To:
- integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses or directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses or directors of nursing
  - chief people officers
- primary care networks

cc.
- NHS England regional teams:
  - directors of commissioning
  - directors of public health
  - medical directors
  - chief nursing officers
  - infection prevention and control leads
  - health and justice leads
- Local authority directors of public health

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

7 November 2024

Dear colleagues

Actions to take following the emergence of clade 1b mpox cases in the UK

The World Health Organisation (WHO) has declared clade 1b mpox as a public health emergency of international concern. The current risk to the UK population remains low. However, as you know, on 30 October 2024 the first case of clade 1b mpox was detected in the UK, a travel-associated case in London and subsequently 3 household contacts have had positive tests. It is the NHS's duty to ensure maximum readiness to respond to outbreaks.

This letter sets out actions we are asking you to take to assure and refresh infectious disease outbreak response plans, further to the measures we set out in September. Further information from the UKHSA is also available.

This letter does not cover the limited pre-exposure vaccination offer to staff at risk of occupational exposure or the pre-exposure offer to other eligible cohorts (mainly gay, bisexual and other men who have sex with men at higher risk of exposure) in London, Greater Manchester and Brighton as a continuation of the 2022 Clade 2 outbreak response. Information on this will be communicated as needed.

Vaccination response to outbreak

Clinical guidance on outbreak response is set out in the Green Book Chapter 29, Smallpox and Mpox. It outlines that vaccination for close contacts of a case should be offered as soon as possible and within 4 days of exposure. However, any identified close contacts of a case who are at high risk of severe complications including children (under the age of 5 years), pregnant women or severely immunosuppressed individuals should be offered a single dose of post-exposure vaccine up to 14 days following last exposure. It also highlights that in certain scenarios subject to a risk assessment by the UKHSA health protection team (HPT) and other relevant individuals, further ring vaccination may be recommended for contacts of high-risk contacts and/or eligible cohorts in closed or semi-closed settings. The time between a recommendation to vaccinate and vaccine being administered must be reduced as far as practically possible. Each trust and ICB has existing outbreak management plans. These should be reviewed to ensure the following:

1. ICBs should be aware of the process to activate their local outbreak and incident response arrangements with UKHSA HPTs and have a clearly designated local ICB lead contact to ensure any response is co-ordinated with clear out-of-hours and weekend cover, and that referral pathways have been developed and communicated.

2. ICBs should ensure that this process is shared with UKHSA HPTs as well as local authorities and sexual health services. Note that ICBs may be required to vaccinate their own population where they are contacts of a case in a different ICB area, and that advice may originate from a different HPT. ICBs should appoint a lead contact responsible for managing and co-ordinating activities regarding clade 1b mpox both in and out of hours. Each ICB must confirm their nominated lead to the Regional Director of Commissioning via the Regional Operations Centre, and an amalgamated list should then be shared with the National Operations Centre (via england.incident12@nhs.net) no later than 5pm on Friday 8 November 2024.

3. ICBs must consider how they would work with HPTs to identify and to vaccinate eligible cohorts in closed environments and high-risk settings. This should focus on, but is not limited to, universities, early years settings, prisons, adult social care and communal settings accommodating vulnerable individuals (for example, rough sleepers, vulnerable migrants).

4. ICBs should identify and agree in advance the appropriate clinical team to undertake the vaccination response, noting that this may include children. This should also include what action needs to be taken when healthcare worker contacts have been identified that require occupational health input (indicative example pathways to support decision making are set out in Annex A).

5. A process is in place for sites to request, transport and store vaccines, including how to maintain the cold chain. This should be agreed with an appropriate designated hospital that holds stock (details below).

6. For the purpose of vaccine administration, ICBs should be familiar with the mpox vaccine Patient Group Direction (PGD) and have arrangements in place for this PGD to be authorised locally for use in the context of outbreak response.

7. Outbreaks solely confined to NHS trust premises, whether acute, community or mental health, will usually be led by the relevant trust in accordance with their operational plans and with the advice and input of their IPC and occupational health teams as well as the UKHSA HPT region. It's important to note that outbreaks may exist across hospital and non-hospital settings and plans should be in place to manage these.

Vaccine supply

While the UK has secured more vaccine to boost resilience against mpox, there is currently a limited supply of mpox vaccine, supplied only to a small number of sites following qualification by the UKHSA. The vaccine is supplied frozen, in packs of 20, and has a shelf-life of only 8 weeks once thawed.

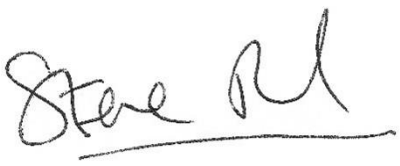
A list of sites that are known to be qualified and either hold, or can order, vaccine is provided as an annex to this letter (Annex B); each organisation on this list, working with their Chief Pharmacist, should ensure they have a legally compliant process to make vaccine available 7 days a week should it be requested by an ICB, local HPT or neighbouring NHS trusts. It's important to note that whatever the reason is that a provider holds stock, they can use it for anyone needing vaccination in response to a case.

All system partners are now asked to ensure appropriate local arrangements are in place ahead of any need to activate them.

We will be holding a webinar soon with ICB identified mpox co-ordinators to provide further information and answer questions. In the meantime, if you have any additional questions, please email england.incident12@nhs.net.

Thank you for your continued efforts and support as the NHS and UKHSA does everything possible to protect the public.

Yours sincerely



Steve Russell
National Director of Vaccinations and Screening and Chief Delivery Officer
NHS England

Professor Susan Hopkins
Chief Medical Advisor
UK Health Security Agency

Annex A: Indicative pathways for vaccination

Post-exposure vaccination of contact or ring in same ICB as case

- HPT identifies and contacts the person eligible for post-exposure vaccination providing appropriate information about the disease and possible next steps.
- HPT informs the ICB as the commissioner.
- ICB identifies and then liaises with the appropriate clinical team who liaises with the HPT to access appropriate patient information for the purpose of vaccination.
- ICB facilitates access to vaccination for the clinical team (joining vaccine supplier up with the clinical team) and transportation (vaccine to patient or patient to vaccine) (following HPT risk assessment and liaising with NHS regional EPRR teams as necessary)*.
- **For contacts**, this is a time critical process and needs to be completed within 4 days of exposure.

Post-exposure vaccination of contact or ring vaccination in different ICB as case

- HPT identifies the person eligible for post-exposure vaccination.
- They also identify the person lives in a different ‘catchment’.
- HPT identifies the HPT in the ‘catchment’ where the contact lives.
- HPT in that place contacts the person eligible for post-exposure vaccination providing appropriate information about the disease and possible next steps.
- HPT in that ‘catchment’ informs the ICB as the commissioner.
- ICB identifies and then liaises with the appropriate clinical team who liaises with the HPT to access appropriate patient information for the purpose of vaccination.
- ICB facilitates access to vaccination for the clinical team (joining vaccine supplier up with the clinical team) and transportation (vaccine to patient or patient to vaccine) (following HPT risk assessment and liaising with NHS regional EPRR team as necessary)*.
- **For contacts**, this is a time critical process and needs to be completed within 4 days of exposure.

Post-exposure vaccination of healthcare worker contact, or ring in same ICB as case

- At the trust where the healthcare worker assesses the possible / probable mpox clade 1 case, possible contacts are identified, and the occupational health department undertakes a risk assessment.
- If post-exposure vaccination is advised, the NHS trust informs the ICB as the commissioner with the HPT in copy. The OH department gives the healthcare worker advice on symptoms, and possibility of vaccination.
- ICB identifies and then liaises with the appropriate clinical team who liaises with trust occupational health department to access appropriate patient information for the purpose of vaccination.
- ICB facilitates access to vaccination for the clinical team (joining vaccine supplier up with the clinical team) and transportation (vaccine to patient or patient to vaccine) (following HPT risk assessment and liaising with NHS regional EPRR team as necessary)*.
- **For contacts**, this is a time critical process and needs to be completed within 4 days of exposure.

Post-exposure vaccination of healthcare worker contact, or ring in different ICB as case

- At the trust where the healthcare worker assesses the possible / probable mpox clade 1 case, possible contacts are identified, and the occupational health department undertakes a risk assessment.
- If post-exposure vaccination is advised, the NHS trust informs the ICB where the healthcare worker lives, as the commissioner, with HPT local to the employing provider in copy. The OH department gives the healthcare worker advice on symptoms and possibility of vaccination.
- ICB identifies and then liaises with the appropriate clinical team who liaises with trust occupational health department to access appropriate patient information for the purpose of vaccination.
- ICB facilitates access to vaccination for the clinical team (joining vaccine supplier up with the clinical team) and transportation (vaccine to patient or patient to vaccine) (following HPT risk assessment and liaising with NHS regional EPRR team as necessary)*.
- **For contacts**, this is a time critical process and needs to be completed within 4 days of exposure.

*There should be pre-arranged local agreements for vaccination, but the expectation is that where a trust is holding stock for an HCID, SRIDC, or designated sexual health service that this stock can be used for the purpose of vaccine administration for contacts and ring vaccination. For example, if a healthcare worker contact is working at a site that is holding stock for a designated sexual health service, they can vaccinate that healthcare worker whether they live in that area or not.