered vaccinations in line with UK's immunisation schedule
New arrivals should receive initial health assessment which screens for common infections
Access to care: all residents should be able to access routine and emergency care
Residents

4. Acute Response – Local

This section outlines the local response for suspected or confirmed cases of notifiable diseases and points of escalation for outbreak management.

Suspected or confirmed infection in accommodation settings

The key actions to take for many different types of suspected or confirmed infection will be broadly similar. Infections which would require the below steps to be taken include:

- Notifiable diseases
- Other diseases of interest in asylum accommodation settings such as outbreaks of norovirus, scabies, or chickenpox

Key steps for management of infections include:

- Carrying out a risk assessment, including identifying a source
- Implementing infection and prevention control measures
- Isolating (when appropriate) and supporting residents
- Testing/screening
- Contact tracing
- Immunisation or prophylaxis

It is key that Clearsprings/ICA staff are confident of their role in supporting residents to

- seek urgent healthcare if unwell, including arranging transport when necessary
- help residents access GP or primary care for advice on non-urgent health matters
- notify local HPT if they feel the setting may be experiencing an infectious disease outbreak, for example more than one resident or staff member has acute respiratory symptoms, or diarrhoea and/or vomiting, or skin rashes
- ensure basic IPC measures are in place as advised by HPT, local health services and local authority
- provide a safe working environment for staff
- attend incident management team (IMT) meetings if require

Guidance such as UKHSA guidance on Outbreak management in short term asylum seeker accommodation supports this capacity in ICA staff.

Action Card 1 describes in more detail steps to be taken by accommodation staff when there is a suspected or confirmed infection in a resident.

Action Card 2 describes how and why to notify the local Health Protection Team about a notifiable disease in a resident.

Action Card 3 details the steps that HPTs take when working with migrant accommodation settings and partners on a suspected or confirmed outbreak.

***Action Card 1**: Actions for ICA staff for a suspected or confirmed infection*

There is an increasing number of infections in people who have come to the UK to seek asylum. These infections include skin infections (Group A strep, MRSA, diphtheria, scabies), respiratory infections (influenza, COVID-19), gastrointestinal infections (norovirus), and others. Accommodation providers may reduce infection risk by:

- Signposting all residents to how they can register with a GP: NHS Entitlements
- Contacting 111 or on-site clinical team if a resident is unwell or has new symptoms (non-emergency), or 999 if very unwell. Inform them of the signs and symptoms

Symptomatic individual

If there is a suspected or confirmed infection in a resident then:

Support residents to isolate in their room immediately until health protection advice can be given.

Provide equipment and products for resident to clean their room.

Advise resident to bag laundry and leave outside their room. Double bag if laundry is going off to a commercial laundry.

Provide meals in room. Ensure resident has their own individual crockery, utensils, linen & towels.

Undertake regular welfare checks. Ask about any new symptoms

What does the Health Protection Team (HPT) need from partners?

The HPT (find local teams here) may need to carry out a risk assessment. See *Action Card 2* for guidance on notifications. Contact the HPT if you are aware of multiple people developing the same symptoms in a short space of time or if you are informed of a diagnosed case of a notifiable disease. The HPT may ask about who the individual has been in close contact with, for example sharing a bathroom or kitchen, so that they can advise on any additional preventive measures such as vaccination and antibiotics. Please provide the HPT with a contact point at the accommodation who can assist as soon as possible

Case definitions:
Possible case: This is usually when a person has symptoms but there are no positive test results
Probable case: Usually a person with symptoms who is a contact of a confirmed case
Confirmed case: This is when an infection has been laboratory confirmed

Close Contacts: generally, this is anyone who is sharing a room, spending a lot of time together, sharing a bathroom or kitchen, or a sexual contact. However, close contact definition varies by disease – your HPT or health professional can provide specific help with who is defined as a close contact

Cleaning
For many infections, hotel staff will need to arrange for the cleaning of areas accessed by the case during their infectious period

If there are further positive cases, the approach then shifts to outbreak management (*see Action Card 3*)

Access UKHSA's Outbreak management in short term asylum seeker accommodation guidance for more information about specific actions for different scenarios

Action Card 2: *How to notify the Health Protection Team about notifiable diseases*

Possible, probable, or confirmed case

A

If a person with a notifiable disease is identified by a registered medical professional (RMP), they have a statutory duty to notify the 'proper officer' at their local council or local health protection team (HPT). The HPT will usually then follow up with the setting to advise on next actions

B

If a person with a notifiable disease is <u>identified by an accommodation staff</u> member, the following steps should be taken:

C

If this case is identified or suspected by outreach services or services such as Find & Treat, they should themselves notify the HPT

<u>STEP ONE</u>

- Contact your healthcare provider or link GP practice for the accommodation and request a clinical assessment and/or testing

<u>STEP TWO</u>

- Contact your local HPT to report the symptoms or suspected notifiable disease that the resident(s) is experiencing
- HPT staff will provide advice on what public health measures need to be taken

<u>NOTE:</u> Accommodation staff have no medical responsibility, but they are often the first port of call for residents and are often the first to notice infections in the setting. Therefore, it is important that they know how to notify the appropriate agencies about suspected notifiable diseases or outbreaks

It is <u>extremely important</u> that you notify your health care provider and the Health Protection Team <u>as soon as you are able</u>. This will allow for prompt public health action to be taken, and this will limit the spread of infection

<u>The details of the local Health Protection Team are as follows*:</u>

Daytime phone number:
Urgent out of hours number:
Email:

**Please print this page and fill out the details of your local HPT in the yellow box (find local teams here)*

There are some key points that should ideally be in place to enable prompt and effective action to be taken in the case of a notifiable disease or outbreak:

- Accommodation staff to be authorised to directly contact HPTs without the need for sign-off from senior staff. This permission and the steps to take should be embedded in the contracted operator's SOPs and training procedures for accommodation staff
- Health Protection Teams (HPTs) should have 24-hour contact details for each accommodation setting in their area, to coordinate a response
- HPT to have information on residents/contacts and room sharing for contact tracing purposes
- Home Office are aware of the importance of not moving a resident during periods of infection and contact tracing due to the risk of increasing potential for spread
- GPs should proactively call ICAs at an early stage to see if other residents have similar symptoms of notifiable diseases or infections such as scabies or chicken pox

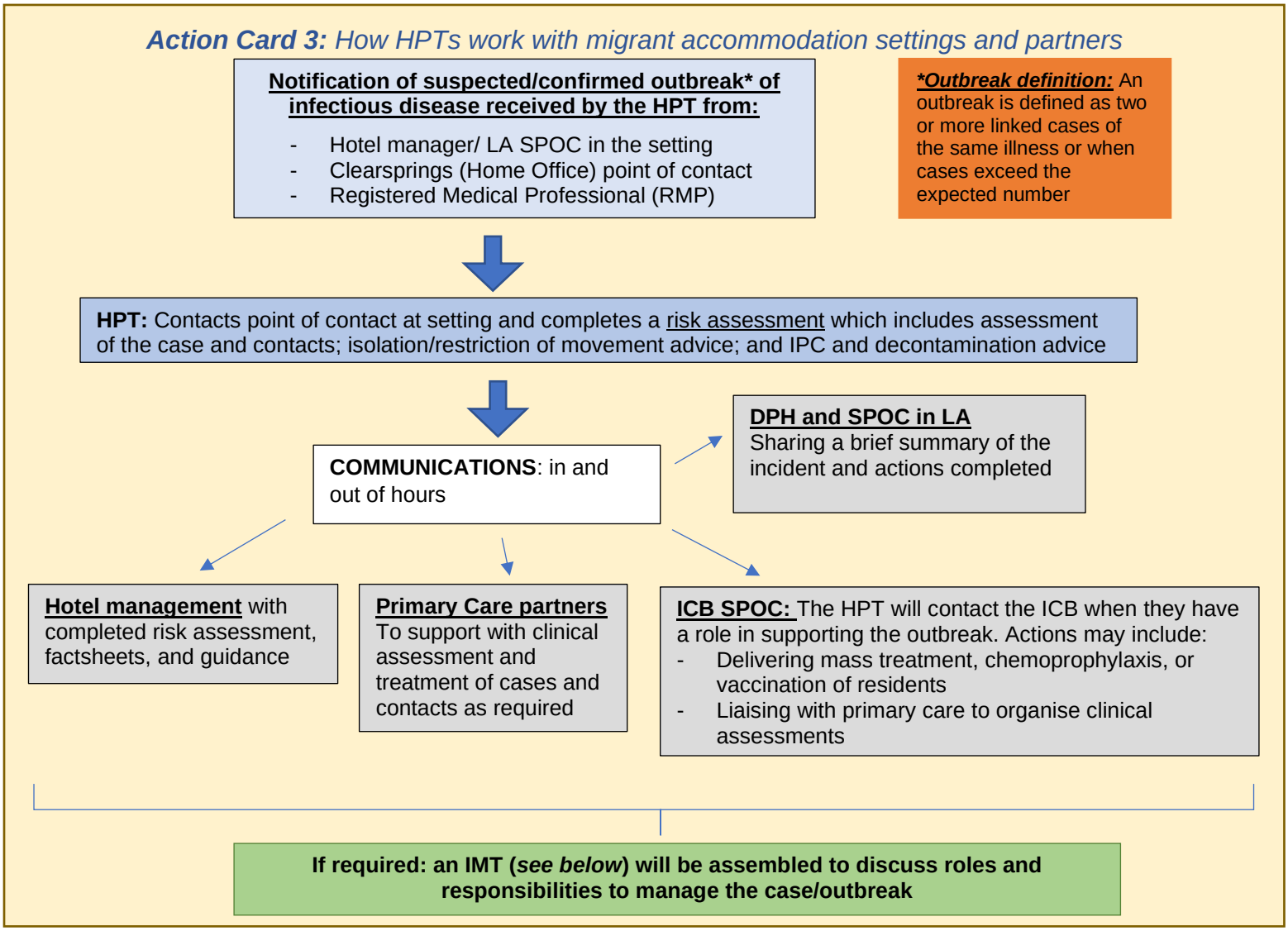
Isolation of residents

During an outbreak, or even sometimes for a single case of a notifiable disease, it may be necessary to isolate residents. The following outlines several core principles which all partners, and ICA staff in particular, should be aware of:

- There should be a clearly documented plan for isolation, who made the decision, when and why, including criteria for when isolation should be stopped. This plan should be made available to all staff in the ICA to avoid confusion and unnecessary isolation
- Reasons for isolation should remain confidential to other residents
- Residents should have the reasons for why and the length of time they are going to be isolated for clearly explained to them with an official interpreter. This should avoid incidents where residents do not understand why they are being isolated; this can have a significant impact on mental health and can retraumatise residents
- The Health Protection Team can assist in advising providers on isolation decisions
- A resident should not be left isolating in a room for numerous days without a confirmed diagnosis or steer from a health professional or a HPT
- Isolating a resident should only be implemented if necessary. If it is needed, staff need to take a trauma-informed approach and be cognisant of the potential stigma surrounding isolation and IPC processes

Local Outbreaks

Action Card 3 provides an overview of how HPTs work with migrant accommodation settings when they have been notified of a suspected or confirmed outbreak.



Suspected or confirmed outbreaks should be immediately reported to the HPT by the designated point of contact or by the ICA manager on duty. The HPT will carry out a risk assessment and provide public health advice on what is needed. If not already carried out, immediate infection prevention, and control (IPC) steps will need to be taken by staff who are on site. The HPT will communicate with stakeholders, either to keep them informed or to explicitly request support with the next public health actions needed. The HPT can only advise on infection control; it does not have the remit to deliver the needed intervention(s).

Incident Management Team meetings (IMTs)

An Incident Management Team meeting (IMT) is a multiagency group which is called together urgently to manage an incident. This is a formal, minuted meeting, which is usually chaired by UKHSA (the advisory agency). Organisations are required to send people who can make decisions on behalf of their organisation. IMTs might vary in scope depending on geographical patch and type of incident, but the general aims usually include:

- Review the information to date
- Agree risk assessment e.g. is this an outbreak
- To discuss and agree the multiagency response and interventions to prevent further cases
- To agree communications

For each incident, UKHSA should outline:

- Where leadership sits
- Where UKHSA's capacity to deliver ends (e.g. they cannot commission and cannot deploy clinical staff to manage an incident)
- Which attendees need to be present and what their organisation's responsibility is
- The decision-making process, including who is able to commission and which organisations have the clinical staff to enable delivery of necessary actions
- How information and decisions taken will be disseminated
- How and when IMTs will be stepped down

Throughout the IMT process, participants should be notified if they still need to attend.

5. Acute Response – Regional and National

Regional or national incidents

A regional or national incident may be declared if a situation has spread to other settings, either locally or nationally. These incidents may require additional vaccination, testing, translation of resources, (which UKHSA can arrange) and capacity in local systems for delivery. If a situation escalates to impact multiple settings and areas, UKHSA may mobilise regional or national surge response. National specialist teams may also become involved in leading on national IMTs, and in the development of guidance and briefings. Information sharing between partners, accountability, and consistent guidance are key in these scenarios. Recent examples where additional capacity was stood up in London include COVID-19, Mpox, polio, diphtheria, and iGAS.

The response will vary depending on the disease and the setting; the above are potential components to the response.

6. Non-infectious public health threats

In addition to responding to infectious diseases, Health Protection Teams, alongside colleagues in RCE (Radiation, Chemical and Environmental Hazards), can also support with non-infectious public health threats in asylum and migrant accommodation settings. This includes situations such as carbon monoxide poisoning, fires, chemical spills, radiation etc. In partnership with emergency services such as the police force, the fire brigade and various other partners, HPTs will offer assistance and expert advice. This is particularly important when the situation involves communicating risk to the public or involves particularly vulnerable groups in the population.

It has been highlighted that other services can lack information and intelligence regarding where people seeking asylum and refugees are housed, and the conditions of the accommodation people have been placed in. The fire service has highlighted the risks of placing people into unsuitable accommodation, and the police force have highlighted the risks of not being able to protect individuals who may be associated with an increased risk of resorting to criminal behaviour if destitute.

7. Safeguarding

Safeguarding is the responsibility of all partners and concerns should be flagged at every opportunity. With regards to safeguarding, it is important that:

- Policy and procedures for safeguarding are shared as the statutory process with all stakeholders
- All partners know the process for referrals locally and what the thresholds for these are
- Implications of isolation on some service users should be considered e.g. if an isolation room is on a corridor used only for men
- Action taken by safeguarding leads should be fed back to the referrer
- Partners know how to further escalate issues
- Residents should be aware of pathways for reporting safeguarding issues and incidents concerning themselves or other residents

8. Concluding comments

The intention of this document is to build on current guidance and to support health and wider partners in London to work together to be able to swiftly react and work collaboratively to prevent, prepare, and respond to notifiable diseases and outbreaks in these settings, placing the safety and dignity of residents at the core. Access to healthcare, safeguarding, and non-infectious health threats should also be considered in asylum and migrant settings in relation to health protection and the wider public health response for the capital.

9. Appendices

Appendix A: Definitions

Terms in this policy space can be contentious, and whilst we are in general talking about forcibly displaced individuals, for the sake of clarity and to help explain legal status, the below terms will be used throughout this guidance document.

Asylum seeker - An individual who is seeking international protection, whose claim has not yet been finally decided on by the country in which he or she has submitted it

Refugee - A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his/her nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country

Migrant - Any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is

NRPF – A person will have no recourse to public funds when they are 'subject to immigration control', as defined at section 115 of the Immigration and Asylum Act 1999. A person who is subject to immigration control cannot claim public funds (benefits and housing assistance), unless an exception applies

Bridging Hotel – Temporary 'bridging' accommodation stood up and sourced by the Home Office, beginning in September 2021, in response to the imminent arrival of newly displaced Afghans to the UK

Initial and Contingency Accommodation (ICA) - Accommodation centres provided to individuals who, under Section 98 of the Immigration and Asylum Act 1999, can show they are destitute when they first apply for asylum, while the Home Office assesses their eligibility for longer-term (Section 95) support. They are typically large full-board hostels with shared bedrooms, living and social areas. Providers are contractually obliged to offer three meals a day, supply toiletries and bedding and provide transport to medical and related appointments. IA costs around three times more to provide than the dispersal accommodation that follows and it is not regarded as suitable for long stays

Contingency accommodation - This is contractually classified as 'Initial Accommodation.' Contingency accommodation refers to temporary accommodation procured on a short-term basis where demand exceeds availability of Home Office accommodation stock

Appendix B: Methodology

Methodology

Stakeholders from across the regional and national system were interviewed using an interview guide between 9th January 2023 and 26th May 2023 for their views on best practice, gaps in the system, challenges, and what can be done to ensure more cohesive and effective practice.

Interviews were held with representatives from the UKHSA's Health Protection Teams; Clearsprings Ready Homes; primary care colleagues working with asylum settings; Emergency Preparedness, Resilience, and Response (EPRR) colleagues from NHS and UKHSA; migrant leads for the Association of Directors of Public Health (ADPH); NHS London; the Office for Health Improvement and Disparities; the Greater London Authority (GLA); Find and Treat; and RESPOND. Colleagues from the North Central London, North East London, and South West London ICBs were all consulted and their comments integrated. Colleagues from the UKHSA National Health Inclusion team and colleagues taking part in London system-wide migrant forums were also consulted and provided valuable feedback.

In order to ensure the perspective and understanding of a wide range of stakeholders was reflected in this document, several iterations of the document were developed and disseminated to key partners, with further adjustments subsequently being made. Challenges in developing this guidance include:

- Different stakeholders having different perspectives on what should be included and on who should hold accountability for actions
- Concern from stakeholders that whilst they may agree in principle to a designated role, there is often no funding available to enable this function
- A rapidly changing migrant health landscape, with frequent changes in policy, guidance, and system capacity to respond

This guidance document has not evolved independently but has been developed by building on existing local and national guidance and Standard Operating Procedures.

Limitations: It has not been possible to interview all partners who work within this space and so there may be additional perspectives that have not been reflected in this document. This includes the fact that not all ICBs were able to respond. Interviewees were selected pragmatically and the interviews from this convenience sample were designed to produce general insights into the needs, gaps, and opportunities within this space, and to inform learning around what minimum processes should be in place in order to be able to effectively support infection control in these settings. Interviews were not conducted with residents or those from the migrant health community for this piece of work; the focus was primarily on organisational responsibilities.

Appendix C: Other sources of guidance

COVID-19: outbreaks in prisons, refuges and other higher-risk accommodation settings - GOV.UK (www.gov.uk) The UK Health Security Agency.

Asylum Accommodation and Support Schedule 2 with a Statement of Requirements Home Office

Outbreak management in short term asylum seeker accommodation. The UK Health Security Agency.

Migrant Health Guide. The Office for Health Improvements and Disparities.

Afghan refugees and newly displaced populations: individual health assessment. The Office for Health Improvements and Disparities.

Refugee and asylum seeking children and young people – guidance for paediatricians. The Royal College of Paediatrics and Child Health

Access to healthcare for people seeking asylum in initial and contingency accommodation: Safe Surgeries Toolkit for ICB and PC commissioners. Doctors of the World

Asylum Accommodation and Support, Schedule 2: STATEMENT OF REQUIREMENTS. Home Office, UK Government.

Asylum Accommodation and Support Contracts (AASC): Summary of the contractual requirements for initial and contingency accommodation for people seeking asylum. Asylum Matters

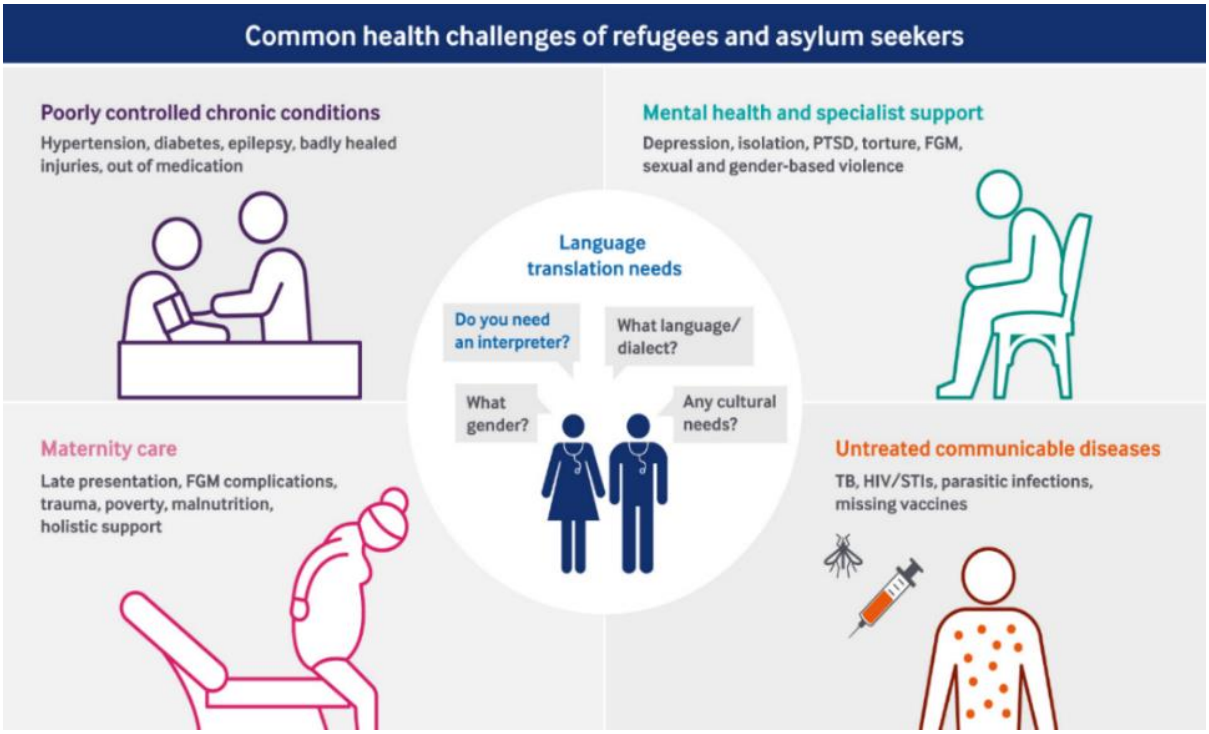
Appendix D: Further Background and context

Background

In the year ending 2022[4], asylum seekers and refugees made up approximately 17% of immigrants to the UK. This included arrivals under the Ukraine schemes, the Afghan relocation and resettlement schemes, and arrivals in small boats; in total, this was around 185,000 individuals. Refugees and asylum seekers are housed in a range of accommodation types, including bridging hotels (most refugees have now been dispersed from bridging hotels to more permanent and suitable accommodations), initial accommodation centres (often large hostels), and contingency accommodation. They face numerous health challenges compounded by any trauma they may have experienced and the variation in healthcare from both their country of origin and the transition and experiences in the UK. Common health challenges are summarised in the figure below. Infectious diseases are among the significant issues faced in people seeking asylum and refugees[5]. In recent years, there have been a number of infectious disease notifications and outbreaks associated with migrant accommodation settings across London. Global issues such as conflict, political and economic instability, and climate change make it inevitable that high levels of migration to the UK will continue, and so it is vital that the system

finds a consistent way to approach the health protection needs of arriving refugees and asylum seekers which is both sustainable and compassionate.

Common health challenges of refugees and asylum seekers
Source: Refugee and asylum seeker patient health toolkit, April 2022, BMA



Notification of infectious diseases is the term used to refer to the statutory duties for reporting notifiable diseases in the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010. There are 34 notifiable diseases including diphtheria and tuberculosis. Health Protection Teams (HPTs) are UKHSA's frontline response teams who respond to reports of notifiable diseases, infectious disease outbreaks, and other environmental threats to the public. This response aims to reduce the impact of infectious diseases and involves providing specialist support through local disease surveillance, maintaining alert systems, investigating and managing outbreaks, and implementing national action plans.

London context

London is home to approximately half of the initial and contingency accommodation in the UK. As of April 2022, there were 12,788 people seeking asylum in 73 contingency hotels across 23 London boroughs. This number has increased by over 100% since May 2021[6]. The unequal distribution of ICAs in London means that some boroughs are facing more difficulties than others in being able to provide high quality services to accommodation residents. In 2021, 42% of asylum applicants were nationals of Middle Eastern countries, and 23% were nationals of African

countries. In 2022 (the year to September), the largest nationality groups were European (28.1%) and Asian (27.7%).

Many displaced populations arrive from countries with disrupted health services, lower vaccination rates[7], and a higher burden of infectious disease. Evidence[8] suggests that some measles outbreaks in the EU/EEA were due to sub-optimal vaccination coverage in migrant populations. People seeking asylum may additionally arrive after a prolonged period of transit where they are in close contact with others and are subject to poor living conditions. Due to untreated communicable diseases, rates of diseases such as tuberculosis, enteric fever, and malaria are often higher in the newly arrived migrant population in the UK[9]. Residents may also be at a higher risk of infections whilst in asylum accommodation. Due to overcrowded or unsuitable accommodation experienced in the UK, residents may become at increased risk of infectious diseases such as chicken pox, scabies, measles, and invasive Group A streptococcal infections[10]. The below provides a summary of good practice with regards to the health protection response in migrant settings. This is based on conversations with partners working in this space:

Good practice for health protection in migrant accommodation settings

Case study of best practice model of care - RESPOND

RESPOND is a rapid access, community-based screening and care planning service for all asylum-seeking adults and children living in temporary, Home Office funded accommodation in Barnet, Camden, and Islington. The aim of the service is to help with the following areas:

- Physical health concerns including infectious diseases
- Mental and emotional health difficulties
- Child development and behavioural concerns
- Oral health needs
- Sexual and reproductive health including need for access to antenatal care
- Safeguarding needs
- Access to healthcare

It is an extremely thorough nurse-led service, with access to MDT for complex case reviews. It involves going into IAC settings and carrying out health screening and tests on the spot. Service users are offered 45 minute – 1-hour slots, with families being seen together in extended 1.5-hour slots. A digital and paper comprehensive care plan is then developed for each individual so that they are not simply signposted to numerous different services. Interim data from RESPOND suggests that 90% of service users have an unmet physical health need, including high prevalence of untreated infectious disease. The impact of this service includes a reduction in the frequency of acute and unscheduled health presentations, effective screening and treatment of infectious diseases, a significant amount of time saved for primary care partners, and a better healthcare experience for people seeking asylum

RESPOND is currently exploring the possibility of running a peer support intervention, which can provide peer-led health promotion information and signposting within accommodations. They are also working on an education package regarding initial health assessments

Appendix E: Notifiable Diseases

Notifiable diseases

A notifiable disease is any disease that is required by law to be reported to government authorities. In the UK, diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010 are as follows:

Acute encephalitis	Haemolytic uraemic syndrome (HUS)	Rubella
Acute infectious hepatitis	Infectious bloody diarrhoea	Severe Acute Respiratory Syndrome (SARS)
Acute meningitis	Invasive group A streptococcal disease	Scarlet fever
Acute poliomyelitis	Legionnaires' disease	Smallpox
Anthrax	Leprosy	Tetanus
Botulism	Malaria	Tuberculosis
Brucellosis	Measles	Typhus

Cholera	Meningococcal septicaemia	Viral haemorrhagic fever (VHF)
COVID-19	Monkeypox	Whooping cough
Diphtheria	Mumps	Yellow fever
Enteric fever (typhoid or paratyphoid fever)	Plague	
Food poisoning	Rabies	

Other diseases of interest

Other diseases of interest in asylum and refugee settings which should be notified include:

- Chickenpox
- Influenza
- Panton Valentine Leukocidin positive *Staphylococcus aureus* (PVL is a toxin produced by certain types of this bacteria)
- Scabies

Concerning symptoms

There are other symptoms of illness which should be reported to a health provider so that they may carry out a clinical assessment. The health provider will decide whether this then needs to be reported to the local Health Protection Team. These symptoms include:

- High fever (over 38C)
- Persistent/severe vomiting
- Visible skin rashes or blisters/sever itching
- Persistent/severe coughing
- Jaundice

Appendix F: Function and responsibilities of London Health Protection Teams (HPTs) and the wider public health system

There have been recent changes to the organisation of health protection functions across the public health system in England. In March 2021, the government announced that Public Health England would be disbanded. In its place, on 1st October 2021, PHE's health protection functions were transferred over to the UK Health Security Agency (UKHSA). PHE's health improvement functions were transferred to the Office for Health Improvement and Disparities within the Department of Health and Social Care (OHID) and NHS England. The Health Protection Teams (HPTs) which transferred to UKHSA are responsible for responding to reports of notifiable diseases, infectious disease outbreaks, and other environmental threats to the public's health.

UKHSA London has three HPTs: North East and North Central London (NENCL) HPT, the North West London (NWL) HPT, and the South London HPT. Each of them

has an on-call team which responds to notifications throughout nights, weekends, and bank holidays. They carry out risk assessments and advise on public health actions. The Director of Public Health has a frontline leadership role within a local authority and within their statutory responsibilities is an expectation that they advise on matters of health protection which affect their residents.

Local Response: Health Protection Teams (HPTs)

HPTs receive notifications of infectious disease cases, outbreaks, and non-infectious threats to the public's health. These notifications come from a variety of sources, including from GPs, hospital clinicians, lab reports, schools, ICAs, and other stakeholders. When a local health protection team receives one of these notifications, this is passed on to that day's on call team and the case is assigned to a team member. This individual will then carry out a risk assessment with the point of contact at a given setting, provide advice, and ensure that the required public health actions are carried out promptly. Where necessary, the HPT will contact wider stakeholders for their input and/or expertise on the given situation – sometimes, wider stakeholders will simply be informed of the situation. This process is the same regardless of whether the infection or outbreak is notified in or out of hours. The only difference is that the out of hours HPT practitioner will risk assess whether the situation needs to be dealt with immediately or if it can safely be dealt with during the following daytime shift.

HPTs are also responsible for developing Standard Operating Procedures (SOPs) for the infectious diseases which they deal with. In some circumstances, the health protection team will decide that they need to call an Incident Management Team (IMT) meeting. The purpose of an IMT meeting is to agree and coordinate the activities of the key stakeholders involved to manage the investigation and control of an individual case or outbreak situation. This includes assessing the risk to the public's health and ensuring that control measures are implemented as soon as possible. It is vital that a representative from the accommodation attends this meeting. The role of the HPT is liaising between key stakeholders, chairing the IMT meeting, and providing public health advice.

As part of their risk assessment, HPTs designate a situation as Routine, Standard or Enhanced (part of the National Incident Emergency Response Plan). This covers the whole spectrum of incidents from those that are dealt with as day-to-day business through to those requiring significant regional or national co-ordination and resource. This risk assessment dictates what level of resource needs to be mobilised from across the system.

Routine: Incident that can be safely managed on existing guidelines and SOPs, not requiring any special management

Standard: Incident requiring local leadership arrangements with incident management team and incident director. No enhanced national incident leadership needed. May require support from specialist services or liaison with relevant external bodies as required e.g., NHS, FSA, EA, DEFRA

Enhanced: National leadership arrangement with national command and control. Will require support from specialist services. Liaison with relevant external bodies as required

Health Protection Team (HPT)	**Email**	**Email for PII**	**Phone number**	**Urgent out of hours contact number**
North West London HPT	NWLHPT.OnCall@ukhsa.gov.uk	phe.nwl@nhs.net	0300 303 0450 (for all teams)	
North East and North Central London HPT	necl.team@ukhsa.gov.uk	phe.nenclhpt@nhs.net		
South London HPT	slhpt.oncall@ukhsa.gov.uk	phe.slhpt@nhs.net		

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