Department of Health & Social Care

Memorandum of Understanding (MoU)

For

The Department of Health and Social Care (DHSC)

And

The UK Health Security Agency (UKHSA)

Project: International Health Regulations Strengthening Project (IHR-S Project)

ITT: [ ]

Version Number: New MoU
Date: 16/08/2022

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Memorandum of Understanding
International Health Regulations Strengthening Project (IHR-S)

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This Memorandum of Understanding template is for use with other Crown Bodies

If you require a Memorandum of Understanding to be used for a non-Crown body, you will need a different template, as some of the clauses might not be suitable

This template will need to be tailored and amended to suit each individual scenario. Please note that more complex clauses might be needed depending on the specific circumstances.

If the MoU to be drafted is for the purpose of data processing as the Activity, the clauses will need to be amended accordingly

VERSION NUMBER	DATE	AUTHOR	DETAILS
1	01/08/2022	[redacted]	INITIAL DRAFT
2	10/08/2022		FINAL VERSION

1. PARTIES

1.1 THIS MEMORANDUM OF UNDERSTANDING ("**MoU**") is between the following parties ("**Parties**"):

1.1.1 The Secretary of State for Health and Social Care of 39 Victoria Street, London SW1H 0EU ("**DHSC**"), and

1.1.2 The Secretary of State for Health and Social Care, acting through its executive agency UKHSA of Noble House, 17 Smith Square, London SW19 3JR, ("**UKHSA**")

2. BACKGROUND AND PURPOSE OF THIS MOU

2.1 The Department of Health and Social Care (DHSC) will make available a contribution to the UK Health Security Agency (UKHSA) a **sum not exceeding £28m** ODA funding over the Spending Review period **2022/23 to 2024/25** to continue to deliver the International Health Regulations Strengthening Project (IHR-S Project).

2.2 The International Health Regulation Strengthening Project (**IHR-S Project**) has the primary purpose of providing tailored technical support for selected Official Development Assistance (ODA)-eligible[1] countries and regions to improve compliance with International Health Regulations (IHR) and thereby strengthen global health security. It has three key aims: to build technical capability, strengthen leadership, and develop sustainable public health systems. As the present COVID-19 pandemic has demonstrated, strengthening international capabilities for outbreak preparedness, detection and response to disease outbreaks and health threats is vital.

2.3 UKHSA should note that the Secretary of State for Health and Social Care proposes to pay the Contribution pursuant to his discretion under Section 1(1) of the International Development Act 2002.

2.4 UKHSA will undertake the Activities in accordance with the provisions of this MoU.

2.5 This MoU establishes the responsibilities of the Parties and the general principles for their cooperation.

[1] As defined by the Organisation for Economic Co-operation and Development (OECD).

2.6 UKHSA will not use any element of the Contribution for paid for lobbying, which means using the Contribution to fund lobbying (via an external firm or in-house staff) in order to undertake activities intended to influence or attempt to influence Parliament, Government or political activity or attempting to influence legislative or regulatory action.

2.7 This MoU is not intended to be legally binding and no legal obligations or legal rights will arise between the Parties from the provisions of the MoU. The Parties enter into the MoU intending to honour their commitments.

2.8 The Project will be extended from **1 April 2022** and will end on **31 March 2025.**

2.9 This MoU supersedes previous commitments in MoUs and related amendments in the financial year.

NOW THEREFORE the Parties have agreed to cooperate under the MoU as follows:

3.1 Unless the context otherwise requires, references to this MoU will be construed as a reference to this MoU as varied or amended in accordance with its provisions. Reference to a person includes a legal entity, words importing a gender include all genders and words importing the singular include the plural and vice versa.

3.2 In this MoU the words and phrases set out below will have the following meanings:

"**Activities**" means the list of activities conducted as part of the Programme as further detailed in Annex A (Activities).

"**Annex/es**" means the annexes attached to this MoU including those subsequently agreed between the Parties.

"**Commencement Date**" means **1 April 2022**.

"**Confidential Information**" means any information which has been designated as confidential by either Party in writing or that ought to be considered as confidential (howsoever it is conveyed or on whatever media it is stored) including information the disclosure of which would, or would be likely to, prejudice the commercial interests of any person or trade and all secrets, personal data and sensitive personal data within the meaning of applicable legislation. Confidential Information will not include information which:

A) was public knowledge at the time of disclosure (otherwise than by breach of a duty of confidence by either Party);

B) was in the possession of the receiving Party, without restriction as to its disclosure, before receiving it from the disclosing Party;

C) is received from a third party (who lawfully acquired it) without restriction as to its disclosure; or

D) is independently developed without access to the Confidential Information.

"**Contribution**" means the sum or sums of money in GBP to be provided to the Partner in accordance with this MoU as set out in Annex B (Payment Schedule)

"**Crown**" means the government of the United Kingdom (including the Northern Ireland Executive Committee and Northern Ireland Departments, the Scottish Executive and the National Assembly for Wales), including, but not limited to, government ministers, government departments, government offices and government agencies and "**Crown Body**" is an emanation of the foregoing. A comprehensive list of Crown bodies can be found in the National Archives, which is updated from time to time.

"**FCDO" means Foreign, Commonwealth and Development Office**

"**Downstream Partners**" means the Partner's partners, consultants and sub-contractors involved in the delivery of the Funded Activities;

"**Financial Impropriety**" means any credible suspicion of or actual fraud, corruption, money-laundering or any other financial irregularity or impropriety;

"**Funding Period**" means the period for which the Contribution is awarded starting on the Commencement Date and ending on **31 March 2025**.

"**Intellectual Property Rights**" means patents, utility models, inventions, trademarks, service marks, logos, design rights (whether registrable or otherwise), applications for any of the foregoing, copyright, database rights, domain names, rights in confidence, know-how, trade or business names, moral rights and other similar rights or obligations whether registrable or not in any country (including but not limited to the United Kingdom) and including, the right to sue for passing off.

"**ODA**" means Official Development Assistance, including ODA administrative costs, as defined by the OECD from time to time;

"**OECD**" means the Organisation for Economic Co-operation and Development;

"**Project**" means the **International Health Regulations Strengthening Project (IHR-S Project)** carried out by the Partner as more particularly described in Annex A (activities);

"**Representatives**" means the lead representatives of each Party, as described in paragraph 20 (Liaison between the Parties). The authorised representatives and addresses for service of notices are listed in Annex C (authorised representatives and address for service of notices).

4.1 UKHSA will perform the Activities described in Annex A (Activities). DHSC will make payments to UKHSA for satisfactory completion of Activities in accordance with the provisions of Annex B (Payment Schedule).

4.2 UKHSA will comply with all applicable laws in carrying out the Activities.

4.3 The UKHSA Director of Global Public Health will be accountable to the Senior Responsible Officer (SRO) of the DHSC Global Health Security Programme (the International Director), for all Project spend and activity. For the avoidance of doubt, HM Treasury has confirmed that the DHSC Permanent Secretary is the accountable officer for the ODA funding of this Project.

5. PRINCIPLES OF COLLABORATION AND THE PARTIES' RESPONSIBILITIES The Parties agree to follow the principles set out at paragraph 0 below (**"Principles"**) at all times during the term of this MoU:

the Parties will:

5.1.1 be accountable to each other for performance of their respective roles and responsibilities as set out in this MoU;

5.1.2 share appropriate information, experience, materials and skills to learn from each other and develop effective working practices;

5.1.3 work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

5.1.4 adhere to statutory requirements and best practice (including any relevant Governmental protocols such as the Regulators Code, Ministerial and Civil Service Codes) as well as all applicable laws and standards including EU procurement rules, data protection and freedom of information legislation;

5.1.5 act in a timely manner;

5.1.6 ensure sufficient and appropriately qualified employees and other necessary resources are available and (in the case of employees) authorised to fulfil the responsibilities set out in this MoU.

6. CONTRIBUTION The maximum amount that DHSC will pay under this MoU to UKHSA is the Contribution.

6.2 It is DHSC's intention that the Contribution will be a combination of both ODA and non-ODA funding, which accounts for One-HMG Platform costs. The ODA funding is as defined by the OECD. The One-HMG Platform costs are classified as non-ODA from a DHSC reporting perspective.

6.3 The Contribution is subject to revision and will depend on the fulfilment of the provisions of this MoU, any revisions to budgets, actual expenditure and need, the priorities of DHSC and the continuing availability of its resources.

6.4 Prior to effecting major changes between categories of expenditure as detailed in Annex B (Payment Schedule) that may be found necessary in the course of implementing the activities, UKHSA will obtain DHSC's prior written approval.

7.1 The indicative DHSC contribution to support the delivery of IHR-S Project Activities (the "**Spend Profile**") is as follows:

Period	**UKHSA Spend Profile**
Year 1 of Programme	£9m
Year 2 of Programme	£9m
Year 3 of Programme	£10m
TOTAL	**£28m**

7.2 The Spend Profile reflects the Payment Schedule in Annex B. It is indicative only and may be amended, dependent on actual expenditure and need.

7.3 DHSC will make available to UKHSA Parliamentary funding not exceeding £28m of Resource Departmental Expenditure Limit (RDEL) over the period 2022/23 to 2024/25 for delivery of UKHSA activity in line with the Implementation Plan.

7.4 DHSC will release project funds incrementally to UKHSA for expenditure incurred on the Project through quarterly payment. UKHSA will administer the funding on behalf of DHSC in accordance with UKHSA's financial regulations, procedures and practices.

7.5 The Project budget and Payment Schedule (Annex B) will be reviewed, confirmed, and set on an annual basis by DHSC (each financial year),

7.6 UKHSA will notify DHSC of variations to the Spend Profile as soon as possible as and when this occurs.

7.7 DHSC makes no commitment to renewing or continuing funding after the term of this MoU and will not be liable for any additional cost incurred by UKHSA either during or after the Funding Period.

7.8 UKHSA will provide evidence to the reasonable satisfaction of DHSC that the above provisions have been met in accordance with the requirements in Annex E (Reporting).

7.9 UKHSA agrees and accepts that it will not apply for duplicate funding in respect of any part of the Activities or any related administration costs that DHSC is funding in full under this MoU.

7.10 The Contribution detailed in paragraph 7.1 will be deposited according to the payment schedule in paragraph 7.3 in UKHSA's bank account:

Bank name and address	[redacted]
Bank branch name	[redacted]
Account name	[redacted]
Sort code	[redacted]
Account number	[redacted]
Swift Code	[redacted]
IBAN	

and the details of the contribution clearly identified using '**IHR-S Project'**.

8.1 The Contribution will not, unless approved by DHSC in writing, be used to meet the cost of any import, customs duties or any other taxes or similar charges, applied directly or indirectly, by national governments or by any local public authority and payable by UKHSA.

8.2 UKHSA will administer and account for DHSC's Contribution in accordance with UKHSA's financial regulations and other applicable rules, procedures and practices, and will keep separate records and accounts for the arrangement. UKHSA will ensure that, to the best of its ability, all goods and services financed under this arrangement will be solely used for the purposes of the Funded Activities and any future arrangements made under this initiative.

8.3 DHSC is providing the Contribution without expectation of services to be supplied to DHSC and therefore considers payments made to UKHSA to implement the Activities to be outside the scope of VAT.

8.4 Any unspent funds remaining at the scheduled end of the Funding Period, must be returned to DHSC within 90 days of the end of the Funding Period, unless specifically decided between the Parties, in advance and in writing.

9. REPORTING REQUIREMENTS

9.1 UKHSA will provide quarterly financial reports and technical reports to DHSC in accordance with the reporting schedule at Annex E (Reporting).

10. DUE DILIGENCE

10.1 DHSC has drawn on its own due diligence assessment of UKHSA for assurance on UKHSA's capacity to effectively manage this funding. Where additional due diligence questions arise that are not covered in currently documented due diligence by the UK Government or partners, UKHSA will co-operate fully with any additional due diligence assessments of its own internal controls and systems.

10.2 In utilising the Contribution, UKHSA will exercise the same care in the discharge of its functions under this MoU as it exercises with respect to the administration and management of its own resources and affairs.

10.3 Additionally, UKHSA will take the necessary steps at the commencement of the Funded Activities and at regular intervals throughout the implementation to assess the internal controls and systems of any Downstream Partners. These assessments will be shared with DHSC, upon request and should determine, relative to programme risk:

10.3.1 Reliability and integrity of the Downstream Partner's financial controls, systems and processes;

10.3.2 Effectiveness and efficiency of their project operations;

10.3.3 Procedures for safeguarding project assets; and

10.3.4 Compliance with national legislation, regulation, rules, policies and procedures.

11. DELIVERY CHAIN MAPPING

11.1 UKHSA will maintain an up to date and accurate record of Downstream Partners in receipt of DHSC funds and/or DHSC funded inventory or assets. This delivery chain risk map should identify the Downstream Partners, demonstrate how funds flow from the initial source to end beneficiaries, and where relevant, the risks and potential risks along the chain.

11.2 The delivery chain risk map should be updated regularly by UKHSA and when there are material changes to the Project risk assessment and/or to Downstream Partners in the chain. As a minimum UKHSA will provide DHSC with an updated delivery chain map at the following intervals: within 6 months of the commencement of this MoU; annually, as part of the annual review Process; and at the end of the Project, as part of the Project completion review process.

12. ODA TRANSPARENCY AND EVALUATION

12.1 UKHSA and DHSC acknowledge and support the requirements of the IATI Standard. UKHSA will work towards applying transparency standards in line with the UK aid Transparency Guarantee and the International Aid Transparency Initiative (IATI), to the funds received from DHSC. UKHSA will make substantive efforts to publish information about DHSC funding in line with relevant categories of the IATI Standard, on their own website. UKHSA gives consent for this arrangement (and any subsequent amendments) and associated funding to be published on DHSC's website.

12.2 UKHSA will provide all reasonable co-operation and assistance necessary for DHSC to meet its obligations under the International Development (Official Development Assistance Target) Act 2015 and the International Development (Reporting and Transparency) Act 2006. Such reasonable cooperation and assistance will include but not be limited to the provision of all information and data necessary for the transparent, accurate, timely and comprehensive publishing of all data on all activities related to the delivery of the Funded Activities.

12.3 DHSC may decide to commission an independent evaluation of this programme, and UKHSA will provide all reasonable co-operation and assistance necessary to allow the DHSC to do so.

13. FRAUD, CORRUPTION AND ETHICAL PRACTICES

13.1 DHSC and UKHSA will immediately and without undue delay inform the other Party of any event which interferes or threatens to materially interfere with the successful implementation of the Activities, including Financial Impropriety. Any allegations of Financial Irregularity should be reported in the first instance to the Authority's Anti-Fraud Unit at [redacted]]

13.2 DHSC and UKHSA have a zero-tolerance approach towards Financial Impropriety that may lead to the misuse of the Contribution and agree in principle to recover such funds. UKHSA will, at first, take timely and appropriate action to investigate credible allegations of Financial Impropriety, however both Parties will fully co-operate with investigations into such events, whether led by UKHSA or DHSC.

13.3 In the event of any credible indications that the Contribution may have been subject to Financial Impropriety, DHSC, may, at any time during the period of this arrangement and up to five years after the end of the programme, arrange for additional investigations, on-the spot checks and / or inspections to be carried out. These may be carried out by DHSC, or any of its duly authorised representatives.

13.4 DHSC reserves the ability to recover the Contribution that has been subject to a proven fraud and will work with UKHSA to do so. Where Financial Impropriety is alleged, DHSC reserves the ability to suspend or terminate funding with immediate effect, in preference to the standard notice period and irrespective of any contractual requirements.

13.5 UKHSA must comply with the recommendations of the Public Accounts Committee and any other expenditure controls specified by the UK Government

13.6 Consistent with numerous United Nations Security Council resolutions including S/RES/1269 (1999), S/RES/1368 (2001) and S/RES/1373 (2001), both DHSC and UKHSA are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. It is the policy of DHSC to seek to ensure that none of its funds are used, directly or indirectly, to provide support to individuals or entities associated with terrorism. In accordance with this policy, UKHSA undertakes to use reasonable efforts to ensure that none of the DHSC Contribution provided under this MoU is used to provide support to individuals or entities associated with terrorism.

14. SAFEGUARDING

14.1 UKHSA will take all reasonable steps to prevent the sexual exploitation, abuse and harassment of any person linked to the delivery of this MoU by both its employees and any Downstream Partner.

14.2 The Parties have a zero-tolerance approach towards sexual exploitation, abuse and harassment. UKHSA will immediately contact Department for Health and Social Care Fraud Unit [redacted] to report any credible suspicions of, or actual incidents of sexual exploitation, abuse or harassment related to this MoU. UKHSA should assess credibility based on the source of the allegation, the content, and the level of detail or evidence provided. All sexual activity with children (persons under the age of 18) is prohibited, regardless of the age of majority, or age of consent locally.

14.3 UKHSA should also report any credible suspicions of, or actual incidents that are not directly related to this MoU but would be of significant impact to their partnership with DHSC or the reputation of DHSC or UK aid. For example, events that affect the governance or culture of UKHSA, such as those related to senior management, must be reported.

14.4 Both Parties will fully co-operate with investigations into such events, whether led by FCDO or any of its duly authorised representatives or agents, or the Partner.

14.5 Both parties acknowledge the “International Development Research Funders Statement on Safeguarding”, of which DHSC is a signatory. Both parties agree to work with the UK Collaborative on Development Research to develop shared guidelines on safeguarding and to implement these guidelines once developed.

15. PROCUREMENT BY THE PARTNER

15.1 The Contribution may be used to purchase goods and services required for the Activities, in accordance with UKHSA’s regulations, rules, policies, procedures and directives.

15.2 Any Programme assets, specifically identified to be procured for the delivery of the Activities, will be operated and controlled by UKHSA for the duration of the Funding Period. UKHSA will be accountable to DHSC for the appropriate use and control of these assets, in line with the Programme's objectives. Ultimate ownership of project assets, after Programme completion, will be decided in writing by all Parties.

16. HEALTH, SAFETY AND SECURITY

16.1 UKHSA is responsible for all security arrangements in relation to the Programme including the health, safety and security of any person employed or otherwise engaged as part of the Programme, including those employed or engaged by any Downstream Partners.

16.2 The Contribution cannot be used to fund any insurance premiums intended to cover medical expenses, injury or disablement, and death unless, by exception, explicitly agreed in writing in advance.

17. VARIATION

17.1 This MoU, including the Annexes, may only be varied by written agreement between the Parties and approved by the authorised Representatives as given in Annex C (authorised representatives and address for service of notices).

17.2 Should DHSC request work to be completed over and above the services described in Annex A (activities) then both Parties will negotiate in good faith to ensure the Partner is fairly compensated for any agreed additional work undertaken.

18. DISSEMINATION OF WORK

18.1 UKHSA will disseminate the results of the work funded by DHSC. Any manuscripts published in non-Partner publications will be published in accordance with UKHSA's policy on open-access and in line with the IHR-S communications protocol. Under this policy, manuscripts must be made publicly accessible within 12 months of the date of publication, under the protocol IHR-S/ DHSC/ UK aid funding must be acknowledged. The Project will communicate announcements, news and case studies through UKHSA's owned channels, with support/ amplification from DHSC. All communications decisions should be guided by an IHR-S communications protocol. This document will be created by UKHSA and reviewed by DHSC. This document will list agreed roles and responsibilities and approval processes. UKHSA may review the protocol in the lifetime of the Project, but any changes to the protocol must be agreed by all Partners.

19. RESEARCH SURVEYS, QUESTIONNAIRES

19.1 DHSC may occasionally conduct research exercises, including by way of surveys, or questionnaires, or requests for feedback, into UKHSA's experience of the Contribution, and on UKHSA's business needs, and other related matters. Participation in any such exercise would be confidential and voluntary, and the results will be handled in such a way that they do not identify individual respondents, unless consent is obtained or, for instance, UKHSA agrees to be contacted as a case study.

19.2 For the purposes of analysing the outcome of any research, UKHSA's input may be combined with other information which DHSC has, but it will do so in a way that does not affect the anonymity of the individual participants. DHSC will share any reports and findings of any such exercise on an anonymised basis with any or all of the UK Government from time to time.

19.3 Any information about UKHSA and/or its business which is disclosed to DHSC in the course of any such exercise will be added to, and become part of, the Data, and the provisions of this MoU will apply to it.

20. LIAISON BETWEEN THE PARTIES

Formal contact between DHSC and UKHSA as Parties to this MoU will be through the Representatives.

20.2 The Representatives are duly authorised to send and receive notices under this MoU at the addresses specified in Annex C (Authorised Representatives and addresses for service of notices).

20.3 Either Party may change the Representative any time by notifying the other Party in writing.

20.4 The Representatives will:

20.4.1 meet at least four times a year at a time and place to be mutually agreed to review the Activities carried out under, and the operation of, this MoU and to address any issues arising from this MoU;

20.4.2 provide assurance to the Parties that the Activities agreed between the Parties are being undertaken and that work is proceeding in accordance with the Principles; and

20.4.3 document key decisions in writing.

21.1 Except as otherwise provided in this MoU, each Party will bear its own costs and expenses incurred in complying with its commitments under this MoU.

22.1 UKHSA will seek written consent from DHSC before using any third party to perform any of the Activities, which DHSC will have the right to grant or deny.

23.1 Any Intellectual Property Rights that arise from or are developed by either Party in performing this MoU (**"Foreground IPR"**) will be vested in and owned by the Crown.

23.2 Both Parties will work together to ensure that in the performance of the Activities and use of any Foreground IPR does not infringe any Intellectual Property Rights belonging to a third party. Where use of Intellectual Property Rights belonging to a third party is required to perform the Activities or to use any Foreground IPR, the Partner will use reasonable efforts to secure licences for both Parties to use any such Intellectual Property Rights on a royalty-free, non-exclusive basis. Where this is not possible, UKHSA will agree with DHSC other means to enable the performance of the Activities and use of Foreground IPR without infringing such rights, which may include modification of the Activities to avoid infringement of any such third-party rights.

23.3 Neither Party will use the name, logo, trademarks, or other brand collateral of the other Party without the owning Party's prior written consent.

24. **FREEDOM OF INFORMATION AND COMMUNICATIONS TO THE PUBLIC**Each Party will provide to the other Party any information relevant to the Activities that may be reasonably requested by the other, subject to any confidentiality constraints, safeguards and statutory rules on disclosure. Each Party will consult the other Party before making to any third party any disclosures of information under the Freedom of Information Act 2000.

24.2 The requirements below are subject to any government requirements as to transparency which may apply to either Party from time to time.

24.3 The Parties will not make any announcement or other disclosure concerning the contents of this MoU or the Activities without the prior written consent of the other Party (such consent not being unreasonably withheld or delayed), except as required by law, any governmental or regulatory authority, any court, or any other authority or competent jurisdiction.

24.4 Where a formal public statement, press release or other publicity in relation to the initiative is required, the Parties will work together to ensure that the publicity statements are coordinated. DHSC will however be responsible for handling media inquiries relating to the Activities.

25. **CONFIDENTIAL INFORMATION** Each of the Parties understands and acknowledges that it may receive or become aware of Confidential Information of the other Party (which may include information where the other Party owes a duty of confidence to a third party) whether in the course of the performance of the Activities or otherwise.

25.2 Except to the extent set out in this paragraph 25 or where disclosure is expressly permitted elsewhere in this MoU, each Party will treat the other Party's Confidential Information as confidential and safeguard it accordingly (which will include complying with any protective markings on documents and instructions supplied by the other Party). In particular, neither Party will do anything that may place the other in breach of a duty of confidence owed to a third party. A Party in receipt of Confidential Information from the other Party will not disclose such Confidential Information to any non-Crown Body without the consent of the other Party.

25.3 The obligations of confidentiality in this paragraph 25 (Confidential Information) will continue in force until the information ceases to be confidential in nature.

26. **PROTECTION OF PERSONAL DATA** The Parties will comply with their responsibilities under the Data Protection Act 2018 (DPA 2018) and will not use any personal data exchanged under this MoU for any purposes which are incompatible with applicable data protection laws and regulations. No personal data collated and/or exchanged under this MoU should be used for commercial purposes without the prior written agreement of the supplying Party (which use may be conditioned as the supplying Party sees fit).

26.2 Each Party must ensure that personal data under this MoU is not transferred outside the EEA without the prior agreement of the other.

27. **RESOLUTION OF DISPUTES** Any dispute between the Parties arising out of or in connection with this MoU will in the first instance be resolved amicably between the Parties through the Representatives and, if no resolution is reached, escalated to the following senior personnel (at Director level):

27.1.1 For DHSC: Director of Global Health Security: Anna Wechsberg

27.1.2 For UKHSA: Global Operations Director: Neil Squires

27.2 If the matter cannot be resolved by the senior personnel specified in paragraph 27.1 within 30 days, the matter may be escalated to the Secretary of State for Health and Social Care for resolution.

28. **TERM AND TERMINATION**This MoU will commence on 1 April 2022 and (subject to earlier termination on the provisions of this MoU) will continue for a period of up to 3 years which period may be extended by the mutual written agreement of the Parties.

28.2 This MoU may be terminated by either Party at any time by giving written notice to the other Party's Representatives as set out in Annex D (authorised Representatives and addresses for service of notices).

28.3 A Party terminating this MoU will give as much notice as reasonably possible and will offer all reasonable assistance to ensure:

28.3.1 an effective handover of Activities, if the Activities are not concluded at the time of termination, and

28.3.2 to mitigate the effect of termination on the other Party by fully co-operating with the other Party in order to achieve an effective transition without disruption to operational requirements.

29. **FINANCIAL CONSEQUENCES OF EXIT FROM THE MOU BY AN INDIVIDUAL PARTY**On termination of this MoU, a financial adjustment will be agreed according to the principle that DHSC will only be obliged to pay for Activities performed in accordance with the provisions of this MoU up to the date of termination (and upon request at any time, the Partner will provide a final report detailing the Activities it has performed).

29.2 Where DHSC has paid any Contribution in advance, the Partner will promptly repay amounts it has received which for Activities it has not performed (such amounts to be agreed with DHSC based on the final report provided further to the above paragraph 29.1).

30. **REVIEW AND AUDIT OF THE MOU**In addition to the regular review meetings to discuss performance in accordance with paragraph 20.4, whenever substantial changes occur to the policies, external relationships and structures of the Parties concerned. Any changes to this MoU will only be effective if set out in writing and signed by both Parties.

30.2 Each Party will keep and maintain until six (6) years after termination of this MoU full and accurate records of the Activities and all sums received in respect thereof. Each Party will on request afford the requesting Party or their Representatives such access to those records as may be requested in connection with the MoU or as otherwise required in connection with audit requirements (including, without limitation, audit by the National Audit Office).

31. **MISCELLANEOUS**This MoU does not confer any rights on any third party. Nothing in this MoU will be interpreted as limiting, superseding, or otherwise affecting any Party's normal operations in carrying out its statutory, regulatory or other duties. This MoU does not limit or restrict any Party from participating in similar activities or arrangements with other entities.

31.2 DHSC will have no obligation to incur any further fees under this MoU, nor will the Partner be required to perform additional Activities unless and until this has been agreed in writing.

31.3 This MoU will be governed by and construed in accordance with English law. Each Party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

32. **EXIT PLANNING**

32.1 UKHSA will prepare an exit plan within the first three months of the signing of the MoU or a timescale proportionate to the funding period, whichever is shorter, to allow the cessation or seamless transfer of the funded activities.

32.2 As part of the exit plan, DHSC will jointly agree a plan for communicating with all partners and employees during the exit period, in a way that avoids any detrimental impact on the respective Parties' businesses resulting from the closure or transfer, and shares responsibilities between the respective Parties.

SIGNATORIES

The duly authorised representatives of the Parties affix their signatures below.

Signed for and on behalf of DHSC

Signature: ..... [redacted] .....
Name: Anna Wechsberg
Position: Director
Date: 16.08.2022

Signed for and on behalf of UKHSA

Signature: ..... [redacted] .
Name: Neil Squires
Position: Director of Global Operations
Date: 16.08.2022

Annex A: Activities (UKHSA)

1. IHR-S Project deliverables 2022-2025

The below Project deliverables outline the high-level objectives the Project aims to achieve from 2022-2025. Each country/region has different areas on which the Project will aim to work due to the differing systems and partner landscape within each context.

Country/Region	High level outputs
Africa CDC and Regional Collaborating Centres (RCC)	• Signed MoU with clear deliverables and action plan including staff members to be embedded within the Africa CDC team • Workforce development and leadership support to Africa CDC in operationalising RCCs • Continued capacity building and training on technical areas, including public health laboratories, emergency preparedness and workforce development
Eastern Mediterranean	• Strengthening multi-sector coordination work with multiple Eastern Mediterranean countries • Building a local presence to work alongside EMPHNET in pursuing further work based on expressed partner need
Ethiopia	• Re-engagement with EPHI, including signing an MoU, to re-establish stakeholder relationships and understand partner priorities • Engage with other stakeholders in Ethiopia, including; WHO, Environment Agency, Ministry of Health to broaden impact and reach of the technical support provided in-country. • Working with the Ministry of Health in Ethiopia to create a national approach to poisons
Indo-Pacific	• Developing a local presence, relationships and enabling infrastructure through embedding senior public health expertise • Based on an assessment of IHR Compliance need and ask from partners support capacity building • Scope a new bilateral country relationship in the region including delivery of technical support and establishment of a local team

Nigeria	• Exploration and identification of needs around chemical hazards • Building on the relationship with WAHO to provide public health expertise at a West African regional level • Further capacity building on PH lab networks, surveillance, One Health and emergency preparedness and response
Pakistan	• Enhance IDSR capacity of PH lab networks • Public health epidemiology capacity building and IDSR upscaling • System strengthening through workforce development and leadership programmes.
Zambia	• Scale up work with Ministry of Health in Zambia, including around public health laboratories • Work with the Africa CDC Southern RCC to support capacity building and training. • Further system strengthening on PH lab networks, One Health and emergency preparedness and response

The table below outlines the main domains of activity, based on the International Health Regulations Monitoring and Evaluation Framework, for each country/region that we anticipate working in:

	Domain of activity					
Country/ Region	**Workforce development**	**Labs**	**Surveillance**	**Emergency Preparedness**	**One Health**	**Chemicals**
Africa CDC	X			X		
EMR	X					
Ethiopia	X	X		X	X	X
Indo-Pacific	X			X	X	X
Nigeria	X	X	X	X	X	X
Pakistan	X	X	X	X		
Zambia	X	X	X	X	X	X

2. Logframe

*The Logframe below will be updated by Q2 2022.

OUTCOME	OUTCOME INDICATOR	Indicator technical definition	Means of Verification	Assumptions
Improved capacity to comply with the IHR (2005) in partner countries and regions	Contribution to improved JEE/SPAR scores within partner countries as a result of Project activities	Analysis of JEE/SPAR scores (overall average and domain-specific scores) over 3 years to assess compliance with the IHR (2005) within the partner countries. An example of domain specific scores is chemicals and surveillance scores, etc. JEE and SPAR are evaluations conducted by WHO. JEE is an external review of progress towards IHR core capacity* implementation, conducted once every 4-5 years (voluntary). SPAR is a country-led multisectoral review of progress towards IHR core capacity implementation, conducted once every year (mandatory) *IHR Core Capacities as set out in the IHR 3rd edition (2005)	Triangulation of JEE/SPAR scores with additional internal/external evaluation to assess contribution	JEE or SPAR evaluation is carried out for all the partner countries by the end of the Project. Strengthening national and regional health systems and structures will improve compliance with IHR (2005).
	Strengthened capacity of national/regional public health structures and systems to prevent detect and respond to public health emergencies	Qualitative external assessment of the ability of national structures to deliver on the IHR regulations (2005) National structures includes national public health institutes, ministries of health, universities, etc. Strengthened means that the national structures/partner countries and regions are better able to deal with public health emergencies compared to initiation of IHR project activities. The components of public health systems to be strengthened includes governance and decision making, participation and influence, robust and resilient internal systems, etc. Capacity is an umbrella term that encompasses skills and	External evaluation	

		knowledge, organisational planning and processes, structures and systems, workforce, networks, information, monitoring and evaluation, and political will. Strong evidence refers to the number of examples, the strength of evidence regarding project contribution, the significance (as described by partners) of project contribution and impact on national/regional structures and systems.		
OUTPUT 1	INDICATOR 1.1			
Strengthened technical capability in country and regional public health organisations	Number of partner country stakeholders trained in IHR core capacity* areas *IHR Core Capacities as set out in the IHR 3rd edition (2005).	Total number of stakeholders in partner countries, trained in IHR core capacity* areas by UKHSA Example of stakeholders include: laboratory staff, delegates from across regional partners, epidemiologists, public health professionals across country IHR core capacity areas are EPRR, OH, WD, RCE, Labs, surveillance, PoE Disaggregation includes type of training i.e., ToT, technical training, simulation exercise, after action review *IHR Core Capacities as set our in the IHR 3rd edition etc.	The data will be taken from internal system and quarterly reports from the country teams	Partner public health workforce support and share ownership of IHR-SP activities There is political will and partner absorptive capacity to implement the proposed IHR-SP activities Training, mentorship and simulation exercises are adopted and supported to upskill the public health workforce The Project is able to reach the most appropriate representatives of the public health workforce For risks, see the IHR-SP Risk Register
	INDICATOR 1.2			
	Number of core products co-developed in IHR core capacity* areas *IHR Core Capacities as set out in the IHR 3rd edition (2005).	Core products are all the documents created as a result of the IHR projects activities in core capacity areas. These products include: National action plans, strategies, SOPs, guidelines, and operational tools such as quality manuals, algorithms, implementation plans, learning management systems, workplans, etc. IHR core capacity areas include EPRR, OH, WD, RCE, Lab, IDSR/PoE	The data will be taken from internal system and quarterly reports from the country teams	

		Co-developed products are defined as core technical products that are developed ***with*** (not for) partner country stakeholders Disaggregation includes level of finalisation with UKHSA support: revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources		
	INDICATOR 1.3			
	Number/Proportion (%) of trained stakeholders demonstrating new/improved technical skills or applying new/improved knowledge in IHR core capacity areas *IHR Core Capacities as set out in the IHR 3rd edition (2005).	A sample of stakeholders that have been trained (captured in indicator 1.1) will be revisited 3-6 months after the training A standardised approach will be tailored to identify uptake of knowledge/skills gained in practises.	The data will be taken from internal system and quarterly reports from the country teams	
	INDICATOR 1.4			
	Changes in technical practices resulting from project's capability strengthening	This is a qualitative indicator using bespoke annual evaluation with a sample of stakeholders to assess the changes in technical practices resulting from contribution of activities conducted to strengthen technical capability in country and regional public health organisations. Strong evidence refers to the number of examples, the strength of evidence regarding project contribution, and the significance	Bespoke evaluation report	

		(as described by partners) of project contribution.		
	INDICATOR 1.5			
	Number of IHR publication or events sharing evidence on improving IHR core capacities* that are shared through a variety of fora including peer review journals, conferences, webinars, etc. *IHR Core Capacities as set out in the IHR 3rd edition (2005).	Total number of publications or events sharing evidence to improve IHR core competencies. It can be shared using variety of forums including but not limited to publications, conferences, webinars, etc. Examples of publications include grey literature, journal publications, articles, presentations, etc.	The data will be taken from internal comms tool that keeps a record of all the publications	
OUTPUT 2	INDICATOR 2.1			Partner public health workforce support and share ownership of IHR-SP project activities There is political will and partner absorptive capacity to implement the proposed IHR-SP activities Public health workforce partners support in identifying and releasing appropriate trainees for development Partner public health workforces are able to successfully implement roles, responsibilities, strategies and plans
Enhanced leadership, workforce and organisational development in partner country and regional public health organisations	Number of partner country stakeholders trained/mentored in leadership	Total number of all the stakeholders in partner countries, trained/mentored in leadership Example of stakeholders include: delegates from regional partners, public health professionals, public health institute's senior staff/staff, etc. Disaggregation includes type of training i.e., ToT, workforce training, mentorship, etc.	The data will be taken from internal system and quarterly reports from the country teams	
	INDICATOR 2.2			
	Number of core products co-developed in workforce development	Core products are all the documents that are created as a result of the IHR-SP activities in leadership, workforce and organisational development. These products include: strategies, SOPs, guidelines, and operational tools such as syllabus, modules, workshop programme, organisational core	The data will be taken from internal system and quarterly reports from the country	

		values, workplans, etc. Co-developed products are defined as core technical products that are developed in coordination with partner country stakeholders Disaggregation includes whether the core-product was revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources Disaggregation includes whether the core-product was revised, co-developed, approved, implemented or resourced/budgeted. Resourced/budgeted refers to activities that have an approved source of finance and resources	teams	National professionals with improved leadership capability will develop and promote effective public health systems For risks, see the IHR-SP Risk Register
	INDICATOR 2.3			
	Number/Proportion (%) of trained staff demonstrating new/improved leadership skills or applying new/improved governance processes	A sample of stakeholders that have been trained (captured in indicator 2.1) will be revisited by the facilitators 3-6 months after the training A standardised tool will be tailored to identify uptake of knowledge/skills gained in practises. this is through a self-reflection survey followed up by FGDs. A scale will demonstrate how deeply skills have been embedded into practise.	The data will be taken from internal system and quarterly reports from the country teams	
	INDICATOR 2.4			
	Changes in workforce and leadership practices resulting from project's activities	This is a qualitative indicator using bespoke annual evaluation with a sample of stakeholders to assess the changes in workforce and leadership practices resulting from activities conducted to enhance leadership, workforce and organisational development in partner country and regional public health organisations	Bespoke evaluation report	

		Strong evidence refers to the number of examples, the strength of evidence regarding project contribution, and the significance (as described by partners) of project contribution.		
OUTPUT 3	INDICATOR 3.1			There is political will to promote IHR-SP activities on strengthening networks Supported networks create a forum for enhancing ways of working, including multi-sectoral collaboration There is a shared understanding among the network on what a partnership is and the roles of the partners in the partnership. Supported networks develop and promote effective public health systems The partnership and networks will provide sustainable added value to public health systems For risks, see the IHR Project Risk Register
Strengthened public health networks at national and regional level	Number and description of public health networks supported across country, regional and global levels	This is a mixed-method indicator i.e., it will have quantitative and qualitative data. The *quantitative* data assesses the total number of networks that are supported across country, regional and global levels. Networks are defined as formal (i.e., TORs, formal membership, secretariat, etc.) or informal (i.e., community of practise, nascent group, etc.) groups interacting together to achieve a shared vision related to public health The *qualitative* data focuses on the description of support and network i.e., which type of network and what kind of support was provided for e.g., facilitation, discussion on national strategy, etc. Supported is defined as activities around creation, co-ordination, expansion and sustenance of existing and new networks. Examples include but are not limited to co-facilitation and training, digital support, admin support, core products development, new network creation, embedding a network within local system, chairing meetings, etc.	The data will be taken from internal system and quarterly reports from the country teams	
	INDICATOR 3.2			
	Number/Proportion (%) of stakeholders report having improved coordination through the	Stakeholders are all the individuals who are part of the network/partnership A bespoke survey/scale will be used annually with a sample of stakeholders asking them to reflect on whether they see	The data will be taken from internal system and cumulative quarterly reports	

	network/partnership	improvements in coordination through partnership/network Cut-off for the scale will help determine improvement which will be used to assess the proportion of stakeholders who report having improved coordination through network/partnership	from the country teams
	INDICATOR 3.3		
	Changes in practices resulting from public health networks	This is an qualitative indicator using bespoke annual evaluation with a sample of stakeholders to assess the changes in public health practices resulting from contribution of activities conducted to strengthen public health systems and networks at national and regional level Strong evidence refers to the number of examples, the strength of evidence regarding project contribution, and the significance (as described by partners) of project contribution.	Bespoke evaluation report

Annex B: Payment Schedule

PAYMENT SCHEDULE FOR SPENDING PERIOD 2022/23 to 2024/25

30 June 2022	£2,250,000
30 September 2022	£2,250,000
31 December 2022	£2,250,000
31 March 2023	£2,250,000
Financial year 2022/23 sub-total	**£9,000,000**
30 June 2023	£2,250,000
30 September 2023	£2,250,000
31 December 2023	£2,250,000
31 March 2024	£2,250,000
Financial year 2023/24 sub-total	**£9,000,000**
30 June 2024	£2,500,000
30 September 2024	£2,500,000
31 December 2024	£2,500,000
31 March 2025	£2,500,000
Financial year 2024/25 sub-total	**£10,000,000**

TOTAL FOR PROJECT

Total IHR-S 2022-2025 Spend Review Period	**£28,000,000**
Total IHR-S Lifetime Project Value 2016 - 2025	**£52,000,000**

Annex C: Authorised Representatives and addresses for service of notices

For the DHSC:

Name	Anna Wechsberg
Office Address	Department of Health and Social Care 39 Victoria Street, London SW1H 0EU
Telephone number	[redacted]
E mail address	[redacted]

For the UKHSA:

Name	Neil Squires
Office Address	United Kingdom Health Security Agency Noble House 17 Smith Square London, SW1P 3JR
Telephone number	[redacted]
E mail address	[redacted]

Annex D: Security and Data Protection

Definitions

"Controller"	means the natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data; where the purposes and means of such processing are determined by Union or Member State law, the controller or the specific criteria for its nomination may be provided for by Union or Member State law, in accordance with DPA;
"**DPA**"	means the Data Protection Act 2018 (DPA 2018)
"**Personal Data**"	means any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person, as set out in DPA;
"**Processor"**	means a natural or legal person, public authority, agency or other body which

	processes personal data on behalf of the controller, as set out in DPA;
"**Personal Data Breach**"	will have the same meaning as set out in DPA;
"Pseudonymisation"	means the processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person;

1. DHSC is the Controller responsible for all personal information it collects for the purposes of the MoU. The Partner will act as Processor for DHSC under the provisions of this MoU.

2. The Partner is the Controller responsible for all personal information it collects for the purposes of the MoU. The Partner will act as Processor for DHSC under the provisions of this MoU.

3. The Processor will act only on instructions from the respective Controller, and will ensure they have mechanisms in place to address the issues of physical security, security awareness and training, security management systems development, site-specific information systems security policy and systems specific security policies.

4. Any request from an individual or a third party for access to personal data, or any complaint about the way in which personal data has been processed, will be referred to the respective Controller.

5. Any information extracted for statistical, planning, or research purposes can only be used after Pseudonymisation.

Annex E: Reporting

1. Financial Reporting

UKHSA will provide quarterly forecast and actuals updates which will be used to identify DHSC to UKHSA transfer values each quarter and be used to monitor IHR-S spend efficiencies/capacity. Quarterly meetings will be organised to discuss actuals against the proposed forecast to assess UKHSA project spend. Over and/or underspend will be monitored through this process.

2. Project Evaluation:

Project evaluation will be measured against outputs and outcomes as defined in the IHR-S Logical Framework found above (Annex A – Activities (UKHSA) – 2. Logframe).

Continual monitoring will take place by UKSHA against the targets set in the Logframe. Reports on progress against the logframe will be provided at the quarterly IHR-S Project Board. Annual reporting will be provided to DHSC for review and evaluation through the Spend Review period.