UK Health Security Agency

Laboratory reporting to UKHSA

A guide for diagnostic laboratories

Version 5 (April 2025)

Contents

Amendments

This guidance was updated in March 2025 to reflect changes to the Health Protection (Notification) (Amendment) Regulations (2025) which place a statutory duty on all diagnostic laboratories in England to notify the UK Health Security Agency (UKHSA) if they identify a causative agent listed in Appendix 1 of this guidance.

From 6 April 2025, 10 additional causative agents have been added to this statutory list.

1. Middle East respiratory syndrome coronavirus (MERS-CoV)
2. Non-human influenza A subtypes
3. Norovirus
4. *Echinococcus* spp
5. Tick-borne encephalitis virus (TBEV)
6. Toxoplasma (congenital toxoplasmosis)
7. *Trichinella* spp
8. *Yersinia* spp
9. Respiratory syncytial virus (RSV)
10. *Candidozyma auris*

The purpose of surveillance

In public health the term ‘surveillance’ refers to the systematic ongoing collection, collation and analysis of data to inform and assess public health response. Communicable disease surveillance has a number of goals, these include detection, analysis, action and information. Each of these is detailed below.

1. Detection

The early detection of changes in the temporal, geographic and age distribution of new and known diseases that indicate outbreaks of infection, or changes in the pattern of sporadic diseases.

2. Analysis

Determining the exposure, prevalence, burden, morbidity, mortality, carriage and long-term trends of infectious diseases.

The generation of information on changes in the type, pathogenicity and drug resistance of the organisms causing human and animal disease.

Monitor the use and coverage of an intervention, any adverse events arising from that intervention and the overall impact of disease control measures including immunisation.

Monitor changes in properties such as prevalence, spatial distribution and time distribution of disease-causing hazards including animal diseases, weather and social factors as well as population vulnerability and susceptibility.

3. Action

Enable appropriate and timely action to be taken, in order to protect the public's health. This will commonly be at the local level.

In incidents that are widespread, the action may be regional, national or international, for example the coronavirus (COVID-19) pandemic. In rare instances, a single case may require prompt national or international intervention, for example a case of Ebola virus disease.

Inform the development of policies to detect new threats and emerging problems, to reduce exposure to a particular hazard or to protect individuals in advance of such exposure. Normally such policies will be developed nationally in the light of trends in disease and the available methods of prevention.

4. Information

Building information on the temporal, geographic and population distribution and epidemiology of new, poorly understood and well understood diseases to inform decision making for public health, health service planning, risk management, research and control priorities.

Inform key disease eradication or control programs. Provide information to support the development of guidance for professionals on the clinical management of individual patients, the choice of the appropriate control strategy and the organisation of services to deliver them to those at risk.

Ensure that the UK makes its full contribution to European and international efforts to protect health.

Informing the public about the risks to individuals and the general public.

To meet these surveillance objectives, it is essential that coverage of diagnostic laboratory reporting is complete, and the information provided is accurate and timely. This document sets out standards and procedures that will enable the organisations to meet the laboratory reporting surveillance requirements of the UK Health Security Agency (UKHSA) and the Health Protection (Notification) Regulations 2010 and Health Protection (Notification) (Amendment) Regulations 2025.

Health Protection (Notification) Regulations 2010

Since October 2010, the Health Protection (Notification) Regulations (2010) have required diagnostic laboratories to notify UKHSA of the identification of specified causative agents in a human sample (from live or deceased patients) within 7 days, unless urgent or otherwise stated, where causative agent can be taken to mean:

- a causative agent listed in Schedule 2 of the Regulations (and replicated in Appendix 1). In 2025, under the Health Protection (Notification) (Amendments) 2025 there have been 10 additional causative agents added to this list
- evidence of an infection caused by such an agent

The legal responsibility to ensure that laboratory notification is carried out in accordance with the Notification Regulations rests with the corporate body that operates the testing service, the director of the laboratory or the relevant persons providing the diagnostic test.

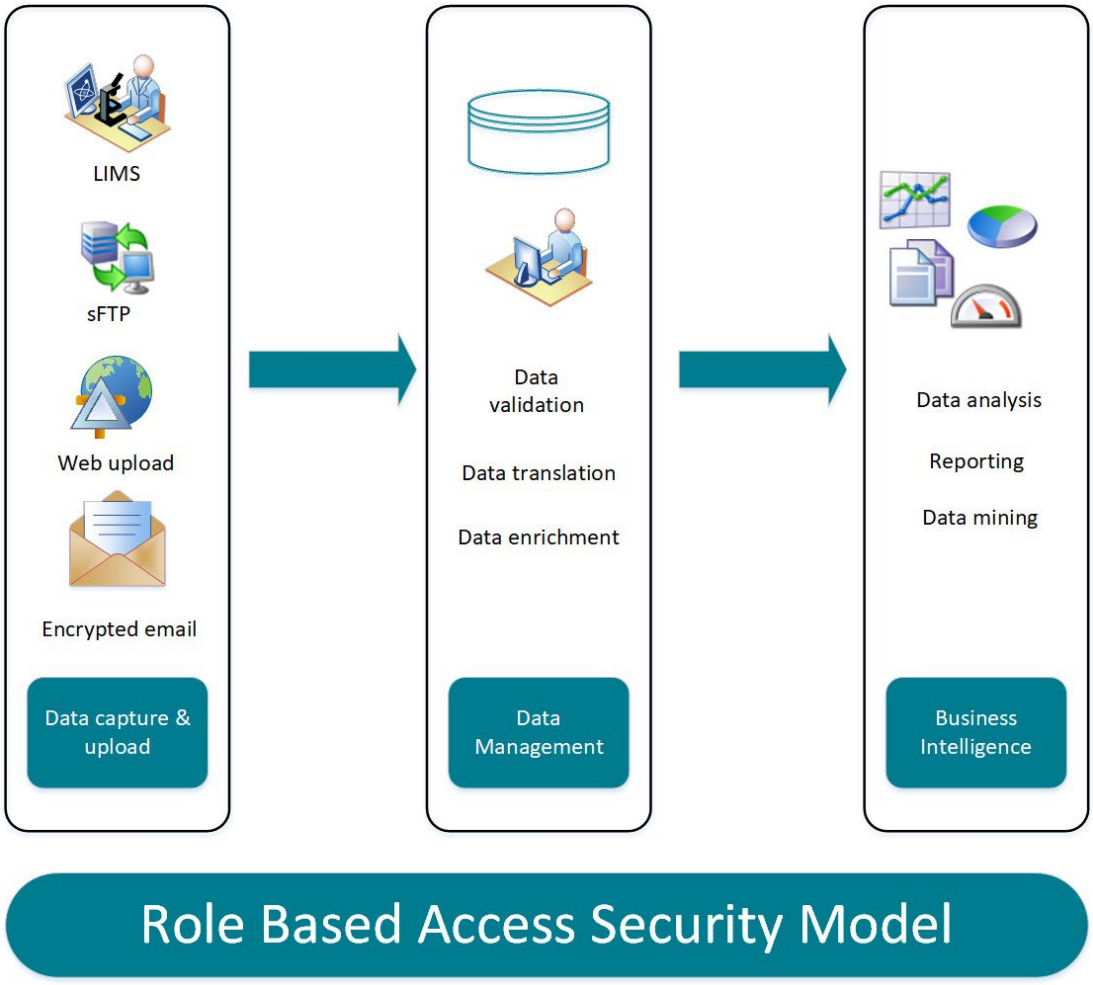
There is a more comprehensive list of causative agents (listed in Appendix 2 and not in the Notification Regulations) that should be reported to UKHSA. Updates to the notification regulations does not replace this voluntary reporting to UKHSA, which should continue for these other causative agents.

UKHSA surveillance systems

Second Generation Surveillance System

The Second Generation Surveillance System (SGSS) is an application that stores and manages data on laboratory isolates and notifications and is the preferred method for capturing routine surveillance data on infectious diseases and antimicrobial resistance from diagnostic laboratories across England. The data is stored in a central database within UKHSA and made available to a limited number of users within and outside the agency, subject to robust access control mechanisms.

Figure 1. High-level flowchart of SGSS data flow



Text version of Figure 1

This flowchart shows how results generated by the Laboratory Information Management System (LIMS) can be sent to SGSS via different routes (that is, secure file transfer protocol (sFTP), web upload or encrypted email). Data Management processes then occur, which include validation, translation of local codes and data enrichment. Finally, the data is made available to the Business Intelligence software for analysis, reporting and data mining. Access to the data is

tightly controlled through use of a role-based access control (RBAC) model that determines if a user can perform a certain task or view a given record.

LabLink+ software enables Communicable Disease Report (CDR) and Antimicrobial Resistance Reports (AMR) reports to be transferred from Laboratory Information Management Systems (LIMS) and then sent to SGSS via secure File Transfer Protocol (sFTP). It is also possible to upload the reports directly to SGSS using the application's user interface, and there is provision to send data in the legacy encrypted CoSurv format.

Once the reports have been loaded into SGSS, each record is subject to a number of validation processes, and local LIMS codes are translated to SGSS codes to standardise the data for analysis. Patient data is validated against the Demographic Batch Service (DBS – NHS England), and the record is updated with additional data received from the Spine (NHS England).

CDR records are transformed into cases using the OPIE principle through a deduplication process, before the data is loaded into a data warehouse for further analysis. AMR data is stored at a test level.

Caldicott and data protection

To achieve its objectives, Communicable Disease Surveillance needs to contain some patient identifiers in order to:

- enable duplicate reports from the same patient to be identified and avoid overestimation of disease prevalence
- enable appropriate follow up to be undertaken with the reporting laboratory
- enable outbreak investigation to be undertaken
- detect geographical and temporal clusters of cases that may represent an outbreak (geographic mapping from postcode)
- examine association between environmental factors and infection such as rainfall and animal population (geographic linkage to other datasets from postcode)
- establish linkage, when appropriate and justified, with the reference laboratory data on the organism concerned

Data containing any personal identifiers being sent to UKHSA electronically should be encrypted. This happens automatically for all data sent via secure File Transfer Protocol (sFTP) using the secure FTP across the Health and Social Care Network (HSCN) or the internet, and the SGSS web application uses 256-bit SSL encryption.

UKHSA is committed to maintaining the highest practical standards for handling confidential personal information (CPI) in accordance with UK General Data Protection Regulations (UK

GDPR) and the Caldicott Principles, ensuring it is legal, ethical, and appropriate while maintaining confidentiality.

Organism-Patient-Illness-Episode

A record within the CDR component of SGSS is based upon the Organism-Patient-Illness-Episode (OPIE) principle. OPIEs record episodes of infection whereby an episode constitutes each positive organism in a patient in a defined period of time. If an individual is infected by 2 different organisms (including 2 different sub-types of a single species) at the same time, that individual will be represented by 2 distinct OPIEs. Similarly, if an individual is infected on 2 separate occasions by the same organism (with recovery implied between those 2 episodes of infection) they will be represented by 2 distinct OPIEs.

The default episode length is 2 weeks, with the following exceptions:

- *Clostridioides difficile*: 4 weeks
- influenza virus A: 6 weeks – tis is to capture, within the same episode, serology testing for zoonotic influenza at 28 days
- *Salmonella* spp: 13 weeks
- SARS-COV-2: 13 weeks
- *Mycobacterium* spp: 26 weeks
- mpox virus: 52 weeks

How to report

Diagnostic laboratories are expected to follow the standards set out in UK Standards for Microbiology Investigations and be accredited to ISO 15189.

These instructions refer to causative agents listed in Appendix 1, which must be reported to UKHSA and causative agents in Appendix 2 that should be reported to UKHSA.

Laboratories are asked to submit reports to UKHSA as electronic files in one of the following formats:

- the LabLink+ format sent via secure sFTP
- the SGSS Excel template or the SGSS disease/test specific template, sent via secure sFTP
- the LabLink+ format or SGSS template formats described above, uploaded directly to SGSS via the web application

There is also an option to directly enter the data into the forms on the SGSS web application. Please contact the regional Field Service information team to discuss electronic file transmission and data file formats. Contact details are given in Appendix 5.

All files in the LabLink+ format require translations to be added to SGSS, which provide mappings between values in LabLink+ and SGSS fields. Translations can be added by authorised users from a laboratory, or by UKHSA staff. Users should contact their local UKHSA Field Services information team for support adding translations, particularly when adding multiple translations or adding organism subtype translations.

Note: Laboratories may send reports to UKHSA in more than one of the formats outlined above, but must only provide one report of any particular episode of illness due to a specific organism should be sent.

Point-of-care tests for COVID-19 and Influenza virus must be reported to UKHSA. Point-of-care test results for all other pathogens should be reported to UKHSA via LIMS download to SGSS where possible.

When to report

Diagnostic laboratories are required to notify UKHSA of the identification of the causative agents specified in Appendix 1 within a maximum 7 days unless urgent or otherwise stated in the regulations. COVID-19 positive test results must be reported within 24 hours. Daily reporting is preferred to enable timely public health action.

Urgent cases

UKHSA health protection teams (HPTs) should be notified of urgent cases as soon as reasonably practicable after the identification of the causative agent. This should be done by telephone. It is recommended that this should always be done within 24 hours. Urgent oral notification must be followed up by written notification within 7 days of identification of the causative agent.

In determining whether a case is urgent, factors that should be considered include:

- the nature of the causative agent, for example a rare and/or re-emerging disease
- ease of spread of that causative agent, including the infectiousness of cases and route of transmission
- ways in which the spread of the causative agent can be prevented or controlled, taking into account, for example, immunisation, isolation and prophylaxis
- nature of the disease it causes, including morbidity and case-fatality
- specific circumstances of the case which might represent particular risks, such as occupation, age and sex – it may be relevant, for example, if a patient is a healthcare worker, a child attending nursery or a woman of child-bearing age

Overall, the key consideration will be the likelihood that an intervention is needed to protect human health and the urgency of such an intervention.

Routine cases

All other reporting subject to the HNPR must be reported within 7 days and should be made as soon as possible after the organism has been identified, preferably at the same time that the laboratory report is being issued to the requester.

Any subsequent information should be reported by updating the original record on SGSS, this additional information should be made no later than 6 months after identification. If circumstances exist where reports older than 6 months will be made, please discuss this with your local SGSS support specialist.

Causative agents listed in Appendix 2 should be reported to UKHSA via SGSS as soon as possible.

Who reports

In most cases the source laboratory or testing service (for example, providers of point-of-care tests) will report to the UKHSA when an organism is cultured or otherwise identified. In some cases, the source laboratory will refer the specimen to a reference laboratory, which provides specialist diagnostic or typing services for specific organisms.

Note: The source laboratory has the legal responsibility to ensure the case is notified to UKHSA and will report the results unless there is a clear agreement in place for the reference laboratory to report. This agreement must be communicated to the UKHSA Field Service team (Appendix 5) to minimise the risk of both or neither laboratories reporting. All reports to UKHSA must identify the source and reporting laboratories (which will usually be the same) and where appropriate, the reference laboratory. The day of identification is the day the source laboratory is made aware of the result from the reference laboratory.

Congenital toxoplasma

We have confirmed with the PHW Toxoplasma Reference Unit in Swansea that all specimens referred there are reported to UKHSA and therefore there is no need for the source laboratory to inform UKHSA of those results. We would strongly recommend sending all samples for the diagnosis of congenital toxoplasma to the Toxoplasma Reference Unit in Swansea for confirmation if diagnosed or tested locally.

What to report

Organisms or infections to be reported

The CDR extract must have:

- positive results of all organisms specified in Schedule 2 of the Health Protection (Notification) Regulations 2025 and listed in Appendix 1 of this document
- negative and void results of tests seeking to detect SARS-CoV-2 (PCR, antigen or antibody), influenza virus and RSV

And should have:

- all clinically significant infections caused by the organisms listed in Appendix 2
- all clinically significant isolates from sterile sites such as blood, CSF, joint fluids, bone, pleural and pericardial fluids, heart valves, and abscesses in the brain, liver and spleen (Appendix 3 lists further sterile sites that may be considered to indicate invasive disease)
- every organism causing meningitis or encephalitis
- every organism causing haemorrhagic fever
- asymptomatic infections when of clinical or epidemiological relevance (for example viral infections in pregnancy, asymptomatic individuals associated with outbreaks, asymptomatic persons infected with HIV, Legionella pneumophila, or Salmonella typhi)
- organisms related to ongoing public health emergencies, for example enteroviruses detected in wastewater

Due to surveillance requirements in advance of and during pandemic influenza, laboratories must report isolates of and should report susceptibility test information for *Streptococcus pneumoniae*, *Haemophilus influenzae* and *Staphylococcus aureus* from lower respiratory tract sites, including sputum.

The AMR extract must include:

- all reports of bacteria that have tested positive for an acquired carbapenemase
- (identified either locally or at the national reference laboratory)
- all reports of bacteria that have antimicrobial test results – all antibiotic susceptibility results should be included, including those suppressed on the LIMS
- any resistance mechanism(s) identified in any of causative agents listed in Schedule 2

Organisms or infections not to be reported in CDR extract

- *Neisseria meningitidis* identified in a throat swab should **not** be reported unless associated with invasive disease in that individual
- uncomplicated urinary tract infections, unless caused by organisms listed in Appendix 1 or Appendix 2
- the isolation of BCG from immunisation sites, unless associated with extensive local or disseminated BCG infection

Note: If a single organism is identified in different specimen types, report it only once, listing each specimen type from which it was identified during that episode. If different organisms are identified as co-infections in the same patient, they should all be reported separately.

Report infections identified in mothers and their babies or foetuses as separate infections by cross-referencing to the other report, using the following appropriate feature description; child of infected mother; contact of case; maternal infection; perinatal transmission; pregnant and feature comment field if necessary.

What information a report should contain

Core data

The following core surveillance data are required on all reports submitted to UKHSA.

Fields marked with an asterisk (*) are mandatory.

- Source Lab: ideally always be specified
- Reference Lab: if relevant
- Reporting Lab*: must always be specified, will usually be source lab, in some cases the reference lab
- Patient identification*: - one of the following must be present:
    - patient's surname and initial or soundex code and initial
    - patient's hospital number (patient PID number)
    - patient's NHS number
- Date of birth (DOB)*: the patient's DOB where known or patient's age
- Sex*: male, female or not known
- Organism*: the full organism name and any typing results, or the description of the illness (for example, toxic shellfish poisoning)
- Date of onset: (dd/mm/yyyy format) the date of onset of the illness caused by the organism being reported
- Specimen type(s)*: for example, CSF, blood, sputum, serum (where the diagnosis is based on serology, please use serum as the specimen type)
- Specimen date(s)*: (dd/mm/yyyy format): the date the specimen was collected from the patient – if this is not known, use the date the specimen was received at the source laboratory
- Identification methods: the method used to identify the organism
- Postcode: the full postcode of the patient residence
- Ethnicity: required under the Race Relations Amendment Act 2001

For notifications of organisms listed in Appendix 1, the following information – insofar as it is known – must also be provided to UKHSA:

- name and address of the diagnostic laboratory
- patient's home address
- patient's current residence (if not home address)

- name, address and organisation of the person who solicited the test which identified the causative agent.
- indicate if a patient is a care home resident
- indicate if patient is a health care worker
- any antimicrobial susceptibility test result and resistance mechanisms identified

AMR data also requires the requesting organisation details. This is used by SGSS to indicate the source of the specimen and includes where the requesting organisation of the specimen is:

- a GP practice: the pathology system code will be translated to the NHS Organisation Data Service (ODS) practice code
- an acute hospital: the pathology system code will be translated to the ODS site code
- a community hospital: the pathology system code will be translated to the ODS site code

Organism-specific data

The following surveillance data is requested on all reports submitted to UKHSA:

- for SARS-CoV-2 antibody and antigen test results each report should contain appropriate information on the testing method used (that is, test manufacturer and model designation of device)
- each hepatitis B report to contain information on whether the case is acute or chronic, and/or if the antibody to core IgM is positive or negative. The suggested case definitions for hepatitis B are:
    - Acute - HBsAg positive and anti-HBc IgM positive and abnormal liver function tests with a pattern consistent with acute viral hepatitis; associated risk factors should be reported for all acute infections (Appendix 4)
    - Chronic - HBsAg positive twice at least 6 months apart or HBsAg positive and antiHBc IgM negative and anti-HBc positive; please also indicate when occurring in risk groups such as pregnant women and health care workers (Appendix 4)
- each hepatitis C report to contain information on the result for the hepatitis C core antigen (HCV AG) and/or the HCV RNA (which is usually detected by PCR test) – the feature codes HCV AG and HCV RNA should be used to capture these results
- *Clostridioides difficile* reports should indicate whether identified by toxin detection or culture of the organism
- *Corynebacterium diphtheriae* and *Corynebacterium ulcerans* whether toxigenic and non-toxigenic
- enteric *Escherichia coli* with the serotype specified
- *Echinococcus* and *Plasmodium* reports should specify the species
- all cases of congenital toxoplasmosis confirmed by the reference laboratory
- all cases of acute infectious syphilis (primary, secondary or early latent in the first 2 years) confirmed by the reference laboratory

Augmented surveillance data

There are a number of enhanced surveillance systems in operation. The routine reporting provided by the CDR system ensures that there is a safety net able to detect incidents or increases across the broad number of infections covered by CDR.

For many organisms, certain clinical and epidemiological data are very useful. Inclusion of such data where laboratories have them is welcomed by UKHSA but is not a mandatory part of the laboratory report. When these data are recorded on request forms, UKHSA would welcome their inclusion in electronic outputs via Lablink as comment fields. When pathology and clinical systems are closely linked, UKHSA would welcome the reporting of the following clinical and epidemiological features in a codified manner.

Epidemiological features or risk factors

Features or risk factors include:

- recent travel abroad (within one year prior to infection) including dates and reasons for travel [note 1]
- place and country (where they have resided /travelled) [note 1]
- patient country (of birth) and dates they first arrived in the UK [note 1]
- outbreak
- hospital acquired
- sexual orientation
- animal contact
- transplant recipient
- blood recipient
- vaccine status [note 2]
- immunocompromised
- pregnancy
- injecting drug use
- congenital infection
- food source or vehicle
- transmission agent (person to person, waterborne, animal, foodborne)

Note 1: it is increasingly important to capture information on imported infections in migrants and/or travellers because of changes in global epidemiology and travel patterns. For a wide range of infections SGSS is the only way in which information about travel and migration history can be captured. This information helps to target appropriate public health action.

Note 2: all vaccine preventable diseases are under enhanced surveillance and laboratories may be contacted for further details about the patient as part of case follow-up.

Clinical or syndrome features

Clinical or syndrome features include:

- died
- bacteraemia
- conjunctivitis
- bronchiolitis
- arthritis
- meningitis
- invasive
- pneumonia
- croup
- enteric fever
- haemolytic uraemic syndrome (HUS)
- asymptomatic

Antimicrobial susceptibilities

Please report antibiotic susceptibility results via susceptibility section for all bacterial infections, noting the following:

Extended-spectrum Beta-Lactamases (ESBLs) reports

If there is confirmatory evidence that the isolate is an ESBL producer then please record in the antibiotic field using the “EXTENDED SPECTRUM B-LACTAMASE” entry. Identify ESBL producers with a result of ‘R’ (Resistant) and non-producers as ‘S’ (Susceptible).

For Enterococci

Please report, if available, susceptibility results for high-level gentamicin (for example, disc content of 200 micrograms) to differentiate from inherent resistance (for example, disc content of 10 micrograms). These reports should be reported selecting the antibiotic field entry “HIGH LEVEL GENTAMICIN”

Reporting of antifungal susceptibility results is also welcome.

Reporting of carbapenemase-producing organisms (CPO)

For each carbapenemase gene you can identify, please create a ‘dummy’ antibiotic code in your LIMS. The results (detected or not detected) need to be reported as a single character, preferably ‘+’ for detected and ‘-‘ for not detected. These results may need to be suppressed for your reports; however, the SGSS AMR feed should be configured to include all test results for the gene targets listed below:

Gene targets

Code	Description
IMP	Imipenemase

Code	Description
KPC	*Klebsiella pneumoniae* carbapenemase
NDM	New Delhi metallo-β-lactamase
OXA48	Oxacillinase 48
VIM	Verona integron metallo-β-lactamase

Appendix 1. Notifiable organisms

Causative agents listed in Schedule 2 of the Health Protection (Notification) Regulations 2025.

Note: These organisms must be reported to UKHSA within 7 days.

Table A1.1 Viral infections

Viral infections	Infections to be reported	Clinical and/or risk factor data requested as part of report?	Enhanced surveillance in place?	Likely to be urgent?
Chikungunya virus	All			No, unless thought to be UK acquired
Crimean-Congo Haemorrhagic Fever virus	All			Yes
Dengue virus	All			No, unless thought to be UK acquired
Ebola virus	All			Yes
Guanarito virus	All			Yes
Hanta virus	All			No, unless thought to be UK acquired
Hepatitis A	All	Yes	Yes	All acute cases and any chronic cases who might represent a high risk to others, such as healthcare workers who perform exposure prone procedures
Hepatitis B	All	Yes	Yes	
Hepatitis C	All	Yes	Yes	
Hepatitis Delta	All			

Viral infections	Infections to be reported	Clinical and/or risk factor data requested as part of report?	Enhanced surveillance in place?	Likely to be urgent?
Hepatitis E	All	Yes		
Influenza virus [note 1]	All	Yes		Only if suspected to be of zoonotic origin
Junin virus	All			Yes
Kyasanur Forest disease virus	All			Yes
Lassa virus	All			Yes
Machupo virus	All			Yes
Marburg virus	All			Yes
Measles	All	Yes	Yes	Yes
Middle East respiratory syndrome coronavirus (MERS)	All			Yes
Mpox virus	All	Yes	Yes	Yes
Mumps	All	Yes	Yes	No
Norovirus	All			No
Omsk haemorrhagic fever virus	All			Yes
Polio virus	All	Yes	Yes	Yes

Viral infections	Infections to be reported	Clinical and/or risk factor data requested as part of report?	Enhanced surveillance in place?	Likely to be urgent?
Rabies virus	All	Yes	Yes	Yes
Rift Valley fever virus	All			Yes
Respiratory syncytial virus (RSV)	All			No
Rubella virus	All	Yes	Yes	No
Sabia virus	All			Yes
SARS coronavirus	All			Yes
SARS-CoV-2	All			No
Tick-borne encephalitis virus	All			Yes
Varicella zoster virus	All			No
Variola virus	All			Yes
West Nile virus	All			No, unless thought to be UK acquired
Yellow Fever virus	All			No, unless thought to be UK acquired

Note 1: Non-human influenza A subtypes have been added to the HPNR in 2025. This requires any non-seasonal subtype of influenza A which may be of zoonotic origin to be reported to UKSHA. As this may be difficult to determine at the laboratory level, laboratories should continue to report all available subtype results for all influenza A cases to SGSS. If the correct subtype does not appear to be available in SGSS, please contact your local UKHSA Field Services (FS) team. Further information on reporting subtypes is given below.

Table A1.2 Bacterial infections

Bacterial infections	Infections to be reported	Clinical and/or risk factor data requested as part of report	Enhanced surveillance in place	Likely to be urgent?
Acquired carbapenemase producing Gram-negative bacteria	All (including screening specimens)			No, unless part of a known cluster
Bacillus anthracis	All			Yes
Bacillus cereus	Food poisoning and invasive disease			No, unless part of a known cluster
Bordetella pertussis	All	Yes		Yes, if diagnosed during acute phase
Borrelia spp	All			No
Brucella spp	All			No, unless thought to be UK acquired
Burkholderia mallei/ pseudomallei	All			Yes
Campylobacter spp	All			No, unless part of a known cluster
Chlamydophila psittaci	All			Yes, if diagnosed during acute phase or part of a known cluster
Clostridium botulinum	All	Yes		Yes

Bacterial infections	**Infections to be reported**	**Clinical and/or risk factor data requested as part of report**	**Enhanced surveillance in place**	**Likely to be urgent?**
Clostridium perfringens	Food poisoning			No, unless known to be part of a cluster
Clostridium tetani	All	Yes		No, unless associated with injecting drug use
Corynebacterium diphtheriae	All	Yes		Yes
Corynebacterium ulcerans	All	Yes		Yes
Coxiella 21urnetiid	All			Yes, if diagnosed during acute phase or part of a known cluster
Francisella tularensis	All			Yes
Haemophilus influenzae	Invasive disease	Yes		Yes
Legionella spp	All	Yes	Yes	Yes
Leptospira interrogans	All			No
Listeria monocytogenes	All			Yes
Mycobacterium tuberculosis	All		Yes	No, unless healthcare worker or suspected cluster or multi-drug resistance
Neisseria meningitidis	Invasive disease		Yes	Yes

Bacterial infections	**Infections to be reported**	**Clinical and/or risk factor data requested as part of report**	**Enhanced surveillance in place**	**Likely to be urgent?**
Rickettsia spp	All			No, unless thought to be UK acquired
Salmonella spp	All			Yes, if *S. Typhi* or *S. Paratyphi* or suspected outbreak or food handler or closed communities such as care homes. No, if sporadic case of other Salmonella species
Shigella spp	All			Yes, except *Sh. Sonnei* unless suspected outbreak or food handler or closed communities such as care homes
Streptococcus pneumoniae	Invasive disease	Yes	Yes	No, unless part of a known cluster
Streptococcus pyogenes	Invasive disease			Yes
Shiga toxin-producing *Escherichia coli* (STEC) (Verocytotoxigenic *Escherichia coli)*	All		Yes	Yes
Vibrio cholerae	All			Yes
Yersinia spp	All		Yes	Yes if *Y. pestis*. Others routine

Table A1.3 Protozoa infections

Protozoa infections	Infections to be reported	Clinical and/or risk factor data requested as part of report	Enhanced surveillance in place	Likely to be urgent?
Cryptosporidium spp	All			No, unless part of a known cluster, known food handler or evidence of increase above expected numbers
Entamoeba histolytica	All			No, unless known to be part of a cluster or known food handler
Giardia lamblia	All			No, unless part of a known cluster, known food handler or evidence of increase above expected numbers
Plasmodium falciparum, vivax, ovale, malariae andknowlesi	All			No, unless thought to be UK acquired
Toxoplasma spp. *Toxoplasma gondii*	Congenital	Yes		No. Labs to forward locally diagnosed cases to the reference lab for confirmation

Table A1.4 Helminth infections

Helminth infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place	Likely to be urgent?
Echinococcus sp. *Echinococcus granulosus*, and *E. multilocularis*	All	Yes		No, except *E. multilocularis* thought to be acquired in the UK
Trichinella spp *Trichinella spiralis*	All	Yes		No, unless known to be part of a cluster

Table A1.5 Fungal infections

Fungal infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place	Likely to be urgent?
Candidozyma auris	All		Yes	No

Appendix 2. Core organisms

Laboratories should report all clinically significant identifications unless specified.

Notes

These lists are not definitive, and do not include the notifiable organisms, which can be found in Appendix 1.

Invasive disease is defined as isolation of the organism, from blood culture, CSF or other normally sterile body site (Appendix 3).

Table A2.1 Viral infections

Viral infections	Infections to be reported	Clinical and/or risk factor data requested as part of report	Enhanced surveillance in place
Adenovirus	All		
Arbovirus	All		
Astrovirus	All		
Calicivirus Norwalk virus / norovirus	All		
Coronavirus	All		
Cowpox	All		
Coxsackie virus	All		
Cytomegalovirus	All		
Echovirus	All		
Enterovirus	All		
Epstein-Barr virus (EBV)	All		
Herpes simplex virus	All		
HIV	All	Yes	Yes
Human T-cell lymphoma virus (HTLV)	All	Yes	
Lymphocytic choriomeningitis virus	All		
Orf / paravaccinia	All		
Orthopox virus	All		
Papillomavirus	All		

Viral infections	Infections to be reported	Clinical and/or risk factor data requested as part of report	Enhanced surveillance in place
Papovavirus	All		
Parainfluenza Parainfluenza 2	All		
Parvovirus B19	All	Yes	
Polyomavirus	All		
Reovirus	All		
Respiratory syncytial virus (RSV)	All		
Rhinovirus	All		
Rotavirus	All		Yes
Sapovirus	All		

Table A2.2 Bacterial infections

Bacterial infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place
Acinetobacter spp	Invasive disease		
Actinomyces spp	All		
Aeromonas spp	Invasive disease		
Bartonella spp	All	Yes	
Chlamydia spp *Chlamydia pneumoniae*	All		
Chlamydia trachomatis	All		
Citrobacter spp	Invasive disease		
Clostridioides difficile	All		
Clostridium perfringens	All		
Clostridium spp	Invasive disease		
Coxiella spp	All		
Enterobacter spp	Invasive disease		
Enterococcus spp	Invasive disease		
Erysipelothrix spp	All		
Escherichia coli spp	All enteric infections and invasive disease		Yes for O157

Bacterial infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place
Klebsiella spp	Invasive disease		
Leptospira spp	All		
Listeria spp	All	Yes	Yes
Lymphogranuloma venereum (LGV)	All		Yes
Morganella morganii	Invasive disease		
Mycobacterium spp	All	Yes	Yes
Mycoplasma spp	All		
Neisseria gonorrhoeae	All		
Nocardia spp	All		
Pasteurella spp	Invasive disease		
Plesiomonas spp	All enteric infections and invasive disease		
Proteus spp	Invasive disease		
Providencia spp	Invasive disease		
Pseudomonas spp	Invasive disease		
Serratia spp	Invasive disease		
Staphylococcus aureus [note 1]	Invasive disease	Yes	Yes
Staphylococcus spp	Invasive disease	Yes	
Stenotrophomonas maltophilia	Invasive disease		
Streptobacillus moniliformis	All		
Streptococcus spp	Invasive disease	Yes	
Treponema pallidum	All	Yes	Yes
Treponema spp	All		
Vibrio spp	All		
Yersinia spp	All	Yes	

Note 1: for those laboratories able to provide data automatically, reports are additionally requested from lower respiratory tract sites.

Table A2.3 Fungal infections

Fungal infections [note 2]	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Name transmitted
Absidia spp	All		
Acremonium spp	All		
Alternaria spp	All		
Aspergillus spp	Invasive disease		
Blastomyces spp	All		
Candida spp	Invasive disease		
Coccidioides spp	All		
Cladophialophora spp	All		
Cryptococcus spp	All		
Curvularia spp	All		
Epidermophyton spp	All		
Exophiala spp	All		
Exserohilum spp	All		
Fusarium spp	All		
Histoplasma spp	All		
Microsporum spp	All		
Paracoccidioides spp	All		
Penicillium marneffii	All		
Phialophora spp	All		
Pichia spp	All		
Pneumocystis spp	All		
Rhizomucor spp	All		
Rhizopus spp(R. Arrhizus)	All		
Rhodotorula spp	All		
Saccharomyces spp	All		
Scedosporium spp	All		
Scopulariopsis spp	All		
Sporothrix spp	All		

Note 2: Manual reporters should prioritise reports of invasive infections.

Table A2.4 Protozoa infections

Protozoa infections	Clinical and/or risk factor data desirable as part of report	Enhanced Surveillance in place
Acanthamoeba sp		
Cyclospora sp		
Hartmannella sp		
Leishmania sp		
Naegleria sp		
Plasmodium spp		
Toxoplasmaspp		
Trichomonas spp		
Trypanosoma *sp*		

Table A2.5 Fungal infections

Fungal infections [note 3]	Clinical and/or risk factor data desirable as part of report	Name transmitted
Trichophyton spp		
Trichosporon spp		

Note 3: Manual reporters should prioritise reports of invasive infections.

Table A2.6 Helminth infections

Helminth infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place
Clonorchis sp	All		
Diphyllobothrium	All		
Dracunculus	All		
Gnathostoma	All		
Hymenolepis sp	All		
Fasciola	All		
Filaria	All		
Hookworm	All		

Helminth infections	Infections to be reported	Clinical and/or risk factor data desirable as part of report	Enhanced surveillance in place
Schistosoma	All		
Strongyloides	All		
Taenia	All		
Toxocara	All		
Trichuris	All		

Appendix 3. Sterile sites

- bladder
- blood or blood components
- bone
- bone marrow
- brain
- csf
- fascia/muscle
- gall bladder
- gland, such as thyroid, parotid
- heart
- heart valve
- joint
- kidney
- liver
- lung
- lymph node
- ovary and fallopian tube
- ocular fluid
- pancreas
- peritoneum
- pleura
- surgical implant, for example, vascular shunt or graft
- spinal cord
- spleen
- tissue or tissue fluid
- uterus
- vascular system (vein or artery)

Appendix 4. Hepatitis B risk factors and groups

Risk factors

- dialysis [note 4]
- heterosexual contact of case
- homosexual contact of case
- household transmission
- injecting drug user
- perinatal transmission
- recent residence in an institution
- recent surgery or dental work
- recent transfusion
- relevant recent travel abroad
- skin piercing [note 4]
- tattooing [note 4]

Risk groups

- child of infected mother
- healthcare worker
- pregnant
- prisoner [note 4]

Note 4: add to comments field if appropriate.

Appendix 5. Contacts

A list of UKHSA Field Service information teams. The relevant Field Service information team is the initial contact point for reporting issues.

Region	Address	Phone number	Email
East Midlands	UKHSA East Midlands Seaton House City Link Nottingham NG2 4LA	0344 225 4524	FSMidlands@ukhsa.gov.uk
West Midlands	UKHSA West Midlands Level 2, Zone 1 23 Stephenson Street Birmingham B2 4BH	0344 225 3560	FSMidlands@ukhsa.gov.uk
East of England	UKHSA East of England Institute of Public Health University Forvie Site Robinson Way Cambridge CB2 0SR	0300 303 8537	EFEU@ukhsa.gov.uk.
South East and London	UKHSA London 10 South Colonnade, Canary Wharf London E14 4PU	0300 303 0450	FES.SEaL@ukhsa.gov.uk
North East	UKHSA North East Civic Centre, Barras Bridge, Newcastle NE18QH	0300 303 8596 (option 1)	FES.NorthEast@ukhsa.gov.uk

Region	Address	Phone number	Email
North West	UKHSA North West Suite 3B 3rd Floor Cunard Building Water Street Liverpool L3 1DS	0344 225 0562	FES.NorthWest@ukhsa.gov.uk
Yorkshire and Humber	UKHSA Yorkshire and Humber Quarry House, Quarry Hill, Leeds LS2 7UE	0113 386 0300	YHREU@ukhsa.gov.uk
South West	UKHSA South West Rivergate House, 2 Rivergate, Temple Quay, Bristol BS1 6EH	0303 4443703	fes.southwest@ukhsa.gov.uk

About the UK Health Security Agency

The UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe, save lives and protect livelihoods. We provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

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For queries relating to this document, please contact: sgss.helpdesk@ukhsa.gov.uk

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