



Memorandum of Understanding For Emergency Preparedness and Service Delivery in the event of a Public Health Incident or Outbreak in Coventry, Solihull and Warwickshire

April 2014

Between

***NHS England Area Teams
Public Health England Centre West Midlands
Local DPHs
Local Authorities
CCGs
Community Provider Trusts
Primary Care (GPs and Pharmacies)***

Note:

While this Memorandum of Understanding has been agreed through the Arden Local Health Resilience Partnership, it is based on significant work undertaken in the Staffordshire and Shropshire NHS England Area Team area. This detailed work, and the permission for it to be shared and used locally is gratefully acknowledged.

Date	April 2014
Audience	This MOU is written for key agencies likely to be involved in planning for, or responding to a public health incident or outbreak within Coventry, Solihull and Warwickshire
Document Owner	
Copy	
Description	This MOU outlines the roles and responsibilities of partners during a public health incident, as well as related emergency preparedness responsibilities.
Reference	
Action Required Timing	
Version	DRAFT
Review Date	January 2016
Contact	Michael Enderby, CSW Resilience Team

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1.0. Introduction

In order to ensure operational clarity across the 3 sub-regional areas the three Directors of Public Health across Coventry, Solihull and Warwickshire are working together to ensure a multi-agency co-ordinated response in the event of a public health incident. This is further facilitated by the CSW Resilience Team who delivers a joint resilience programme under a single management structure thus increasing the capability of a co-ordinated and efficient response to any major public health incident.

This Memorandum of Understanding (MOU) sets out the agreed contribution to Emergency Preparedness and Service Delivery in the event of a Public Health incident or outbreak by Local Authority Public Health Teams and:

- Public Health England
- Local Authorities – Coventry City Council, Solihull Metropolitan Borough Council, Warwickshire County Council (including the CSW Resilience Team)
- NHS England Area Team(s) - Birmingham, Solihull & the Black Country Area Team AND Arden Herefordshire and Worcestershire Area Team;
- Clinical Commissioning Groups (CCG's) – Solihull CCG, Coventry & Rugby CCG, Warwickshire North CCG & South Warwickshire CCG

2.0. Background

On 1st April 2013 large changes took place in the health and social care landscape through implementation of the new NHS and Social Care Act (2012). This established NHS England, Public Health England (PHE), Clinical Commissioning Groups (CCGs) and transferred the majority of former NHS Public Health responsibilities into local authorities, including Director of Public Health responsibilities, from 1st April 2013. These responsibilities include emergency planning in the Local Authority. NHS England also retains some public health functions as well as the overall lead for local NHS emergency and incident planning and response.

Encouragingly, whilst there have been a number of good recent examples of well-coordinated NHS responses to local public health incidents, there are potential risks relating to the new arrangements which need to be recognised and mitigated. It is therefore necessary to formalise local arrangements for ensuring an effective and streamlined response to support the management of public health (health protection) emergencies and incidents and the expected NHS response from providers and commissioners, and to describe these in a Memorandum of Understanding.

NHS England, through its local Area Teams, is responsible for ensuring coordinated preparedness, resilience and response for emergencies across NHS service providers in the local area and for ensuring effective liaison with wider partners. Although public health incidents are not necessarily considered as major incidents in this context, they can be described as 'significant' in that they require preparedness and immediate response. The principles captured in this agreement are therefore consistent with the spirit of the NHS England Incident Response Plan and consistent with requirements (under the Civil Contingencies Act 2004) that providers of NHS services should provide mutual aid for NHS incidents when required. These requirements are set out in the NHS Standard Contract as outlined in Appendix 1.

Following the recognition and declaration of a significant incident or outbreak, a coordinated response (often through a multiagency Incident Management Team) aims to protect the public's

health by identifying the source of the outbreak and implementing the necessary control measures in a timely way, to prevent further spread or recurrence of infection. Examples of an outbreak can include: nursery outbreaks (meningococcal septicaemia/ meningitis); school based outbreaks (hepatitis A, measles, mumps); prison outbreaks (varicella; hepatitis; influenza; E. coli; etc.); and care/ nursing home outbreaks (influenza and respiratory disease) and these might require a co-ordinated response.

Lack of agreement about how any necessary NHS resources should be deployed to support the management of such an incident can delay the response and lead to avoidable illness and sometimes deaths for patients. Poor management of outbreaks and incidents also present a major risk to the reputation of local health services and can undermine public confidence in the NHS. It is also important to ensure there is agreement between partners with regard to roles and responsibilities, particularly in relation to expectations regarding the role of the Director of Public Health. Major incidents, whether they be related to communicable disease (e.g. flu pandemic), environmental hazards (e.g. chemical incidents, flooding) or big bang events (train crashes, bomb blasts), will usually be of public health significance. The role of local authority public health in such incident command and control structures is not currently outlined clearly at a national level, and is considered in this MOU.

In addition to service delivery aspects of public health incident response, the arrangements for associated multiagency emergency planning work is also outlined.

This MoU has been influenced significantly by, and is compliant with the guidance issued on 31st January 2014 jointly from the Association of Directors of Public Health, the Department of Health, the Faculty of Public Health, the Local Government Association, NHS England, and Public Health England. This is entitled 'Agreeing local roles for responding to Health Protection Incidents'.

3.0 Purpose

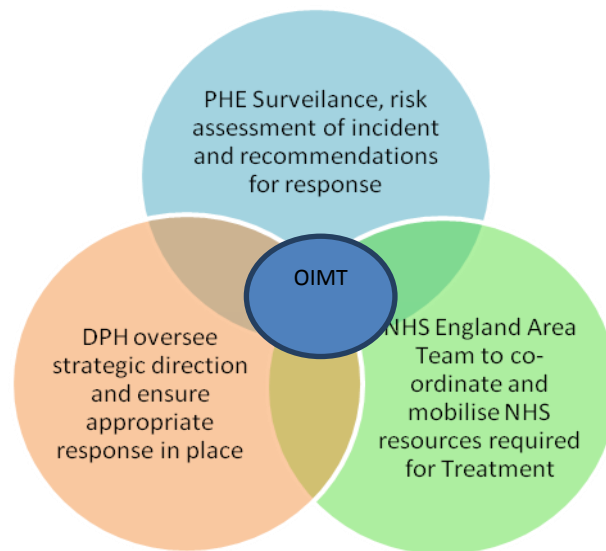
This MOU aims to ensure:

1. Respective roles and responsibilities of NHS England, Public Health England, Local Authority, CCGs and providers of NHS services and the CSW Resilience Team, in the event that a response to a public health incident is required, are clear and understood.
2. That there is provision and timely release of sufficient resources by the above organisations to support the investigation and management of a health protection incident in line with the duty of NHS provider organisations to respond accordingly as defined in the NHS Standard Contract.
3. Clear definition of funding responsibilities of each organisation involved including arrangements for committing resources early in the response and securing payment after the response.

4.0 Management of public health incidents

The successful management of Public Health incidents will be in facilitating mutually supportive three-way working between the NHS England Area Teams, local PHE Centres and Directors of Public Health in Local Authorities, with the support of other key partners.

Fig 1: Management Roles



The Emergency Preparedness Framework (NHS England 2013)¹, PHE Concept of Operations (PHE 2013)² articulates the roles and responsibilities of NHS England, Directors of Public Health and Public Health England in response to a significant incident as follows:

4.1 Public Health England

Will normally lead the epidemiological investigation and the specialist health protection response to public health incidents and has responsibility to declare a health protection incident, major or otherwise. PHE would Chair the 'Outbreak' Incident Management Team (OIMT) meetings/teleconferences and keep the health protection risks under review during the incident, providing expert health protection advice to the OIMT (drawing on specialist advice from regional and national PHE and other experts as required). PHE will normally coordinate the public communications/ media response as required in collaboration and agreement with other local organisations represented in the OIMT

Public Health England provides public health EPRR leadership and scientific and technical advice at all levels, working with NHS, national and local government to protect the public against infectious diseases and minimise health impact from hazards. Appropriate secretariat support will also be provided by PHE.

4.2 NHS England Area Team

Has responsibility for managing/overseeing the NHS response to the incident, ensuring that relevant NHS resources are mobilised to support the incident and commanding/directing NHS resources as necessary. NHS England are key players within the OIMT and may, on occasions, take the lead role

¹ NHS England Emergency Preparedness Framework 2013 Chpt 9 – Roles & Responsibilities

² Public Health England Concept of Operations 2013

instead of PHE in responding to an incident. Transfer of the lead response role from PHE to NHS England would be dependent on:

- a. The size and spread of the incident requiring the deployment of significant NHS resources with significant cost implications
- b. Where the incident requires complex coordination and/or communications in order to mobilise the NHS response
- c. Where provider organisations and PHE are not co-operating with each other.

The decision to transfer the lead response role from PHE to NHS England will be undertaken with the agreement of the OIMT.

Although not included in the PHE Concept of Operations at the local level, there will be a role for CCGs in the OIMT, where it is necessary to mobilise the NHS resources required provided within their contracts or otherwise provided by their local NHS providers.

4.3 Local Authority

4.3.1 Director of Public Health

Has overall responsibility for strategic oversight of an incident. He/she should ensure an appropriate response is put in place by NHS England and Public Health England; however has no authority to direct, command or make decisions relating to mobilisation of NHS resources. The DPH should brief Local Authority colleagues and local politicians and mobilise any local authority resources necessary to support the incident ensuring any relevant information is communicated to the public in a timely fashion

4.3.2 CSW Resilience Team

Has responsibility for:

- Supporting the Outbreak Incident Management Team and Director of Public Health from a Tactical Advisory perspective
- Providing an out of hours (OOH) contact for the DPH and other senior local authority directors.
- Cascading messages through LA staff communication channels and briefing members
- Supporting logistics of outbreak management e.g. setting up meeting rooms
- Providing loggist and message handling support depending on Local Authority pressures within the incident.
- Mobilising appropriate LA resources.

4.3.3 Environmental Health

Environmental Health Officers will be contacted by PHE during an outbreak, and will form part of the OIMT where necessary. Out of Hours they will be contacted through their out of hours arrangements (or through CSW Resilience). Environmental Health Officers will be responsible for the following:-

- Investigating potential sources/causes of outbreak/incident and secure relevant improvements as appropriate where the local authority is the enforcing authority e.g. for food safety, health and safety and health protection.
- Provide help and advice with the epidemiological aspects of the outbreak/incident, including the investigation of cases (and contacts where appropriate).
- Provide the mechanisms for out of hours communications with the CCDC, OIMT, the public and other stakeholders as appropriate.

- Be responsible for arranging the collection and transport of appropriate specimens to the laboratory for screening of patients, contacts and staff, as well as food, water and environmental sampling.
- Undertaking any necessary enforcement action and monitor the progress of the investigation (e.g. sources/causes, cases/affected individuals, contacts within their area)

5.0 Response to a public health incident

Response to a public health incident frequently requires the assistance, both in and out of hours, of NHS providers, particularly when clinical investigations and treatment of patients is necessary (e.g. taking swabs, prescribing medicines or vaccinating patients).

Normally this is straightforward and can be arranged through Public Health England with local general practitioners for their own registered patients (without needing to convene an OIMT), however sometimes this is not feasible for a number of reasons e.g.:

- The incident occurs, or interventions are urgently required, outside normal GP service hours
- There are too many cases, requiring complex coordinated interventions, and this is not feasible within normal GP service delivery arrangements
- There are too many individual GP practices involved making a coordinated response difficult
- It would be more effective to provide a community 'settings based' response to the incident (e.g. through a dedicated mini-clinic providing investigations and treatment in a school or other community setting)
- The urgency of providing a particular intervention

Essentially, this usually boils down to a combination of factors in relation to the setting, the patient group and the complexity and urgency of the intervention required. It is therefore difficult to precisely codify incidents and emergencies, ahead of the event, where PHE or the NHS England Area Team would need to call on the assistance of Out of Hours Providers (including secondary care and primary care providers), Community services providers, CCG resources (e.g. relevant commissioners and Medicines Management colleagues if appropriate), NHS England resources (e.g. relevant immunisation team and Medicines Management colleagues if appropriate) or other NHS services. However it is possible to scope the most likely outbreaks and incidents and common interventions required (see Appendix 2).

In the event that a complex multi-agency response is required to a public health incident, relevant organisations will be required to participate in an Outbreak Incident Management Team (OIMT). Occasionally, it is necessary to mobilise NHS resources to assist with investigations in order to confirm a potential outbreak, before it is declared (e.g. taking swabs from residents in a care home in order to confirm causative organism and ensuring transportation to the appropriate local laboratory). The IMT will enable PHE and NHS England to effectively coordinate and command the provision of necessary staff and supplies which enable a swift and timely response to the incident, and enables the Director of Public Health to have appropriate strategic oversight. A request for participation in an OIMT can be made at any time and providers of NHS services have a duty to respond accordingly in line with the requirements of the NHS Standard Contract.

Any recommendation by Public Health England to provide a very specific NHS response requires an initial risk assessment by PHE, which would consider both the nature of the threat and the complexity of the intervention and communications required. The risk assessment should be communicated to the OIMT, including a consideration of the feasibility of providing these alternatively through local general practitioners and appropriate to the incident. The risk assessment will be made by either a Consultant in Communicable Disease Control (CCDC) or Public Health Consultant from PHE and any requests for NHS support will be initiated by the PHE Incident Director as per the PHE Incident Response Plan.

Dependent on the type/ size of the incident, it is important to note that the required response may exceed that which has been contracted / planned for as part of normal business and could impact on the activity performance of the NHS service provider, based on the following factors:

- The number of operational staff required to support the incident and,
- The time period covered.

In this situation, any impact on normal service delivery should be recognised and agreed how activity monitoring should be treated in the statistics required as part of CCG, NHS England and/or Local Authority contract monitoring to ensure that the provider is not penalised as a result of the incident that has occurred. In this situation, the provider should quantify the cost of all extra pay and non-pay resource utilised as a direct result of any requested response.

It is acknowledged that further work will be required to secure appropriate changes to contracts of providers for service delivery in outbreaks to secure resilient responses at any time.

6.0 Funding Arrangements

These arrangements take account of the guidance issued by several national organisations on 31st January 2014, 'Agreeing local roles for responding to Health Protection Incidents'. This indicates, on pages 2 to 3, paragraphs 8 to 13, that allocation changes already made to the new organisations are sufficient for them to be able to meet their funding obligations and includes the underlying principles that the safety and well-being of patients is paramount, that no treatment should be refused or delayed due to uncertainty as to which CCG is responsible for funding an individual's day to day healthcare provision, and that the NHS is expected to act in the best interests of the patient at all times and to work together in the spirit of partnership.

The guidance highlights the importance of all commissioning agencies (Local Authorities, Public Health England, NHS England and CCGs) specifying in contracts they hold the requirements of their providers with regard to supporting the response to public health incidents.

In more detail, for the NHS response to public health incidents, the guidance states: 'In practice, the funding at local level of clinical interventions whether investigative or curative, is a responsibility of the NHS. NHS England and CCG finance officers will agree an appropriate methodology for sharing costs on a case by case basis from within budget allocations, to support the locally agreed clinical responses. The sharing of more significant costs will be agreed as appropriate, with NHS England Regional and National finance directors'.

Upon agreement of the required response to an incident by the Outbreak Incident Management Team (OIMT), should the response (in terms of staff/resource commitment) exceed that detailed in relevant surge plans, providers will quantify the cost of extra pay and non-pay resources utilised as a result of the enhanced response. Costs will need to be presented with evidence, with details of additional costs incurred being forwarded to the Area Team in the first instance.

Payments to final invoices will be implemented only on the express agreement of both parties. Discussions of this nature need to take place with the Directors of Finance (or equivalent) from the respective organisations. Further rules and guidance for determining the responsibility for payments to providers is outlined in the document 'Who Pays – Determining responsibility for payments to providers' published on the NHS England website.

Patients should not be expected to pay the prescription charge for medications prescribed for outbreak or communicable disease control reasons.

7.0 Response requirements:

7.1 NHS England Area Team

- The Area Team will co-ordinate the primary care response to the incident with the Area Team Pharmacy Advisor key to the CT.
- The Area Team will also co-ordinate any response required by Community Trusts and/or Acute Trusts
- The Area Team will co-ordinate NHS discussions regarding the payment of any additional NHS costs (which exceed that detailed in surge plans) submitted by providers in relation to public health incident management.

7.2 Clinical Commissioning Groups

- Local CCG(s) should form part of the OIMT as necessary and help inform the OIMT's decisions about the appropriate level of NHS response from providers and any CCG resources needed to be released for an integrated approach in response to an incident. These resources could include EPRR Officer time, staffing and/or financial resource for investigation and treatment responses as appropriate (please refer to Section 6 regarding funding arrangements and Appendix 2, which highlights a range of common outbreak scenarios and the required responses).
- CCGs may be requested by the Area Team to provide clinical support for the prescribing and administration of medication and specialist infection control advice where required, depending on the nature of the incident, and as determined by the OIMT. This refers to the possible support from GPs to sign a PGD as well as medicines management/pharmacy advice support (whether the latter is provided through the CCG or Commissioning Support Unit).
- The Dispensing of medications would be carried out by Community Pharmacists unless covered by a Patient Group Direction (PGD)

7.3 NHS England Area Team Screening and Immunisation Team

- The Screening and Immunisation Team will advise on/support the management of incidents requiring immunisation interventions covered by the section 7a agreement https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256502/nhs_public_health_functions_agreement_2014-15.pdf. This may include sourcing immunisations, mobilising community immunisation resources/teams and production of PGDs. In non 7a immunisation interventions the Screening and Immunisation Team role will be mainly around providing general guidance e.g.: on principles of PGD production. Funding associated with staff time and vaccinations in these circumstances will be managed as outlined in Section 6.

7.4 Community Pharmacy Services

- Under the direction of the Area Team Pharmacy Advisor, Local community pharmacy services will support the incident response by obtaining the necessary medication as determined by PHE, dispensing and supplying in a flexible way to meet the needs of the outbreak.

7.5 NHS community provider(s) and General Medical Practitioners – In and Out of Hours

- Local community services providers and GPs will deploy and coordinate relevant and available NHS community resources as determined by the Incident Management Team to support an NHS response including as necessary eg. clinical and administrative staff to enable clinical advice to be given and investigations undertaken (including ensuring sampling equipment is available and any samples taken are conveyed appropriately to the local laboratory), and prescribing and administration of medications or vaccinations, which includes activities related to confirming an outbreak, prior to an OIMT being called.

7.6 Ambulance Trust

- The specialist skills that Ambulance Trust providers contribute in the context of a public health incident relate more to the major incident end of the public health emergency spectrum, by having appropriately trained staff to undertake decontamination of individuals during a chemical incident, and providing essential support during a pandemic. It is essential that Ambulance Trust colleagues are kept informed about community-related outbreaks where there is potential for ambulance services to be required to convey individuals to hospital, in order for the appropriate infection control precautions to be taken by staff.

8.0 Activation Process

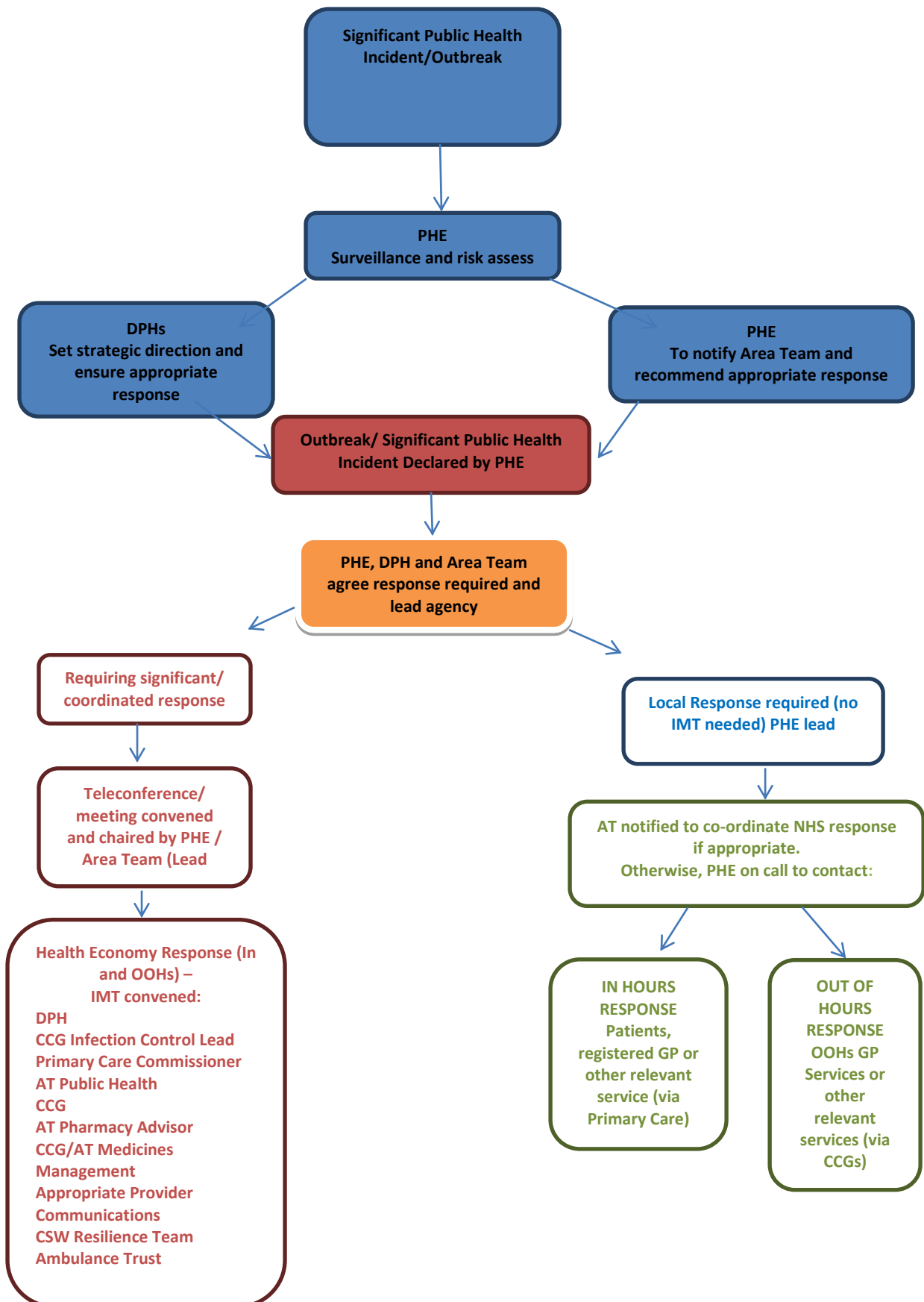
An initial risk assessment by PHE, will consider both the nature of the public health threat and the complexity of the required response including communications and coordination.

Where the risk assessment identifies that complex NHS resources need to be deployed, PHE will declare an Incident or Outbreak and contact both the relevant local Director of Public Health and the NHS England Area Team to discuss the risk assessment, response requirements and arrangements for an OIMT. The lead organisation - either PHE or NHS England - will be determined at this stage.

The lead organisation (either NHS England or PHE) will then arrange for an OIMT to be held and, through normal on call arrangements, will notify relevant organisations.

The local DPH, PHE and NHS Area Team are core players in a public health incident and must always be involved in an OIMT.

Fig.2 Activation Algorithm for when NHS resources are required or have the potential to be required. (PHE can declare a incident / or outbreak and respond directly without the need to involve a coordinated response via this algorithm)



9.0 Major Incidents

The definition of a major incident and references to key documents outlining the NHS, local government and Public Health England response to a major incident can be found in Appendix 3. Each agency has its own appropriate emergency arrangements which are regularly reviewed to ensure best practice and enable each agency to respond to any incident in the most appropriate way and to keep abreast of the changing NHS landscape.

The Local Authority will have a role in response to a major incident in this context that will include the public health elements of the incident response. Therefore, outlining where local authority public health resource and expertise may need to be used during such an incident is important. Depending on the nature of the incident, the DPH (and public health team) may be required to:

- Provide support to the tactical (silver) NHS response or the Public Health England response as appropriate
- Chair the Scientific and Technical Advisory Cell, which advises the Strategic Co-ordinating Group (multi-agency response)
- Support the Local Government response in the recovery phase of an incident

The above may require significant staff resource, and will include temporary public health team members (e.g. Specialty Registrars in Public Health, Foundation Year 2 doctors and GP registrars). Mutual aid will be provided between public health teams, according to Local Authority Mutual Aid agreements, and support provided to the local authority response and to those of external organisations will be decided with the DPH according to the nature of the incident, and will be supported by CSW Resilience Team. Details of how emergency response is co-ordinated in Warwickshire between the County Council and the districts and borough councils is outlined in the Warwickshire County Council Major Emergency Plan with detailed information of specific duties outlined in the CSW Resilience Team's Standard Operating Procedures.

10.0 Preparing for health protection incidents and emergencies

In order to ensure that the quality of the multiagency response is maximised, and in accordance with the principles of an integrated emergency management response, a coordinated approach to planning, preparation, training and exercising is important, and should be conducted in partnership through the local LHRP. Lessons learned from any public health incidents will be identified through participation in a post incident debrief and fed back to the LHRP who will ensure learning is incorporated into future plans and training exercises. The LHRP is co-chaired by a local DPH and the NHS England Area Team. The LHRP will maintain oversight of all single agency and multiagency plans and clearly identify lead agencies for each plan and when there is need to create new/review current plans. All agencies will support each other in areas they are competent and able to support.

PHE, through the LHRP will provide advice to local NHS Providers and Commissioners regarding preparation that they might need to do to ensure an effective and timely response when a public health incident occurs (e.g. PGDs, microbiological swabs and contingency drugs supplies). PHE (where they have the requisite expertise to do this) will support any necessary training of staff and participate in local exercises where this would be helpful.

PHE will also provide leadership, advice and staff resource for the support of strategic communicable disease control programmes e.g. TB prevention and control programmes, Sexual Health and Sexually Transmitted Infection work programmes, Blood-borne Virus workstreams, Gastrointestinal Infection and Vaccine Preventable Disease among others. Where there is overlap with local authority commissioning or assurance responsibilities regarding communicable disease or environmental hazards (e.g. TB prevention and control Programmes, Drug and Alcohol Services, Environmental Health), the available local authority and Public Health England resource available to support this should be identified at the outset of all joint work and projects, and reviewed on a regular basis.

The Local Authority will ensure they maintain emergency arrangements for the areas they are responsible for and work with partners as appropriate including but not limited to the LRF and LHRP's. Local authority public health teams will provide scientific and technical advice on internal plans with a specific health element, e.g. cold weather and heatwave, pandemic flu, and will support local authority (including public health) action related to these plans. Local authority public health will also provide advice and support NHS and PHE led plans re communicable disease control where appropriate.

11.0 Review

The LHRP will review the effective operation of this MOU after at least annually or more frequently when requested to do so by any of the signatories or by NHS England or PHE.

This document was formally presented to the Arden, Hereford and Worcestershire LHRP on 28th March 2014 and tested at a multi-agency desktop exercise on 29th April 2014. Therefore formal electronic signatures will not be required. The MoU has been sent out for ratification to the Birmingham, Solihull and Black Country LHRP.

12.0 Signatures to the MOU

Signed:

Name: David Williams

Designation Area Director, NHS England (Arden, Hereford And Worcester Area)

Date:

Signed:

Name: Les Williams

Designation Area Director, NHS England (Birmingham, Black Country and Solihull)

Date:

Signed:

Name: Dr Sue Ibbotson
Designation: Centre Director, Public Health England (West Midlands)

Date:
Signed:

Name: Dr Jane Moore
Designation: Director of Public Health, Coventry

Date:

Signed:

Name: Dr Stephen Munday
Designation: Director of Public Health, Solihull

Date:

Signed:

Name: Dr John Linnane
Designation: Director of Public Health, Warwickshire

Date:

Signed:

Name: Dr Patrick Brooke
Designation: CCG Accountable Officer, Solihull Health

Date:

Signed:

Name: Diane Reeves
Designation: Accountable Officer, Birmingham South Central CCG

Date:

Signed:

Name: Gillian Entwistle
Designation: CCG Accountable Officer, South Warwickshire CCG
Date:

Signed:

Name: Andrea Green
Designation: Accountable Officer, Warwickshire North CCG
Date:

Signed:

Name: Steven Allen
Designation: Accountable Officer, Coventry and Rugby CCG
Date:

Signed:

Name: Paul Sykes
Designation: Accountable Officer, Coventry and Warwickshire Partnership Trust
Date:

Signed:

Name:
Designation: Accountable Officer, South Warwickshire Foundation Trust
Date:

Signed:

Name:
Designation: Accountable Officer, Heart of England Foundation Trust
Date:

Appendix 1: Standard Contract clause pertaining to Emergency Preparedness and Resilience requirements for NHS Organisations.

SC30 Emergency Preparedness and Resilience Including Major Incidents

- 30.1 Each Party must identify and have in place an Accountable Emergency Officer
- 30.2 Each Party must have and maintain an up-to-date Business Continuity Plan
- 30.3 Each party must have and maintain an Incident Response Plan
- 30.4 The Provider must have in place evacuation plans which provide for relocation of Service Users to alternative secure premises in the event of any Significant Incident or Emergency and how that relocation is to be effected in such a way as to maintain public safety and confidence.
- 30.5 The Provider must:
 - 30.5.1 assist in the development of and participate in joint planning and training exercises connected with its Incident Response Plan, including by conducting as required:
 - 30.5.11 a communication exercise every 6 months
 - 30.5.12 a desktop exercise annually; and
 - 30.5.13 a major live or simulated exercise if such an exercise has not been conducted within the previous 3 years;
 - 30.5.2 have in place and maintain Staff who are suitably trained and competent in emergency preparedness, resilience and response;
 - 30.5.3 have in place and maintain adequate facilities (including an Incident Co-ordination Centre) from which an Significant Incident or Emergency can be effectively managed,

In accordance with the NHS CB Emergency Planning Framework
- 30.6 For ambulance services the training requirement referred to in Service AM Condition 30.5.2 will be in addition to the enhanced training for Hazardous Area Response Team (HART) support staff.
- 30.7 The Provider must comply with:
 - 30.7.1 national and local civil contingency plans;
 - 30.7.2 the Civil Contingencies Act 2004;
 - 30.7.3 any other Law and/or Guidance, including the EPRR Guidance, to the extent applicable

- 30.8 The Parties must, through the LHRPs and any applicable sub-groups of the LHRPs, co-operate with and contribute to the co-ordinated development and review of any local area Business Continuity Plans and Incident Response Plans.
- 30.9 If there is a Significant Incident or Emergency:
- 30.9.1 the Parties must comply with their respective Incident Response Plans; and
- 30.9.2 each Party must provide the others with whatever further assistance they may reasonably require to respond to that Significant Incident or Emergency; and
- 30.9.3 the Provider must comply with its Business Continuity Plan
- 30.10 The Provider must notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 Operational Days following:
- 30.10.1 the activation of its Incident Response Plan
- 30.10.2 any risk or any actual disruption, to Commissioner Requested Services or Essential Services; and / or
- 30.10.3 the activation of its Business Continuity Plan
- 30.11 The Commissioners must have in place arrangements that enable the receipt at all times of a notification made under Service Condition 30.10
- 30.12 The Provider must at the request of the Co-ordinating Commissioner provide whatever support and assistance may reasonably be required by the Commissioners and/or Healthwatch England in response to any national, regional or local public health emergency or incident.
- 30.13 If the Provider is subcontracting all or part of a Service, the Provider must;
- 30.13.1 ensure that its Incident response Plan and its Business Continuity Plan make provision in relation to the subcontracted services; and
- 30.13.2 require the Material Sub-Contractor or Permitted Sub-Contractor to have in place and maintain plans which are equivalent to the Provider's Incident Response Plan and Business Continuity Plan
- 30.14 The right of any Commissioner to:
- 30.14.1 withhold or retain sums under General Condition 9 (Contract Management); and/or
- 30.14.2 suspend Services under General Condition 16 (Suspension), will not apply if the relevant right to withhold, retain or suspend has arisen only as a result of the Provider complying with its obligation under this Service Condition 30.
- 30.15 The Provider must use its reasonable efforts to minimise the effect of a Significant Incident or Emergency and to continue the provision of Elective Care, as well as Non-elective Care. If a Service User is already receiving treatment when the Significant Incident or Emergency occurs, or is

admitted after the date it occurs, the Provider must not:

- 30.15.1 discharge the Service User, unless clinically appropriate to do so in accordance with Good Practice; or
 - 30.15.2 transfer the Service User, unless it is clinically appropriate to do so in accordance with Good Practice
- 30.16 Subject to Service Condition 30.15 if the impact of a Significant Incident or Emergency Incident is that the demand for Non-elective Care increases, and the Provider establishes to the satisfaction of the Co-ordinating Commissioner that its ability to provide Elective Care is reduced as a result, Elective Care will be suspended or scaled back as necessary for as long as the Provider's ability to provide it is reduced. The Provider must give the Co-ordinating Commissioner written confirmation every 2 calendar days of the continuing impact of the Significant Incident or Emergency on its ability to provide Elective Care.
- 30.17 During or in relation to any suspension of Elective care in accordance with Service Condition 30.16:
- 30.17.1 General Condition 16 (Suspension) will not apply to that suspension;
 - 30.17.2 if requested by the Provider, the Commissioners must use their reasonable efforts to avoid any new referrals for Elective Care and the Provider may if necessary change its waiting lists for Elective care; and
 - 30.17.3 the Provider must continue to provide Non-elective Care (and any related Elective Care) subject to the Provider's discretion to transfer or divert a Service User if the provider considers that to be in the best interests of all Service Users to whom the Provider is providing Non-elective care whether or not as a result of the Significant Incident or Emergency (using that discretion in accordance with Good Practice)
- 30.18 If, despite the provider complying fully with its obligations under this Service Condition 30, there are transfers, postponements and cancellations the Provider must give the Commissioners notice of:
- 30.18.1 the identity of each Service User who has been transferred and the alternative provider;
 - 30.18.2 the identity of each Service user who has not been but is likely to be transferred, the probable date of transfer and the identity of the intended alternative provider;
 - 30.18.3 cancellations and postponements of admission dates;
 - 30.18.4 cancellations and postponements of out-patient appointments;
 - 30.18.5 other changes in the Provider's list
- 30.19 As soon as reasonably practicable after the Provider gives written notice to the Co-ordinating Commissioner that the effects of the Significant Incident or Emergency have ceased, the Provider must fully restore the availability of Elective Care

Appendix 2: Examples of more common significant public health incidents

Table: Examples of type of setting, incidents/outbreaks and interventions where surge capacity and a significant coordinated response is likely to be required. Please note this list is not exhaustive:

Settings	Schools/Colleges; Nurseries; Care Homes; Special Schools; Prisons/ Detention centres; Workplaces; Ports/airports/oil refinery; Hotels; Leisure Centres; Selection of community – geographical areas; Travellers’ sites; Private camp sites/holiday parks; nursing/care homes; Community hospitals; poultry farms & rendering plants; etc.
Incidents/ outbreaks	Influenza; E coli O157; Tuberculosis; Diphtheria; Hepatitis A; Hepatitis B; Meningitis; Pertussis; Measles; Mumps; Varicella; Anthrax; Botulism; Avian Influenza; Invasive Group A Streptococcal infection; other new and emerging infections, e.g. novel coronavirus; PVL MRSA; Influenza A/H7
Interventions (see note below)	<ul style="list-style-type: none"> • Undertaking clinical and public health assessment and delivery of effective interventions to agreed guidelines and protocols. • Collecting data of people exposed, in order to follow up later
Investigations to support diagnosis	<p>Carrying out a range of activities to support investigation including:</p> <ul style="list-style-type: none"> • Nose and throat swabs for viral studies • Pernasal and skin/wound swabs • Blood samples (including for very young children) • Oral fluid samples • Urine tests for legionella • Mass blood tests (IGRA testing) for TB infection • Mass chest X-rays for TB clusters and exposures
Administration of treatment or prophylaxis	<ul style="list-style-type: none"> • Immunoglobulin (including IM injections for very young children) • Vaccines (including e.g. MMR post exposure vaccination after hours /weekends) • Antivirals treatment/prophylaxis • Antibiotics • Anti-toxins
Follow-up	Telephone or clinic attendance Reporting of test results to individuals
Reporting/ administration	Instituting a robust data collection/surveillance system to report back to key stakeholders, GPs, and PHE Centre. This includes provision of administrative support for identification of potential patient/population ‘at-risk’ groups requiring assessment/follow up. Ensuring all relevant GPs are informed of interventions relating to their patients.
Preparation required to	Identification of laboratory stock (swabs, tubes, etc.) and training

support response	of staff to take samples. Formulation of PGDs, PSDs, and identification of vaccine/prophylactic antibiotic/antiviral stock and supply route. Training of vaccinators/prescribers.
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Specific examples of types of settings, incidents & interventions

Example 1 – Two cases of meningococcal disease in the same school

Administration of mass meningococcal prophylaxis in a setting predominantly involving children is required when linked cases have occurred. The response needs to be rapid. Although the administration of prophylaxis is most likely to take place on a normal working day, it is conceivable that a response could be mounted out of hours, e.g. children /students in a boarding school could have prophylaxis administered at a weekend. Even if the administration takes place on a normal working day, preparations and mobilising of resources are likely to take place out-of-hours to achieve a rapid response.

The public health response to manage this scenario includes access to the following resources:

- Clinical staff, e.g. school nurses, health visitors, etc., to administer prophylaxis at the nursery/boarding school
- Pharmacist to prescribe the prophylaxis for the children and adults
- Admin support to record the administration of the prophylaxis to the children and adults; admin support to take notes of incident meetings
- PHE Consultant and PHE Practitioner to attend the school setting during the administration of the prophylaxis to offer advice as necessary; and convene /chair CT as necessary
- Communication with parents, schools, school governors, Local Education Authority, media, and setting up a helpline if needed.
- Necessary key personnel to be part of multi-agency incident control team
- Other interventions as agreed the incident/outbreak control team

Example 2 – Two confirmed and one possible case of hepatitis A in a care home

The following public health actions will need to be implemented and access to the following resources will be required:

- Practitioners/clinical staff, e.g. infection control nurses, health visitors, community/district nurses to provide advice on infection control, complete questionnaires for both residents and staff, and administer vaccine as appropriate
- Environmental Health Officers [EHOs] to undertake site visit, inspect kitchen facilities and take samples, and completion of questionnaires as appropriate
- Pharmacist to facilitate access to the vaccine and immunoglobulin as required
- Consultant Microbiologist to advise on samples and immunoglobulin as required
- Admin support to record the administration of the vaccine to the residents and keep up-to-date database; admin support to take notes of incident meetings
- PHE Consultant and PHE Practitioner to visit the care home to support investigation with the residents and staff as appropriate
- Communication with the affected individuals and relevant carers/family. Setting up a helpline if needed.
- Necessary key personnel to be part of multi-agency incident control meeting (as per Outbreak of Infectious Diseases Plan)
- Other interventions as agreed by the incident/outbreak control team

Example 3 – Two linked cases of TB in a primary school setting

Incident control team will need to be convened and the following resources will be required:

- Practitioners/clinical staff/admin staff to organise mass screening of children, e.g. blood test, Interferon Gamma Release Assay [IGRA]
- Practitioners/clinical staff to complete questionnaires and provide advice to pupils and parents at the school
- Communication with parents, schools, School Governors, Local Education Authority, media
- Practitioners and admin staff to set-up and staff the helpline for advice to pupils parents and the general public
- PHE Consultant and PHE Practitioner to visit the school to provide advice as appropriate
- Necessary key personnel to be part of multi-agency incident control meeting (as per Joint Outbreak of Infectious Diseases Plan)
- Other interventions as agreed by the incident/outbreak control team

Example 4 – Protracted community outbreak of measles affecting a large number of children and adults from more than one local authority area

Multi-agency outbreak control team will need to be convened and the following resources will be required:

- Administrative staff to support:
 - Outbreak control team
 - PHE health protection team acute desk data input and case investigation and management
 - Support setting up and running of a helpline
- Practitioners/clinical staff to support:
 - PHE health protection team acute desk / measles response centre
 - Set up and run community clinic to provide public health advice and administer immunisation / immunoglobulin as appropriate
 - Support contact tracing activity of community settings
 - Support training and education of primary and secondary care staff
 - Other activities as per PHE health protection team advice such as staffing helpline
- Practitioners/clinical staff to complete questionnaires and provide advice to pupils and parents at the school
- Communication with parents, schools, School Governors, Local Education Authority, media
- Necessary key personnel to be part of multi-agency incident control meeting (as per Outbreak of Infectious Diseases Plan)
- Other interventions as agreed by the incident/outbreak control team

Appendix 3: Roles and Responsibilities in a Major Incident

What is a major incident?

The Local Authority and NHS would define their major incident's according to the Civil Contingencies Act (CCA) 2004: <http://www.legislation.gov.uk/ukpga/2004/36/section/1> as

- (a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom,
- (b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom, or
- (c) war, or terrorism, which threatens serious damage to the security of the United Kingdom.

All CCA category 1 responder organisations follow the nationally recognised 'operational, tactical and strategic' command levels as outlined below:

Operational Command (Bronze)

This level refers to those responsible for managing the main working elements of the response to an incident carrying out specific tasks within a service area, geographical area or functional area, i.e. hospital ward, or at the scene of the incident. This team will act on tactical commands.

Tactical Command (Silver)

The tactical team are responsible for directly managing their organisation's response to an incident, developing a tactical plan which will achieve the objectives set by the strategic command. Tactical command should oversee and support, but not be directly involved in the operational response to an incident. If an organisation has several key sites providing an operational response, such as a large Acute Trust, there may be a tactical commander for each site.

Strategic Command (Gold)

The Strategic command has overall command of the organisation or sector's resources. They are responsible for liaising with partners to develop the strategy and policies and allocate the funding which will deal with the incident. This level is also responsible for maintaining the organisation's normal services during the incident and the organisation's reputation at all times, taking into consideration the wider context to establish its longer term and wider effects.

Gold Commanders must consider the incident in its wider context to establish its longer term and wider effects by delegating tactical decisions to the tactical commanders.

If a significant incident or emergency is large or widespread, it may be necessary to coordinate the response of several organisations. This may be at a tactical level or at both tactical and strategic level. Multi-agency strategic coordination is undertaken through a Strategic Coordinating Group (SCG).

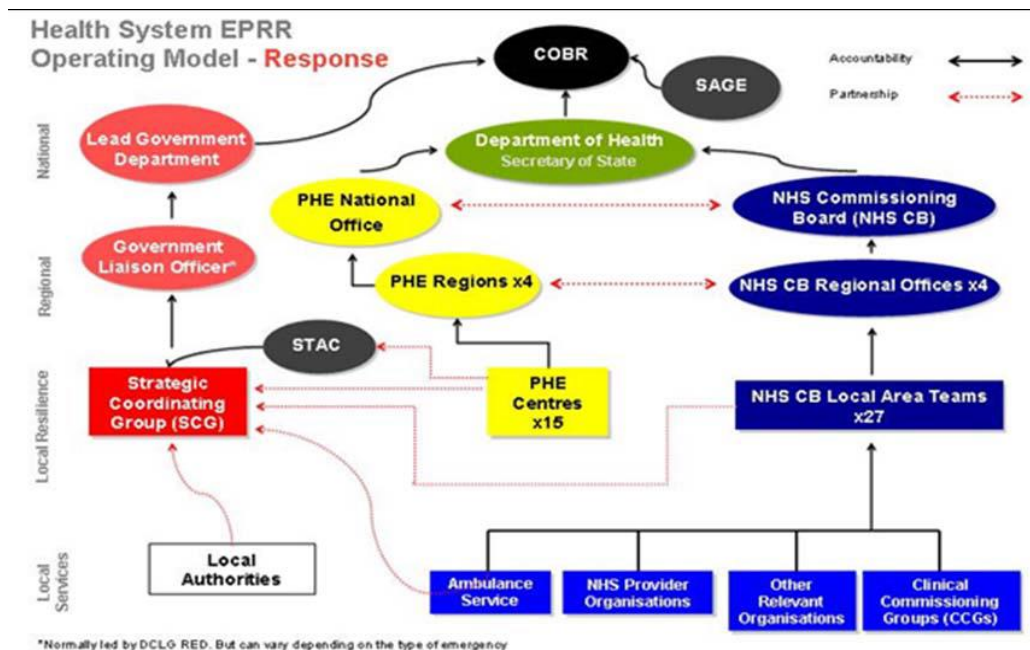
All agencies need to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations, Local Authorities and sub-contractors of both these organisations must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparation, resilience and response' (EPRR).

During a major incident – other local authorities, central and regional government departments, emergency services, hospitals, utility companies etc may all be involved and needed to initiate their emergency arrangements. For the overall response to be truly effective a multi agency strategic level of management has to be established to avoid conflict of interests and to agree overall priorities. The multi agency Strategic Coordinating Group (SCG) will normally be established and usually chaired by the Police Gold Commander when an incident requires coordination of response across agencies in keeping with agreed LRF plans. Other agencies can request the establishment of a SCG. The role of the SCG is:

- To determine the aims and objectives for responding to the incident and agree the strategy to achieve these.
- To prioritise and co-ordinate the actions taken by all agencies.
- To provide a link to central government.
- To manage all external communications.

Depending on the nature of the incident, there may be occasions when it is more appropriate for other agencies to chair the group for example the NHS or PHE. The group does not have to be a permanent group and membership may change as the incident progresses. The representatives on this group should ensure they are senior enough to be able to make high-level decisions on behalf of their organisation without referral to others.

The diagram below shows who attends the SCG. It will require a representative from the Local Authority usually the Chief Executive, PHE, Gold Commanders from Police, Fire and Ambulance if required, and representation from NHS England Area Teams. The SCG may decide to convene a Scientific and Technical Advisory Cell (STAC) to provide scientific and technical information on the incident. The STAC provides Scientific, Environmental and Public Health advice to the SCG during the response and recovery phases of an emergency. A STAC is usually requested by the Police Gold Commander. The details and triggering mechanisms for activating a STAC is outlined in the NHS England's Emergency Preparedness Framework.



The roles of NHS and health organisations, Local Authorities and Public Health England, with regard to health emergency planning, response and resilience, are outlined in the NHS England Emergency Preparedness Framework 2013:

<http://www.england.nhs.uk/wp-content/uploads/2013/03/eprf-framework.pdf> The response arrangements for the NHS are outlined in incident response plans and the NHS Command and Control Framework (2013), all of which can be found at: <http://www.england.nhs.uk/ourwork/gov/eprf/>

The response arrangements for the three sub-regional local authorities are outlined in the CSW Recovery Plan which is supported by the individual organisations emergency response plans which can be accessed by contacting the agencies directly.

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 delegate to local authorities the critical role of providing information and advice to relevant organisations (including PHE) so as to ensure all parties discharge their roles effectively for the protection of the local population. Regulation 6C of the NHS Act 2006, provides for each local authority to provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to the authorities area, with a view to promoting the preparation of appropriate local health protection arrangements or the participation in such arrangements by that person or body.

The Director of Public Health is responsible for the local authorities contribution to health protection matters including the local authorities role in planning for and responding to incidents that present a threat to the public's health. Unitary and lower tier local authorities have existing health protection functions and statutory powers under the Public Health (Control of Disease) Act 1984. The local authority role in health protection is not a managerial, but a local leadership function. The DPH will provide information, advice, challenge and advocacy on behalf of their local authority to promote preparation of health protection arrangements by relevant organisations operating in their local authority. The DPH should be assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs.

Some of the responsibilities and collaborative working relationships between local authorities, PHE and other health organisations to deliver effective arrangements to protect the public's health is summarised below:-

Local Authorities

The health EPRR role of the Local Authorities via their DPH is to:

- provide leadership for the public health system within their local authority area;
- take steps to ensure that plans are in place to protect the health of their populations and escalate any concerns or issues to the relevant organisation or to the LHRP as appropriate;
- identify and agree a lead DPH within an LRF area to co-chair the LHRP and to co-ordinate LA public health input to preparedness and planning for emergencies at the LRF level by;
- co-ordinating issues from fellow DPH in LAs within the LHRP area;
- collaborating with DPH colleagues to ensure the lead DPH is fully apprised of issues affecting all LAs to inform the work of the LHRP;
- communicating with colleague DPH and PHE local centre director to ensure a coherent public health approach within the LHRP;
- provide initial leadership with PHE for the response to public health incidents and emergencies within their local authority area. The DPH will maintain oversight of population health and ensure effective communication with local communities. PHE will deliver and manage the specialist health protection services;
- fulfil the responsibilities of a Category 1 responder under the CCA.

PHE Centres

The EPRR role of the PHE centres is to:

- support the NHS CB with local roll-out of LHRPs, coordinating with local government partners;
- ensure that PHE has plans for emergencies in place across the local area;
- where appropriate, develop joint emergency plans with the NHS and local authorities, through the LHRP;
- provide assurance of the ability of PHE to respond in emergencies;
- discharge the local PHE EPRR functions and duties;
- provide a representative to the LHRP who will also represent the PHE on the LRF;
- have the capability to lead the PHE response to an emergency at a local level;
- ensure a 24/7 on-call roster for emergency response in the local area, comprising staff with the appropriate competencies and authority to coordinate the health protection response to an emergency, establish a STAC when requested to do so.

NHS England – Area Teams

In terms of EPRR, the NHS CB area teams will be:

- responsible for ensuring the local roll-out of LHRPs, coordinating with PHE and local government partners;
- ensuring the NHS has integrated plans for significant incidents and emergencies in place across the local area and within health economies;
- where appropriate, developing joint emergency plans with PHE and local authorities, through the LHRP;
- seeking assurance, through the LHRP, that there are appropriate information governance agreements in place to enable the sharing of individual identifiable

information in a timely manner in response to an emerging or ongoing event within the relevant legislative / regulatory frameworks;

- seeking local health economies assurance of the ability for NHS funded organisations to respond to, and be resilient against, emergencies that cause increase demand or disruption to patient services;
- discharging the local NHS CB EPRR functions and duties;
- providing the NHS co-chair of the LHRP who will also represent the NHS on the LRF;
- providing the capability to lead the NHS response to an emergency at a local level;
- providing a 24/7 on-call roster for NHS emergency response in the local area, comprising staff with the appropriate competences and
- authority to coordinate the health sector response to an emergency;
- determining, the impact on NHS resources and with advice from the Director of Public Health (DPH), at what point the lead role in response to a public health incident or emergency will transfer, if required, to the NHS.

Clinical Commissioning Groups (CCGs)

In summary, the EPRR role of CCGs is to:

- ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements;
- support NHS CB in discharging its EPRR functions and duties locally;
- provide a route of escalation for the LHRP should a provider fail to maintain necessary EPRR capacity and capability;
- fulfil the responsibilities as a Category two responder under the CCA including maintaining business continuity plans for their own organisation;
- be represented on the LHRP (either on their own behalf or through representation by a 'lead' CCG);
- seek assurance provider organisations are delivering their contractual obligation.