



Activation Thresholds and Governance for Regional Outbreak Control Teams

Please note that this document provides a generic framework for determining thresholds for escalation and for the activation and governance of Outbreak Control Teams (OCTs) and must be used alongside relevant pathogen-specific public health management guidance. It is intended to be used in tandem with disease-specific public health management guidance (e.g. Acute Respiratory Infections [ARI], vaccine-preventable diseases, zoonotic infections, and High Consequence Infectious Diseases). It should not be used in isolation and does not replace pathogen-specific guidance, statutory notification requirements, or clinical management protocols.

Readers should not rely solely on the information contained in these guidance outputs. Guidance information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance document. This guidance document is regularly reviewed based upon emerging evidence at national and international levels and national policy decisions. In tandem with this, the guidance will be formally reviewed on a three-year cycle.

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STATUS AND INTENDED USE OF THIS DOCUMENT

This document has been developed by the National Health Protection Office (NHPO) as a supportive, non-mandatory framework to assist Regional Departments of Public Health (RDPH) in considering thresholds for activation of Incident Management Teams (IMTs) and Outbreak Control Teams (OCTs).

It does not mandate changes to regional IMT/OCT procedures and does not replace regional outbreak management protocols.

Adoption or adaptation of this framework is at the discretion of the Regional Directors of Public Health (RDsPH) or delegates.

The document should be read in conjunction with the [National Health Protection Incident Response Plan](#) for events requiring national coordination.

PURPOSE

This document provides a non-statutory, standardised framework to support Regional Departments of Public Health when considering thresholds, principles, and governance arrangements for the activation of Outbreak Control Teams (OCTs) in the management of infectious disease incidents and outbreaks.

The purpose of this guidance is to:

- Support **timely, proportionate, and consistent activation** of OCTs;
- Support decision-making on need for formal activation of OCTs.
- Distinguish between **incident coordination and technical outbreak control** functions;
- Promote **effective multi-agency coordination**, including One Health approaches;
- Ensure alignment with **international best practice** and national statutory responsibilities.

Activation of an OCT is a structured, risk-based decision intended to strengthen coordination, ensure clarity in governance, and facilitate an organised multisectoral response. It supports early situational awareness, consistent technical decision-making, and effective public health action as an incident evolves with clear documentation of decisions and action owners. Effective and consistent activation of OCTs is essential to ensure proportionate, coordinated, and timely management of infectious disease incidents across Ireland.

This guidance is designed primarily for use by Regional Departments of Public Health and local incident leads. It provides a framework for decision-making at the regional/departmental level. Where escalation to national coordination is required, this document should be applied in conjunction with the [National Health Protection Incident Response Plan](#).

This framework is intended to **complement**, not direct or override, existing regional OCT procedures. Each RDPH may adapt or integrate these recommendations as appropriate.

1 SCOPE

This guidance may be used by Regional Departments of Public Health when considering response to any incident or outbreak, relating to either infectious diseases or other hazards.

This guidance **does not replace disease-specific guidance nor other guidance relating to specific non-infectious hazards**. Rather, it provides a **generic management framework** to be used alongside other public health management guidance.

Regional Departments of Public Health maintain established OCT guidance. This document is intended to be consistent with and complementary to these regional documents and may be adapted locally as required by the Regional Departments of Public Health.

1.1 Definitions

1.1.1 *Outbreak Control Team (OCT)*

A multidisciplinary, multiagency group led/supported by public health convened to **direct technical outbreak investigation and control measures** for a defined outbreak of an infectious disease. An OCT may be convened in response to even a single case of a high-consequence infectious disease or other serious infection e.g. polio- such events are usually managed at national level – see National Incident Management Plan.

1.1.2 Outbreak

An outbreak is the occurrence of cases of disease **above what would normally be expected** for a given population, place, or time, **OR** the occurrence of **two or more epidemiologically linked cases** associated with a common exposure or setting. ¹⁻³

An incident may also be designated as an outbreak by Public Health where factors such as **severity, vulnerability of affected populations, transmission risk, or the potential public health impact** warrant an enhanced, coordinated response.

1.2 Legislative Framework

1.2.1 Legislative Basis

The investigation, surveillance, prevention, and control of notifiable infectious diseases and outbreaks in Ireland are legally mandated public health functions.

These duties arise under:

- The **Health Act 1947**, as amended;
- The **Infectious Diseases Regulations 1981**, as amended;
- **EU legislation on serious cross-border threats to health** (including Decision 1082/2013/EU and subsequent regulations);
- **International Health Regulations** (IHR, 2005), which require States Parties to maintain core public health capacities for surveillance, risk assessment, and response.

Under this legislative framework, all medical practitioners and clinical directors of diagnostic laboratories are legally required to notify the **Medical Officer of Health (MOH)** of prescribed notifiable diseases. These statutory notification pathways enable timely surveillance, risk assessment, outbreak detection, and public health action.

These statutory functions are **not discretionary** and **must not be slowed or constrained by research governance processes**. They exist to protect population health, support emergency response, and fulfil Ireland's obligations under EU and IHR public health systems.

1.2.2 Role of the Medical Officer of Health (MOH)

The MOH, based within Regional Departments of Public Health, is the statutory officer responsible for receiving infectious disease notifications and initiating appropriate public health measures including case and contact management and ongoing outbreak surveillance. These functions include:

- epidemiological investigation;
- implementation of control measures;
- coordination with the Health Protection Surveillance Centre (HPSC);
- fulfilling statutory surveillance, reporting, and response obligations under national legislation, EU cross-border threat systems, and the IHR.

These responsibilities ensure that surveillance, investigation, incident management, and outbreak control activities are carried out consistently and in compliance with Ireland's legal obligations.

This OCT activation framework **operates in support of—rather than in place of—the statutory duties of the MOH**. It provides a governance structure for coordination and documentation but does not alter, override, or delay legally mandated public health functions.

2 PRINCIPLES UNDERPINNING OCT ACTIVATION

Activation decisions should be guided by the following principles:

- **Proportionality:** The response should match the level of risk and complexity.
- **Precautionary approach:** Early coordination is preferred where uncertainty exists.
- **Scalability:** OCTs may be expanded, adapted, or stood down as the situation evolves.
- **Risk-based decision-making:** Epidemiological, clinical, environmental, and operational risks must be considered jointly.
- **Clear governance:** Leadership, accountability, decision-making authority, communications arrangements and key functional responsibilities should be explicit and documented at the outset of the OCT informing membership of the OCT and delegated authority of those attending to deploy resources in support of decisions and agreed actions.
- **One Health integration:** Animal, human, and environmental health sectors must be engaged where relevant.
- **Timeliness:** Early activation may prevent escalation, even where case numbers are low.

2.1 Relationship to the National Health Protection Incident Response Plan

This document provides a framework for regional management and coordination.

For events where risk, complexity, or cross-regional implications exceed regional capacity, escalation to the National Incident Management Team (NIMT) is governed by the [NHPO National Health Protection Incident Response Plan](#), which takes precedence in defining national-level governance and coordination pathways.

A regional OCT may still be required alongside, and in coordination with, an NIMT when convened, to coordinate regional investigation and response actions. Where

regional and national structures operate concurrently, their respective roles, responsibilities, reporting and communication arrangements should be clearly defined.

3 Thresholds for Considering OCT Activation

No single criterion mandates activation. An OCT should be **considered when one or more of the following thresholds are met**, following a Public Health Risk Assessment (PHRA).

Thresholds are not discrete and often co-occur; activation decisions should consider cumulative risk across epidemiological, operational, and governance domains following PHRA.

3.1 Epidemiological Thresholds

- Two or more epidemiologically linked cases outside expected background levels may prompt consideration of activation;
- Rapid increase in cases over a short period may warrant consideration of activation;
- Any indication of unexpected severity—including increased morbidity, mortality, or atypically severe clinical outcomes compared with expected epidemiological patterns—should be considered a potential threshold for activation, particularly where it may signal an evolving or poorly understood risk.
- Evidence of ongoing transmission despite standard control measures may indicate a need to consider activation;
- Infection in populations with **unexpected susceptibility** (e.g. age-appropriately vaccinated cohorts) may be a factor supporting activation;
- Unusual clinical presentations, severity, or atypical transmission patterns;
- Difficulty defining exposure windows, contacts, or transmission pathways;
- Any situation where early activation would materially improve situational awareness, stakeholder coordination, or risk mitigation should be considered as a potential trigger.

3.2 Setting-Based Thresholds

Activation may be considered where an incident involves settings such as:

- Congregate residential settings (e.g. nursing homes, prisons, Direct Provision);
- Healthcare facilities;
- Childcare, school or educational settings;
- Occupational settings with potential amplification (e.g. farms, meat plants, factories);
- Settings where **isolation, cohorting, or contact management is operationally challenging**.

3.2.1 Public Health involvement in acute hospital outbreaks

Hospital Infection Prevention and Control Teams should seek Public Health involvement early **where there are potential public health implications** arising from an acute hospital outbreak, in line with international principles. Regional Departments of Public Health provide independent epidemiological assessment and technical advice to support hospital IPC and clinical teams in identifying transmission pathways and implementing appropriate control measures.

Public Health involvement is **not required for all hospital outbreaks**. Routine, low-complexity outbreaks that are well understood and effectively managed within hospital governance structures—such as typical seasonal norovirus or influenza outbreaks—may be managed solely by hospital IPC and clinical teams.

Public Health input is generally indicated **only where PH expertise adds value**, including situations where:

- nosocomial transmission is suspected but routes are unclear;
- the outbreak involves high-risk or vulnerable patient groups;
- there is uncertainty regarding outbreak dynamics or case definition;

- the event has potential implications beyond the hospital (e.g., community, inter-facility transfer, regional signalling);
- the scale, severity, operational challenges, or governance complexity warrants epidemiological support; or
- alignment with national or international best practice is required.

Public Health does not chair hospital OCTs. Instead, PH contributes specialist epidemiological expertise to ensure consistent, risk-based outbreak management across diverse hospital governance structures (HSE statutory, voluntary, private, and CHI services).

3.3 Population Vulnerability Thresholds

Involvement of the following population groups in an incident or outbreak may support decision-making regarding activation of an OCT:

1. **Pregnant individuals, neonates, infants, or other clinically vulnerable groups.**
2. **Immunocompromised populations or individuals at increased risk of severe disease.**
3. **Groups for whom passive monitoring may be unreliable** due to age, disability, language, or social circumstances.
4. **Populations with limited access to healthcare or public health follow-up,** including those experiencing social exclusion or barriers to care.

3.4 Operational and System Thresholds

Consider OCT activation when:

- The **scale or complexity** of the incident requires response beyond routine:

- **Multiple agencies or sectors** will require coordinated action.
- Specific roles for particular partners or stakeholders need to be discussed and agreed.
- **Significant media interest, public concern, or misinformation** is likely.
- There is potential disruption to **critical services** (e.g. healthcare, education, food supply, workforce).
- **Legal directions, formal restrictions, or escalation pathways** are being considered.

3.5 Governance and Strategic Thresholds

Independent of case numbers, escalation may be considered when:

1. Decisions require balancing public health risk against societal or economic impacts.
2. Cross-jurisdictional or multi-regional coordination is required, or where the scale/complexity exceeds the capacity of a single Regional Department of Public Health.
3. International reporting, surveillance, or notification obligations are triggered, in which case NHPO involvement is expected.
4. Strategic communications are likely to require coordination across agencies due to anticipated public concern, media interest or misinformation, and communications leadership and approval pathways should be clarified early in the response, including between Regional and National Communication teams within HSE and partners.
5. Activation decisions remain the responsibility of the Regional Department of Public Health or the designated incident lead under regional governance structures.
6. **Where risk, complexity, or required coordination exceeds regional capacity**, escalation to the NHPO National Incident Management Team (NIMT) should be considered in line with the National IMT Framework.

4 ADDITIONAL CONSIDERATIONS REQUIRING NATIONAL ESCALATION (BEYOND/IN ADDITION TO REGIONAL OCT ACTIVATION)

The following factors indicate incidents with potential for significant national-level implications and should prompt early engagement with the National Health Protection Office (NHPO), in line with **the National Incident Management Team (NIMT)** in accordance with the National Health Protection Incident Response Plan. These scenarios are listed here to support regional situational awareness rather than imply regional lead responsibility:

- Designation or consideration of **High-Consequence Infectious Disease (HCID)** status;
- Suspected or confirmed infection with a **novel, emerging, or unknown pathogen**;
- Pathogens associated with **high severity, high case fatality**, or significant uncertainty, even where case numbers are low;
- Events likely to interface with **national emergency management structures**;
- Situations with major **One Health** implications (e.g., concurrent animal–human outbreaks) requiring national coordination;
- **International alerts**, risk assessments, or WHO/EU notifications indicating elevated threat levels;
- Incidents with anticipated **national-level political, societal, media, or cross-sectoral implications**.

In such cases, early engagement with the **National Health Protection Office (NHPO)** is expected to support coordinated risk assessment, governance, and response planning. Activation of a regional OCT may still be appropriate as part of an initial or integrated response, depending on the specific context and governance arrangements.

5 CORE COMPOSITION (Indicative)

Membership should be **proportionate and context specific**, and may include:

- Chair (depending on incident setting and statutory responsibility);
- Regional Department of Public Health ± National Public Health Office;
- Health Protection Surveillance - Regional/National;
- Infection Prevention and Control;
- Clinical Microbiology / Virology;
- Setting owner or operational lead;
- Communications and public information;
- Occupational health (where relevant);
- Regional preparedness, resilience functions or emergency management, (where relevant); and
- One Health partners (animal health, environmental health) where applicable.

Members of the OCT representing specific structures or functions within HSE and from partner organisations should be delegated appropriate authority by their organisations to support decision making including deployment of resources if necessary and/or have ability to quickly escalate such requests to senior decision makers within their respective organisational structures in a timely manner to support coordinated, effective and speedy actions.

6 DOCUMENTATION & REVIEW

At a minimum, OCT activation should include documented:

- Rationale for activation (thresholds met);
- Governance model and chairing arrangements;
- Agreed roles and responsibilities of key participants, including leadership, decision-making authority, communications arrangements and liaison functions where relevant;
- Key decisions and actions;
- RAID (Risk, Action, Issue and Decision) log for significant or complex incidents;
- Criteria for escalation, de-escalation or stand-down.

Following conclusion, a **proportionate lessons-learned or After-Action Review (AAR)** should be undertaken, in line with WHO, ECDC, UKHSA and PHAC methodologies, particularly for complex, novel, or high-impact incidents.

Documentation requirements should be consistent with regional protocols and may be adapted for local use. Regional Departments of Public Health should utilise standardised documentation templates where available, including meeting records, action logs, SitReps and RAID logs.

6.1 Public Health Surveillance and Monitoring Responsibilities

As part of outbreak investigation and control, Regional Departments of Public Health are responsible for the ongoing surveillance and monitoring of cases and contacts associated with public health outbreaks. These functions are conducted in line with statutory responsibilities and relevant disease-specific guidance and may include:

- Case identification, verification, and line listing;
- Contact identification, risk assessment, and categorisation;
- Active or passive follow-up of cases and contacts, including monitoring for symptom development where indicated;

- Implementation and monitoring of public health measures (e.g. exclusion, isolation, prophylaxis, vaccination);
- Updating epidemiological information to inform dynamic risk assessment and decision making; and
- Escalation of findings where new risks, transmission patterns, or control challenges emerge.

The intensity and duration of monitoring should be proportionate to the pathogen, transmission dynamics, and population risk, and should align with relevant national and international guidance.

These activities form part of routine public health outbreak management and may be undertaken within or alongside OCT structures, depending on the scale and complexity of the incident.

Where cases and contacts are managed within acute healthcare settings, clinical responsibility for patient care remains with the treating clinical teams. Public Health provides epidemiological input, risk assessment, and advice to support infection prevention and control measures and broader outbreak management.

Where national coordination structures (e.g. National Incident Management Team [NIMT]) are established, surveillance and monitoring activities may be informed by national guidance, with delivery continuing through Regional Departments of Public Health in line with agreed governance arrangements.

Intelligence from national and international sources (e.g., EWRS, WHO, ECDC, UKHSA and national surveillance systems) should be incorporated into ongoing dynamic risk assessment where relevant. NHPO and its integrated functions (HPSC and NIO) will provide intelligence, information and SitReps on national and international evidence or data to inform Regional planning and response.

6.1.1 Health and care worker exposure (in occupational settings)

Where exposures occur among health and care workers (H&CWs) in the course of their duties, arrangements for assessment, risk stratification, and follow-up should be coordinated through the relevant employing organisation in line with national guidance. Management should align with national infection prevention and control guidance, including recommendations on exposure risk assessment, work restrictions where indicated, and return-to-work criteria. Public Health may provide epidemiological advice and support risk assessment, particularly where there are implications for patient safety, onward transmission, or wider outbreak control.

7 RELATIONSHIP TO DISEASE-SPECIFIC GUIDANCE

Disease-specific guidance (e.g. ARI, pertussis, measles, zoonotic influenza) may include **additional escalation triggers specific to transmission dynamics, severity, or vulnerable populations**.

Where inconsistencies arise, **disease-specific guidance supersedes** this generic escalation framework. Regional outbreak procedures also remain valid unless explicitly replaced by disease-specific or statutory requirements.

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