Public Health England

PUBLIC HEALTH ENGLAND

EPRR OVERSIGHT GROUP MEETING

28 <Novwember> 2013

Health EPRR Workshops Common Themes
Presented by: John Simpson

1. **PURPOSE OF THE PAPER**

1.1 The attached paper has not been seen by the EPRR Partnership Board. PHE has the opportunity to consider if it should continue to champion developing the understanding of the role and responsibilities of the DsPH in EPRR, working closely with key stakeholders.

2. **RECOMMENDATION**

2.1 The PHE EPRR OG is asked to **COMMENT** on the appropriate common themes as described in the attached paper; to quote from the paper *"3. What are the detailed role and responsibilities of the DsPH in all phases of Emergency Preparedness, Resilience and Response? Including on-call and alerting arrangements"*

Public Health England

12 November 2013

EPRR Partnership Board

REGIONAL HEALTH EPRR WORKSHOPS 2013 - COMMON THEMES

Background

- The aim of the programme of four regional workshops was to build a shared understanding between senior health leaders and health multi-agency partners of the new health systems and models. A total of 384 participants and observers attended the workshops
- The final draft of the regional workshop report was agreed by the regional director prior to publication. All four reports have now been published.

Common Themes

- The workshops identified nine common themes that can be grouped under the three key headings of roles & responsibilities, command & control and communications. They are listed at Appendix A.
- The clear message from the workshops was that whilst a great deal has been achieved over the last 12 months to develop and implement the new health EPRR processes, the detail of specific roles & responsibilities was not yet widely understood or embedded across health EPRR organisations; in particular there is still a lack of clarity on the role of CCGs and DsPH in all phases of the EPRR process. Work is still required to review and update plans (both for surge and in response) and communications still presented a real challenge as this function is now spread in several organisations across a region. The need for a joined-up health message was widely understood, however the mechanisms and processes to achieve this was not widely understood.
- For background, the common themes from last year's workshops are appended. The issue with regard to CCGs and DsPH was flagged-up last year.

Next Steps

- The workshops have indentified and confirmed some fundamental common themes that will benefit from national level direction and if that direction is not available, then I suspect that the regions will begin to implement their own local arrangements. The workshops have raised an expectation that these issues will be resolved.
- These common themes were also very evident during last month's four regional tabletop exercises. The ERD Exercise team is now the process of working with the regional planning team to write the reports and the first report will be the South's; we are on track to achieve the target publication date of Week 25 November.

John Simpson
Head ERD
Dir EPRR (Interim)

Appendices:

Appendix A - Health EPRR Regional Workshops 2013 - Common Themes
Appendix B - Health EPRR Regional workshops 2012 - Common Themes

Health EPRR Regional Workshops 2013 - Common Themes	Region			
	N	M&E	S	L
Roles & Responsibilities				
1. It was evident that whilst partner agencies wanted to work together, the new structures and the detail of specific roles & responsibilities was not widely understood or embedded across health EPRR organisations.	✓	✓	✓	
2. What are the detailed role and responsibilities of the CCGs in all phases of Emergency Preparedness, Resilience and Response? Including on-call and alerting arrangements.	✓	✓	✓	✓
3. What are the detailed role and responsibilities of the DsPH in all phases of Emergency Preparedness, Resilience and Response? Including on-call and alerting arrangements.	✓	✓	✓	✓
Command & Control				
4. Further work needs to be carried out to ensure that all plans are updated to reflect the new structures and local structures. In particular a common methodology and a coordinated approach to the system of triggers and escalation, during both surge and response, is required. The North workshop identified that the detailed STAC processes were not clear in all areas.	✓	✓	✓	✓
5. The passage of information between within and between health organisations to would benefit from review. Specifically the mechanics of the information cascade, especially to CCGs, LAs etc, and the detail of the information required to be shared, such as SITREPs, vulnerable groups and health surveillance data.		✓	✓	✓
Communications				
6. Communications still presented a real challenge as this function was now spread in several organisations across a region. The requirement for co-ordinated and 'joined-up' public health messaging was widely recognised and acknowledged, however the processes and mechanism to achieve this were not widely understood, in particular the role of the Local Authority.	✓	✓	✓	✓
7. Can NHS 111 be used to cascade health messages? It was widely assumed that it could, but the detailed local processes were not always clear	✓			✓
8. A policy is needed on how health is going to respond to digital social media as it is impractical to response to every tweet / post etc		✓		
9. How do we get the message to primary care providers? It was widely assumed that this would be through CCGs, but the detailed local processes were not always clear.			✓	

Health EPRR Workshop - North 3 September 2013	
1. Communications	
	It was felt that communications presented a real challenge as this function was now scattered across the region and organisations and linkages were not as strong as prior to the transition in April of this year. It is not clear who does what and when at the local level in particular and in some areas who signs off multi-agency health messages. New protocols need to be developed for the new structures with linkages mapped out and the management of communications embedded in plans. (It was noted that some of this work is currently being undertaken by NHS England).
2. Roles and responsibilities of CCGs	
	Many of the groups were still struggling with the CCG role in both a rising tide and a major incident. There was a need for further clarity in the roles and responsibilities for CCGs in order for their part in surge management and incident response to be fully understood. Clear and precise guidance was requested on what is expected of CCGs, to include out of hours on-call requirements, capacity, accountabilities and command and control. Training for on-call staff was also requested.
3. Role of DPH	
	The role of DsPH in planning was understood. However there was lack of clarity in most (but not all) areas about the role of DsPH in response. Specific issues included the role of the DPH in activation and chairing of a STAC; representation at the Strategic Coordination Group; robustness of out of hours arrangements.
4. Roles and responsibilities of health economy agencies	
	It was evident that whilst partner agencies wanted to work together effectively, the new structures did not appear to be fully understood in all respects. There was a need to further define with absolute clarity the relationships, roles and responsibilities of the different agencies involved in preparedness and response and achieve uniformity on procedures where possible (with the caveat that there could be necessary local variations). There was also a need to communicate and embed understanding of these roles and responsibilities with stakeholders, especially those of the new organisations; this could be achieved through collaborative planning, joint training and testing/exercising plans.
5. STAC	
	STAC processes were not clear in all areas and plans need to be revised, agreed and shared with stakeholders. Clarity over the roles of PHE and DsPH in STAC activation and roles within the STAC is required in plans.
6. Plans	
	Further work needs to be carried out to ensure all plans are updated to reflect the new structures and local arrangements. This to include operational detail, escalation triggers, as well as who has authority to trigger escalation, clear information flows, and practical detail such as up to date distribution and alert lists.
7. Assurance	
	The workshop grappled with what assurance meant for the health system. There were several questions around what constitutes effective assurance, that is, not just a simple audit, where assurance would come from and who should hold organisations to account. Provider readiness and resilience assurance was considered essential and the mechanisms and responsibility for ensuring this needs to be clear.
8. Winter planning	

Health EPRR Workshop - North 3 September 2013	
	Whilst many groups are involved in winter planning, it was unclear who had the responsibility for the lead role in driving the planning and who would lead when winter pressures worsen. Winter plans needed to include planning for escalation, a description of those changes and also how the communications/health messages are managed. (It was noted that the region is working on surge guidance for winter; the guidance and tools are still to be published but will include a checklist for CCGs when issued).
Executive Summary	
	New protocols for the EPRR communications function and production and sign off of health messages needed within the new structures and to be embedded into plans
	A better understanding of the roles and responsibilities of CCGs, in capacity planning and in surge and incident response
	Further clarity on the role of the Directors of Public Health (DsPH) in incident response
	Clearer definition of the roles and responsibilities of existing and new health organisations and to embed understanding of these roles and responsibilities with stakeholders
	All plans updated to reflect the new structures and new local arrangements, including STAC plans and surge and winter planning

Health EPRR Workshop - Midlands & East 24 September 2013	
1. Greater clarity is required relating to organisations' individual and collective roles and responsibilities towards planning and responding to incidents, including major incidents	
	Delegates agreed that greater clarity was required within guidance issued in order for organisations to understand their own, and others', role and responsibilities.
	Delegates reiterated that the extant guidance available has not enabled them to understand the role and responsibilities of PHE, CCGs and NHS England both in terms of planning for and responding to major incidents. Of particular note, many DsPH continue to be unsure of their role and responsibilities with respect to EPRR since transferring to local authorities.
	il was unclear who maintained the overall responsibility of protecting the health of the public both in 'business as usual' incidents and major incidents or where the trigger for handover should occur. Organisations were confident that all would work together in a major incident, but feedback identified that this lack of clarity, particularly related to who pays providers, was continuing to impact on normal operational responses and LHRP planning
	It was evident organisations wanted to work together effectively despite confusion caused by the restructuring. Delegates advised it would be useful if lead organisations could be nationally identified to lead on health planning work streams
	Where local planning and response arrangements vary from national guidance on roles and responsibilities, a formal local memorandum of understanding (MoU) was suggested to ensure common understanding of the variations.
	Further work is required to embed understanding of new arrangements across all health organisations and wider local stakeholders. This will only be achieved if the clarity and detailed guidance requested by health delegates is available. Joint local multi-agency training and exercising can then be used to test and embed understanding within Local Resilience Forum areas
2. Greater clarity is required for all organisations relating to communicating with the public and the media	
	Some delegates expressed concern that it was unclear which health organisation would lead on public and media communications and what support they should get form partners. It was suggested that national guidance be issued to clarify the position. Delegates were reminded that the Incident Director was responsible for coordinating local response including public and media communications.
	Use of digital social media by health organisations varied significantly. Delegates recognised that it is potentially a powerful communication medium in support of traditional forms of public communication; however most health organisations present did not use it as a proactive means of public messaging. In particular NHS England Area Teams felt unable to use social media in an incident as policy currently requires all messages to be cleared at a national level.
	Further work is required in some parts of the region to clarify inter-agency communication cascades during a major incident, particularly out of normal working hours.
	Delegates recognised the need to ensure situation reporting took place and reiterated that a single multi-agency process should be developed rather than each central department causing duplication of effort from responders by requesting completion of their own templates.
3. Significant planning work has been undertaken by LHRPs; however, the pre-transition guidance given to health organisations needs to be updated in order to enable further progress to address hazards and threats.	
	LHRPs noted the need to ensure that local plans and procedures were reviewed and

Health EPRR Workshop - Midlands & East 24 September 2013	
	updated to reflect new structures and local arrangements.
	Definitions and triggers for incident levels continue to vary between organisations' plans across the region
	Particular concerns were highlighted relating to Outbreak Control Plans and planning, which should be reviewed and updated by LHRPs as a priority.
	Concerns were also expressed relating to PHE's capacity and capability to deliver STAC since DsPH were transferred to Local Authorities and taken off formal on-call rotas in most instances. Clarity is required to confirm the roles of PHE and DsPH in STAC activation and delivery of scientific and technical advice.
	Local Authorities recognised they should ensure they have mechanisms in place to alert and contact their DPH, and include them in their major incident plans.
	Business continuity arrangements remain untested in many cases, particularly within newly formed organisations.
	Developing effective mutual aid arrangements continue to be hampered by legislative requirements. Examples given included HR and employment checks for health staff deploying to an alternate NHS provider in the event of severe weather; and, Provision of temporary work-place crèche facilities.
	Finally, it was acknowledged that LHRPs are generally well developed and supported by Accountable Emergency Officer attendance. However, there remain some organisations that continue to fail (or are regularly unable) to send appropriate support, affecting organisations' ability to progress planning and resilience. Co-Chairs highlighted that they do not have authority to compel attendance or take action in instances of persistent absenteeism; statutory powers have not been awarded to them, nor are there processes to escalate to an appropriate body or individual that might.
Executive Summary	
	Clearer definition of the roles and responsibilities of existing and new health organisations and to embed understanding of these roles and responsibilities with stakeholders; particularly the role of Clinical Commissioning Groups and Directors of Public Health in response
	Clarity on which health organisations and with what authority should be attending Strategic and Tactical Coordination Groups
	Clearer guidance on who leads on communications with the public and media in an incident, which organisations should provide support and how widely messages should be distributed
	Clearer guidance on the use of digital social media during an incident
	Some organisations' plans still need to be updated to reflect the new structures and local arrangements, including trigger and escalation points

Health EPRR Workshop - South 26 September 2013	
1. Further work is required to understand the detail of how communications will operate across the health economy during an emergency. In particular the consistency of messaging across the health economy and the place and role of the community providers in the communication cascade.	
	"Joined up" health communications. In the first session six of the LHRP groups indicated that the communications arrangements under the new structures could be clearer. Particularly the manner in which PHE, NHS and the local authorities would work together during and outside of an incident.
	Communicating with Primary Care providers. In the feedback from the first session six of the LHRP groups identified that greater clarity is needed about how the health economy will ensure that CCGs, GPs and pharmacies are included in the communications strategy and how to ensure that they are passing on consistent information to their patients
	Coordinating messages to the public. Six of the LHRP groups is session two identified the coordination of public messaging as a High priority. This will require coordination between the NHS, PHE, local authorities and community providers
2. Command and control **There is a need to ensure that organisations are focussed on strategic (national and regional) guidance on the roles and responsibilities of organisations in the new EPRR structure. In particular the understanding of the role of the CCGs in a response could be improved. This will allow further development of compatible operational arrangements for a health response at the local level across the region.**	
	Understanding of organisational roles and responsibilities could be improved further. Four of the groups identified a need for further clarification of organisations' roles during an emergency. Six of the groups reported that changes have taken place in staff over the past year and therefore ensuring continuity of organisational understanding and learning of the EPRR systems is important and could be improved. There is also a need to ensure that the command and control structures are clear and more regularly communicated .
	The definition of the role of CCGs in a response could be improved. Eleven of the groups over the three sessions identified that the understanding of responsibilities of the CCGs in a response could be improved further. This includes ensuring relationships with area teams, the wider health economy and multi-agency responders are clear
3. Coordination **There needs to be a more effective mechanism for coordinating information, intelligence and surveillance data across all organisations and for coordinating assets.**	
	Consistency of terminology and procedures across the region. Six of the groups in the first session raised this as an area for development. Further work is required on developing a shared system of triggers and escalation, as the current approach differs between organisations and at the regional and community level. There is also a need to ensure common terminology is used across all organisations and areas.
	Information cascade. Nine of the groups in session three identified the need for the cascade system which includes community providers, GPs, pharmacies and the local authority as well as the regional and local level NHS and PHE to be clearer. There needs to be a mechanism to mobilise pharmacies, GPs and CCGs when required.
	Information sharing. The need to be able to quickly ascertain and assess the requirements of vulnerable people was also raised during this session and the requirement for an improved method of sharing this information was identified. One of the groups noted that weekly winter pressures reports from PHE are not currently shared with CCGs and DsPH.
	Coordination of transport. Six of the groups identified the coordination of 4x4 and patient transport services as an area for improvement during the second session. The suggestion was that these organisations needed to be brought into the winter planning procedures,

Health EPRR Workshop - South 26 September 2013	
	possibly through LRFs
Executive Summary	
	Further work needs to take place to improve internal and external communications arrangements. Understanding of the current arrangements needs to better communicated so that links between Public Health England, the NHS and Local Authorities are clear; not having clear systems in place risks giving incomplete or mixed messages to the public in an emergency
	National and regional guidance on the roles and responsibilities of the organisations in the new structure, particularly the role of the Directors of Public Health and the Clinical Commissioning Groups needs to be clearer
	Further development is required on systems for sharing data across the region, examples include sharing of surveillance data between Public Health England and Local Authorities and information about vulnerable people

Health EPRR Workshop - London 18 September 2013	
1. Embed the plans and processes for roles and responsibilities in surge response	
	Increase awareness of the difference between emergency response and surge capacity
	A need to define the data required for effective information sharing during surge periods, making this a systematic process incorporated within the planning process
	Embed and gain ownership of local plans and processes for surge capacity including expectations, roles, escalation and mutual aid. The need for an organisational chart with partner links
	Identified gaps in understanding what the private sector can provide and consideration for CCGs pre-arranging commissioning of services with the private sector as a contingency
	Assurance work needs to be carried out to ensure business continuity planning is still robust following the transition
2. Understanding of the escalation strategy, including trigger points, for local and region in surge response	
	Ensuring an understanding of trigger points as part of clear escalation plans for informing CCGs
	Identified information flow both up and down the reporting structure would be helpful in effective management of surge
	Awareness and understanding of mutual aid agreements in place
3. Understanding of the EPRR communications function within the new structures and embed in plans, specifically the use of social media and the sign-off of health messages	
	Clear understanding of local roles and responsibilities in public communications, achieving a joined up approach to give a consistent, timely and effective message to the intended audience
	Include any information on impact caused by the weather when sending out weather alerts
	Consideration for tailoring communications in content and method to the target public audience
	Forming a CCG link with NHS 111 to give assurance on public communications
4. Effective utilisation of the voluntary sector and their community links	
	Strengthening existing partnerships and building direct links with the voluntary sector
	Whilst acknowledging that voluntary organisations are not able to guarantee a full '24/7' capability, continuing the progress on utilising their capability as providers of welfare, humanitarian support and language services during a response or surge
	Focus engaging with the voluntary sector on the provision for discharge and home welfare support
	A strategy to manage existing staff willing to respond as volunteers during a major
5. Understanding the roles and responsibilities of CCGs in capacity planning, during surge and during incident response	
	Understanding and embedding the roles and responsibilities of CCGs in both a rising tide and a major incident
	Clear and precise guidance was requested on what is expected of CCGs, to include out of hours, capacity, accountabilities, command and control
	Clarity on alert arrangements and communications between CCGs, CSUs and across the health community
6. Improving situational awareness and information sharing within and across health capabilities	
	Effective and timely dissemination of information across the health community
	Ensuring information receiving methods are fit for purpose
	Effective information protocols to confirm 'action required' or 'for information only'

Health EPRR Workshop - London 18 September 2013	
7. Other key issues raised	
	How NHS 111 can support incidents. In particular the previous role of NHS Direct in supporting incident response (messaging, responding to queries, establishing help lines) appears to not be in place
	Effective use of NHS 111 service to reduce pressures on Emergency Departments
	Cross regional border working
	Defining data required for sharing in a winter surge scenario as well as in a major
	Local authority assurance in cold weather planning, ensuring relevant assurance structures are in place for DsPH, the Health and Well-being Board and CCG assurance

18 December 2012

REGIONAL HEALTH EPRR WORKSHOPS - COMMON THEMES

This is a consolidation of the reported common themes, grouped into four broad themes, as identified in the four regional Health EPRR workshop reports.

Common Theme	Workshop
One. Maintaining EPRR Capability	
CCGs have little or inconsistent levels of EPRR experience or knowledge.	North, Mids & East, South, London
Complete training needs analysis[1] and define national competency standards. Include DsPH and CCGs.	North, Mids & East, South, London
Potential loss of corporate knowledge during transition.	North, Mids & East, South
Potential loss of trained staff and/or new staff recruited too late. Impact on on-call rotas.	North, Mids & East, South
Two. New EPPR Structures	
Lack of clarity as to how DsPH, CCGs and other health providers (including non NHS) will be integrated into preparedness and response.	London, Mids & East, South
Clarify leadership and command & control of the new health EPRR system.	Mids & East, London
Cross boundary issues during response.	South
National guidance on the assurance process required for Care Quality Commission and Monitor requirements.	North
Three. Resources	
Lack of detail on the funding and resourcing of LHRPs	North, Mids & East, South
Decline of NHS emergency planners to support the CCGs and the DsPH during preparedness.	London
Four. DsPH Indemnity	
Clarification of the indemnification of DsPH	North, Mids & East, South

[1] The HPA ERD Training Team has completed an EPRR training needs analysis and sent their report to both DH and NHS CB in April 2012.