Public Health England

Emergency Preparedness, Resilience and Response Concept of Operations

For use in	:	Incident Response
For use by	:	Public Health England
For use for	:	Public Health England Incident Response
Document owner	:	Public Health England, Corporate Resilience Team
Status	:	Final Approved Version 1.0
Author	:	Name Redacted Strategic Emergency Planning Manager Name Redacted, Supra Regional Emergency Preparedness Manager/National Support
Other Contributors	:	
Accreditation and Endorsement	:	
Issue No and Date	:	Version 1.0 20130308
File Name	:	Public Health England Emergency Preparedness, Resilience and Response Concept of Operations
Supersedes	:	HPA Incident and Emergency Response Plan
Additional Information	:	

Amendments

Page No	Description of Amendment	Date	Signature/Post Holder

Review and Governance

Review Dates	Completed	Reviewed By	Accredited By
01 July 2013			

INQ000090415_0003

Foreword by Duncan Selbie, Chief Executive Officer

This EPRR Concept of Operations describes Public Health England's internal and external partner arrangements, in types of response to an incident at local, regional and national levels. This includes the provision of specialist advice and specific support to DH, NHS CB, Central, Local Government and Local Resilience Fora.

This document, together with the Local, Regional and National Incident Response Plans, will inform staff of the key roles, responsibilities and processes required for PHE in the activation, escalation and de-escalation of an incident. Specific processes include: Risk Assessment; Training and Exercising; Business Continuity and post incident Constructive Debriefing following standing down from an incident.

Duncan Selbie

Chief Executive Officer

Public Health England

Table of Contents

Paragraph/Annex Title	Heading	Page Number
Cover	Cover Sheet	1
Amendments and governance	Amendments and review and governance	2
	Foreword by Duncan Selbie	3
TOC	Table of Contents	4
1	Introduction and Roles & Responsibilities	5
1.6	Role of Public Health Centres in EPRR	6
1.7	Role of Public Health England regions	7
1.8	PHE National functions	7
2	Aims & Objectives	9
3	Roles & Responsibilities	10
4	Alerting	12
5	Incident Levels & Activation	14
	Public Health England Activation Flow Chart	16
6	Response	17
7	Escalation and De-escalation	23
8	Standing down the Response	24
9	Debriefing and lessons identified reports	25
10	Training & Exercising	26
11	Review & Governance	27
12	Glossary of Acronyms	28
Annex A	Public Health England Incident Levels	30
Annex B	Daily Schedule	31
Annex C	Incident Decision Log	33
Annex D	Teleconference Protocol	34
Appendix 1	Temporary Agenda for Emergencies	36
Appendix 2	Teleconference Provider Call Controls	37
Annex E	Records Management Policy	38
Annex F	Briefing Note Template for Level 1 and 2 Incidents	39
Annex G	Public Health England Situation Report (Sit Rep)	41

1. INTRODUCTION

1.1 Responsibilities for Public Health England's (PHE) Emergency Planning Resilience and Response are outlined in the Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013. (Department of Health: 2012).

"Emergency Planning Resilience and Response (EPRR) will work in the new health landscape following the changes made by the Health and Social Care Act 2012. This will ensure that the Health Sector can provide an effective response to the whole range of incidents and outbreaks". (Department of Health 2012).

1.2 PHE discharges its duties as a Category 1 responder to emergencies within the scope of the Civil Contingencies Act 2004 (CCA 2004). However, specific to Public Health and within the context of this Concept of Operations (CONOPS), the term incident is used. An 'Incident' is defined as:

'An event or a situation which threatens or causes damage to the health of the public and that requires urgent action from PHE at whatever level'

The above definition of an incident for PHE includes events or situations which would constitute an emergency under the CCA 2004.

1.3 Incidents are assessed as being 1 of 5 levels: Level 1 and Level 2 are a major part of the normal acute activity of PHE Public Health Centres (PHC) supported by the relevant specialist service of PHE as required.

PHE roles and responsibilities

1.4 PHE provides an integrated approach to protecting UK public health through the provision of public health support and advice to the NHS, local authorities, emergency services, other arms-length bodies, and the Department of Health and Devolved Administrations. Specialist advice areas include infectious diseases, outbreak surveillance, chemical, biological and radiation hazards.

1.5 PHE is responsible for providing public health Emergency Preparedness Resilience and Response leadership, and scientific and technical advice at all organisational levels, working in partnership with other organisations to protect the public. In fulfilling these responsibilities PHE will:

a. Provide national leadership and coordination for the public health elements of the emergency preparedness, resilience and response system.

b. Provide health protection services, expertise and advice, and co-ordinate PHE response to major incidents.

c. Provide risk analysis and assessment of emerging diseases, natural extreme events, chemical and radiological incidents and deliberate release threats (including CBRNE), to inform the Department of Health and other stakeholders in the health

sector, other government departments and agencies, and partners in the multi-agency response to incidents.

d. Ensure provision of high quality and timely public health data to the Secretary of State and NHS CB, local authorities and across Government, in preparedness and response.

e. Communicate with Devolved Administrations to coordinate investigation and management of cross-border public health incidents.

f. Provide guidance to professionals in health, local government and other partners.

g. Communicate with the public by providing information and advice relevant to PHE's responsibilities.

1.6 Role of Public Health England Centres in EPRR

a. Planning

I. PHCs provide senior representation to each Local Resilience Forum and actively participate in multi-agency planning, training and exercising.

II. Agree reporting criteria for incidents with Local Authority Directors of Public Health

III. Provide senior representation to each Local Health Resilience Partnerships (LHRPs) to support the development and implementation of robust multi-agency health emergency planning arrangements

IV. Contribute to the revision and maintenance of community risk registers through LHRPs and LRFs using guidance issued by PHE Nationally

V. Agree with the DPH reporting on health protection and emergency preparedness issues to the Health and Wellbeing Boards. This will need to include:

- Local agreement of health protection priorities on an annual cycle of reporting.
- Ad-hoc reporting for serious incidents.
- Provide assurance about both health protection and emergency planning arrangements through the LHRP. This is a common duty for all organisations.

b. Response

I. Public Health England Centres will deliver a 24/7 public health response to communicable disease, environmental incidents and other public health incidents in PHE Centre area, calling on the expertise and capacity of the wider organisation as necessary.

II. In a wider emergency (level 2 or above) support other Centres in the PHE region or provide national support following direction by the Incident Director.

1.7 Role of Public Health England Regions

a. Planning

I. Provide strategic emergency planning advice and support to Centres

II. Maintain capacity and capability to co-ordinate the regional response to emergencies 24/7

III. Assure the emergency plans of the PHE Centres in the region, including the integration of Centre plans to deliver a unified PHE response across more than one LHRP/LRF.

b. Response

I. Co-ordinate the resource available across the region to enable effective PHE involvement in all incidents (local, regional and national) with public health implications.

1.8 PHE National functions

Field Epidemiology

The field epidemiology service and the Centre for Infectious Disease Surveillance and Control collate information on communicable diseases from a wide variety of sources in order to give early warning of outbreaks and enable monitoring of interventions and trends.

The Centre for Infectious Disease Surveillance and Control provides specialist advice on infectious disease control.

Centre for Radiation, Chemical and Environmental Hazards

The Centre for Chemicals, Radiation and Environmental Hazards (CRCE) provides leadership and specialist advice, public health risk and consequence assessment for environmental hazards including radiation and chemical incidents. It works closely with and through PHE Centres and liaises across partner agencies at local and national levels in areas of shared responsibility. It works closely with Government Departments and Devolved Administrations in response to radiation and chemical incidents with national or international implications. As appropriate, it works with partner organisations to develop and implement radiation and chemical emergency exercises.

INQ000090415_0008

Communications

The communications division (national and regional) provides proactive and reactive lines and advises on information provision for health protection issues.

Laboratory Services

PHE provides a comprehensive public health microbiology service. The main focus is on human health and disease but laboratories also work with pathogens from animals, food, water and the environment. The service provides a focus for widespread international collaborations as well as having well established relations with other UK based agencies. This capability is geographically dispersed and includes the ability to work with high hazard agents at two sites. Alongside expert diagnostic, specialist and reference testing there is also 24/7 access to expert clinical and scientific advice. The service is able to provide leadership, risk assessment and laboratory testing in infectious disease outbreaks and events. Microbiology Services staff work in close partnership with other PHE colleagues to provide advice on infectious disease control. This is both locally and at a national level

Both Colindale (MS Colindale and CIDSC) and CRCE provide leadership in national responses pertinent to their specialist areas

The National Specialist EPRR function

The national PHE emergency preparedness, resilience and response function provides co-ordination and support to the response to emergencies and incidents, is responsible for National Incident Response Plan, establishing the National Incident Coordination Centres, liaising across national organisations in relation to emergency preparedness and response arrangements and supports the NHS and the Local Resilience Forums in planning, exercising and responding to a range of threats. will continue to be a wide range of specialist advice available from within Public Health England to deal with infectious and non-infectious hazards.

Public Health England operates a five level response structure described in these CONOPS. (PHE CONOPS April 2013).

2. AIM AND OBJECTIVES

2.1 The aim of this document is to detail the arrangements for Public Health England's response to incidents at Local, Regional and National levels.

2.2. Objectives

a. The objectives of this document are:

I. Identify organisational roles and responsibilities.
II. Detail Incident Levels.
III. Detail escalation and de-escalation procedure

INQ000090415_0010

3. ROLES AND RESPONSIBILITIES

3.1 Chief Executive Officer

The PHE Chief Executive Officer has overall accountability and responsibility for the whole Public Health England system.

In response to an incident he/she will ensure the direction and availability of resources delegating responsibility to the Director for Health Protection/or designate to oversee PHE's response to significant public health related incidents.

In the Chief Executive's absence the responsibility for the incident defaults to the Director for Health Protection/or nominated deputy (in and out of hours)

3.2 Director of Health Protection

The Director for Health Protection is responsible for the corporate direction and delivery of PHEs response to incidents by:

a. Having overall leadership of EPRR function in PHE

b. Leading national incidents/responses as required.

c. ensuring the system is in place and working for all levels of emergency and incident response

d. Leading liaison with DH, CB and other national bodies (e.g. FSA, AHVLA etc)

e. As appropriate, he/she will either assume the role of Incident Director or delegate the role to a Regional or Public Health Centre Director or a national specialist lead.

3.3 The Chief Operating Officer

The Chief Operating Officer is responsible for the operational management and delivery of regional and local services. He/she is responsible for ensuring effective local planning arrangements are in place within the Operations Directorate. In response to outbreaks & incidents and emergencies he/she will:

a. Ensure resources are available and in place

b. Ensure all national standards are appropriately applied

3.4 Incident Director

An Incident Director will be identified for each incident according to the nature and level of incident. (Detailed in section 5 and Annex A) They will be responsible for:

a. The overall management of the incident

b. Leading incident management team established as appropriate (as detailed in section 6)

3.5 Other Executive Directors/National Directors

Other Executive Directors/National directors will ensure that their respective directorate

supports Public Health England's response in line with the agreed response strategy. In addition they will be expected to participate in National Director on Call arrangements as appropriate.

3.6 Incident communications Lead

The Communications Lead is responsible for the provision of communication support including ensuring that the appropriate heath protection advice is made available to the public and the media throughout the response.

3.7 In addition to the roles outlined above, the response may require a number of specialist teams relevant to the nature of the incident and resource requirement (see above). Teams will comprise of trained staff from across the organisation to provide the required expertise.

4. ALERTING

4.1 The great majority of incidents and emergencies are dealt with as part of the normal acute service provision in the PHE centres. There are a number of routes through which PHE can receive these alerts:

Initial Alerting During Working Hours

4.2 During working hours, initial alerting may be the result of an incident notification via Public Health England's Local and national tiers, DH Emergency Preparedness Resilience and Response (EPRR) and / or NHS Commissioning Board national, regional and local tiers.

4.3 Alternatively, the alert may be received from external sources such as Other Government Departments (OGDs) and Agencies, Devolved Administrations, international bodies and the media.

Initial Alerting Outside of Working Hours

4.4 Outside working hours, initial alerting will come from PHE on call staff at Local and National Level. Internal PHE rotas provide staff with contacts across all sites to allow any escalation required up to the Executive Director.

4.5 Escalation of an incident is dependent on dynamic risk assessment of the level of incident at Local/Regional or National in or out of hours Directors (see section 7).

4.6 Urgent potential level 3 and above alerts will be communicated to the Director of Health Protection/or designated deputy who will:

a. Agree the definition and level of the incident

b. Direct the activation of required PHE Incident Response.

4.7 When incidents need escalating because they cover more than one PHE Centre then the leadership for these will need to be agreed between the Regional Director (in the first instance), COO and the Director for Health Protection. If it is a national incident then the Director for HP will decide the leadership of the incident, in discussion with the COO and others as appropriate.

Alerting of National Risk Assessment Threats

4.8 The alerting of National Risk Assessments Threats (Counter Terrorism) and potential CBRN incidents will be through the Emergency Response Department Corporate Resilience Team during working hours and Emergency Response Department Duty Officer outside working hours

Alerting Public Health England Staff

4.9 For major incidents an initial alert will be sent to Public Health England staff to place them on standby for a potential incident response.

4.10 Public Health England's iModus alerting system will be used for this.

Alerting Local Authority Directors of Public Health

4.11 Public Health Centres will agree alerting criteria for incidents with their local Directors of Public Health and ensure that mechanisms are in place for the timely passage of information.

5. INCIDENT LEVELS AND ACTIVATION

Incident Levels

5.1 Public Health England operates an integrated 5 level response structure. On receipt of an alert to a public health incident via a Public Health England Centre, Public Health England Specialist Service or a Duty Officer. An initial dynamic risk assessment will be undertaken by the appropriate Director (as detailed below) to establish the appropriate level of response.

PHE Five level response structure

Level	Authority to assign response level
1: Local with limited public health impact	PHE Centre Director/Leader of Local Health Protection Service
2: Local with limited public health impact but greater than can be managed by one Public Health England Centre	PHE Regional Director (in consultation with the Director for Health Protection if appropriate)
3: Public health impact across regional boundaries or national. May require national co-ordination	PHE Director of Health Protection/Duty Director in consultation with the COO
4: Public health impact severe. Requires central direction and formal interaction with Govt	PHE Director for Health Protection in consultation with CEO/Duty Director and COO
5: Catastrophic. Central direction and extensive commitment of resource	PHE CEO/Duty Director

5.2 The level and organisation of the response will be determined through a five dimensional dynamic risk assessment process, using the criteria listed below. The following is not exhaustive but will be considered when determining both the appropriate level of response and any subsequent escalation or de-escalation.

Severity: Dynamically assessed risk of the degree of foreseeable harm that may be caused to individuals or to the population.

Confidence: Knowledge, derived from all sources of information that confirm the existence and nature of the threat and the routes by which it can affect the population.

Spread: The size of the actual and potentially affected population.

Interventions: The availability and feasibility of population interventions to alter the course and influence the outcome of the event.

Context: The broad environment, including public concern and attitudes, expectations, pressures, strength of professional knowledge and external factors including political decisions.

5.3 The risk assessment will be applied with the response level matrix to establish the appropriate incident level for Public Health England's response. The response level matrix is located at Annex A to this CONOPS.

Activation

5.4 Once the initial response level has been agreed, the following actions will be taken:

a. Appoint an Incident Director

b. Appoint Incident Management Team

c. iModus alert sent to PHE Staff confirming alert level.

d. Alert sent to NHS Commissioning Board[1].

e. Alert Local Authority Director of Public Health

f. Activate Local Incident Coordination Centre or National Incident Coordination Centre (as appropriate).

5.5 Out of working hours, the initial response may be dealt with remotely if appropriate.

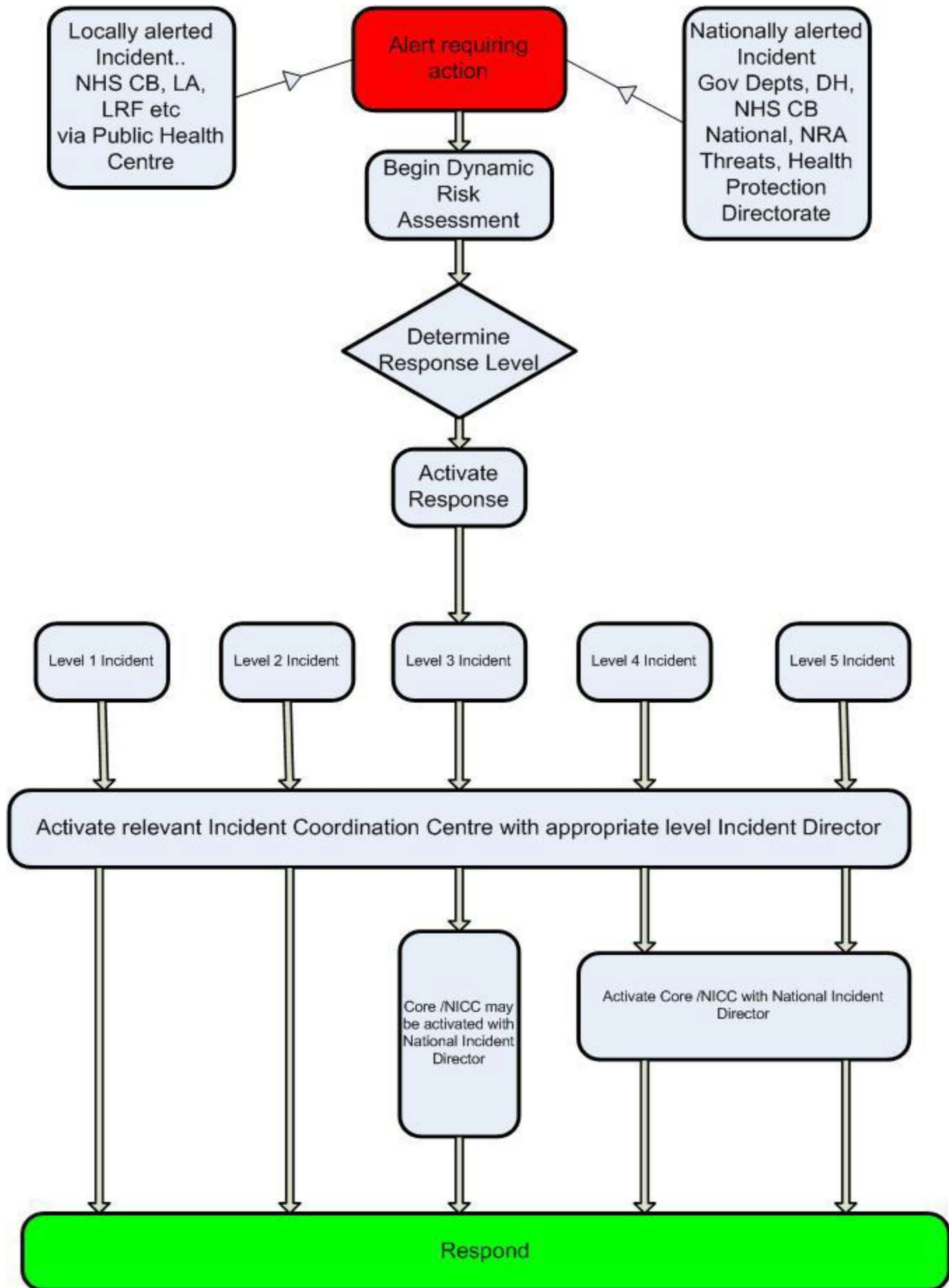
5.6 Public Health England Centres will maintain a Local Incident Response Plan for activating their Local response to incidents. A template plan has been issued to all Public Health Centres and Regions based on this Concept of Operations.

5.7 The Corporate Resilience Team will maintain a National Incident Response plan for activating the National response arrangements.

5.8 Health Protection Directorate will maintain appropriate plans to facilitate the coordination of specialist Health Protection advice for the response to infectious diseases, outbreak surveillance, chemical, biological and radiation hazards.

[1] NHS Commissioning Board Local Area Team, Region or National Operations as appropriate

Public Health England Activation Flow Chart



6. RESPONSE

Coordinating Public Health England's Response

6.1 Public Health England will coordinate its response to Level 2, 3 and 4 incidents using Incident Coordination Centres. These will be established as follows:

Business Unit	Incident Coordination Centre	Activation Plan held by
Public Health Centre	Local Incident Coordination Centre	Public Health Centre
Operations Directorate Regions	Regional Incident Coordination Centre	Operations Directorate Regional Office
Public Health England Corporate	National Incident Coordination Centre	Corporate Resilience Team

6.2 Once activated, the Incident Coordination Centre will:

a. Support the Incident Director to direct and coordinate the response strategy and operations across the agency in accordance with the established coordination cycle.

b. Advise on Policy as directed.

c. Manage information relevant to the incident and disseminate as necessary.

d. Communicate with stakeholders engaged in the response to the incident.

e. Provide Situation Report (SITREP) briefings, to those involved in the response within Public Health England and others as required.

f. Ensure that Public Health England's responders receive logistical and resource support within appropriate health and safety guidelines.

g. Provide a forward look to issues that may arise, their consequences and forecasting the response. This has particular significance for "slow burn" incidents

h. Coordinate and direct strategic meetings and/or teleconferences.

i. Manage the information flow to the public domain via the media and to other stakeholders.

j. Produce specialised briefing papers for use by PHE representatives.

Strategic Objectives

6.3 Public Health England's Strategic Objectives are to be established at the earliest opportunity. These will contain a number of very short objectives key to PHEs response.

6.4 Strategic Objectives will be developed by the Incident Management Team and signed off by the Incident Director. Strategic Objectives for Level 4 and 5 incidents will be signed off by the CEO.

6.5 Once agreed, the Strategic Objectives are to be communicated to all PHE responders involved in the incident.

6.6 Strategic Objectives will be reviewed at the end of each incident management team meeting to ensure they are still relevant for the response.

Daily Schedule

6.7 To ensure essential information flows between the responding elements, PHE will establish a Daily Schedule at the onset of the incident. This will provide a clear structure to ensure the following:

a. Clear timelines for information reporting.

b. Confirmation of meeting/Teleconference times.

c. Timings for the issue of briefs and SITREPS.

6.8 An example of the Daily Schedule is located at Annex B to this CONOPS.

6.9 A draft Agenda is located at Appendix 1 to Annex D to this CONOPS.

6.10 Teleconferences should be conducted in line with the Teleconference Protocol located at Annex to this Conops

Records Management

6.11 Public Health England will maintain records and data in relation to our response. All records and data will be captured and stored in a readily retrievable manner.

6.12 Records and data will be retained to:

a. Provide a record of key actions, decisions and rationale.

b. To facilitate our post incident review and debrief.

c. Ensure continuity of evidence for any inquiry, technical review or inquest.

6.13 Regardless of the scale of incident, the Incident Director is formally responsible for sign off of all advice and documents relating to the incident, provided by any part of PHE.

6.14 All such advice/documents and Incident Director Sign off must be logged by the Incident Coordination Centre.

6.15 Public Health England will maintain a decision log during an incident. The decision log records key decisions, options and rationale. A draft decision log is located at Annex C to this CONOPS.

6.16 Guidance for Records Management during an Incident is located at Annex E to this CONOPS.

Briefings and Situation Reports

6.17 Depending on the nature of the incident, PHE will produce a daily briefing unless the coordination cycle states otherwise. This briefing will take the form of a daily briefing (Level 2 Incidents) or a SITREP (Levels 3 and 4).

6.18 Briefings for Level 2 Incidents will be produced by the responding Public Health England Centre. SITREPS for Level 3 and 4 will be produced by the relevant specialist team or the Emergency Response Department, Corporate Resilience Team.

6.19 Briefings and SITREPS will be shared with key stakeholders as relevant.

6.20 Briefings and SITREPS will be signed off by the Incident Director and logged by the Incident Coordination Centre.

6.21 The briefing template for Level 2 Incidents is located at Annex F to this CONOPS.

6.22 The SITREP template for Levels 3, 4 and 5 incidents is located at Annex G to this CONOPS.

Communications

6.23 Internal Communications: It is important that staff are kept informed about incidents, whether they are directly involved in the response or not. The PHE alerting tool iModus will be used for early alerting. More detail will be included in formal reports communicated within Public Health England will make use of the agreed internal briefing template and will be made available to staff via PHEnet.

6.24 Public Health England will release key public health messages, in consultation with the NHS and other agencies where appropriate within the first hour of the incident taking place.

6.25 When dealing with a national incident, it is often the case that a 'Gold' communications group is formed, comprising staff from relevant government departments. A formal e mail group of communication specialists will be formed and this group will be consulted by e mail with draft statements for agreement before release, allowing as much time as circumstances permit for consultation.

6.26 Public Health England's website is the main medium for publishing advice and information for both the public and healthcare professionals. The online services section of the Communications Division is responsible for publishing to the site and 24/7 cover is provided via an on call system,

6.27 When dealing with a level 4 or 5 incident, a teleconference will be called by the Communications Lead, as soon after notification of the incident as possible, to provide an overview of the incident and to gain an understanding of the communications requirements .

6.28 In a major incident, the Communications Lead may decide the optimum use of available resources will be to create a central Comms team – be this at London HQ or within the region where the incident is taking place. The location of the NICC may determine the location of the Comms team.

INQ000090415_0020

6.29 Where other activities preclude the fielding of a full team of staff, the Communications Lead should agree with the communications team which positions are to be activated, and if appropriate which of the roles are to be fulfilled by individuals working remotely.

6.30 Frequent teleconferences according to need will be held with all members of the incident communications team (this may include those who are not on shift) to give updates on the situation, forward looks and to review staffing levels.

6.31 Regular meetings will be held between the press office, web team, public information access and publications staff to look at material that was being or needed to be created for the web, or hard copy. This will ensure consistency of approach, version control, an understanding of what materials are required and the retention of archive copies of material for reference and audit purposes.

Provision of Scientific and Technical Advice (local and national)

6.32 Public Health England is responsible for the provision of scientific and technical advice at all organisational levels.

6.33 A number of pre-prepared templates for a variety of incidents, outbreaks and emergencies already exist to speed up the process. The source from whom this information and expertise is sought will depend on the nature and level of incident.

6.34 Strategic Coordination Groups (SCG). The provision of scientific and technical advice to a Strategic Coordination Group will be provided through the Public Health England Centre Local Incident Coordination Centre. Local plans will include in and out of hours activation, management processes, Health Protection Directorate will provide specialist Health Protection advice in support as appropriate.

6.35 Where a local SCG is called to respond to an incident, arrangements may involve the establishment of a STAC. PHE will provide the local co-ordination, management and signing off public messages. It is important that any national arrangements put in place to co-ordinate the PHE response do not conflict with local responsibility and work patterns. The establishment of good communication links is required between the affected local team and the battle rhythm which takes account of the timing of local meetings, briefings and other deadlines to ensure effective internal joint working.

6.36 For some chemical incidents, an Air Quality Cell (AQC) may be activated, by agreement between EA and PHE. The process will be discussed and agreed early in the incident.

6.37 Scientific Advisory Group for Emergencies. The provision of scientific and technical advice to the Safety Advisory Group for Emergencies will be coordinated via the National Incident Coordination Centre. If both STAC and SAGE are convened, it is the responsibility of the STAC chair to maintain an effective dialogue with the Chair of SAGE, to ensure consistent advice to both the local and national levels.

Major Incidents Health Register

6.38 Following a major incident, it may be considered necessary to establish a register of hose people affected by or exposed to the incident. The purpose of establishing a major incident health register is to enable appropriate advice on relevant immediate interventions to be provided and to facilitate access to appropriate services, to provide reassurance to the public and to enable longer term epidemiological studies to be conducted. The decision to establish a Health Register should be taken as early as possible and will be taken by the PHE Incident Director in consultation with the Director of Field Epidemiology, the Duty Director for CRCE (for incidents involving chemical or radiological materials) and the Chief Medical Officer or appropriate deputy from the Department of Health.

Staffing and Shift Patterns

6.39 In the event of a major incident having a substantial impact, it may be necessary to continue operation of emergency teams for a number of days or weeks. In particular, in the early phase of an emergency, some teams may need to be staffed continuously for an extended period of time. The Incident Director is responsible for deciding the scale and staffing of the response.

6.40 These shift arrangements will depend on the nature of the incident and must take into consideration any requirements for preparatory work to support external (e.g. COBR) meetings and activities that may require very early morning starts to meet briefing deadlines etc. Another example would be a pandemic incident requiring overnight shifts in order to liaise with countries in different time zones, In all events, compliance with the working time directive must be monitored and adhered to.

6.41 Outline shift arrangements are:

a. Requirements for each shift should be monitored at each handover.

b. Handover briefings must be appropriately detailed.

c. During the first two shift changes 1-2 hours of hand over time is probably required.

d. The Incident Director is accountable for ensuring appropriate staffing of all shifts.

e. Shift changes should be considerate of both staff welfare and operational requirements. For example shifts could change in the morning (7-9am) and evening (8-10pm).

f. Where possible initial shift changes in teams should be staggered.

g. Where possible there should be continuity of staffing.

h. Staff welfare and health and safety policies must be followed.

Maintaining Critical Business Functions

6.42 As a CCA Category 1 responder PHE is required to put in place an effective Business Continuity Management System that ensures that PHE can continue to function in an emergency situation and also reassure stakeholders that the agency will be able to maintain continuity of service and its response function.

6.43 During incident response, PHE will maintain critical business functions

6.44 BC Recovery group will be formed at the onset of response to ensure critical services are maintained and any suspended services can be recovered, in line with service restoration priorities.

7. ESCALATION AND DE-ESCALATION

7.1 Escalation or de-escalation through the incident levels need not occur sequentially, but will be driven by the nature, scale and complexity of incidents, coupled with the expectations of Public Health England's' response. Any incident response can be changed following a review, including a risk assessment of the strategic direction and operational management of the emergency.

7.2 The level of Public Health England's response may need to be escalated or de-escalated for a number of reasons. These may include:

Criteria for Escalation	Criteria for De-escalation
➢ the need for additional internal resources ➢ increased severity of the incident ➢ increased demands from partner agencies or other government departments ➢ heightened public or media interest ➢ increase in geographic area or population affected	➢ reduction in internal resource requirements ➢ reduced severity of the incident ➢ reduced demands from partner agencies or other government departments ➢ reduced public or media interest ➢ decrease in geographic area or population affected

7.3 Any changes to incidents response levels will be authorised by the Health Protection Director (or nominated deputy) in discussion with the Chief Operating Officer/Regional Director.

7.4 All response level changes will be communicated both internally and externally as appropriate.

8. STANDING DOWN THE RESPONSE

8.1 Once it has been decided that a response from Public Health England is no longer appropriate, the stand down process will be initiated by the Incident Director. This will be communicated to staff via PHE Net and iModus.

8.2 All records relating to the response both electronic and other media must be appropriately labelled, and archived for possible future reference.

9. DEBRIEFING AND LESSONS IDENTIFIED REPORTS

9.1 Level 2 and above incidents will be debriefed using the Constructive Debrief process. Significant Level 1 incidents may be debriefed at the request of the Public Health England Centre Director.

9.2 Constructive debriefs will be held with involved staff no later than 2 weeks after de-escalation and stand down.

9.3 As part of the debriefing process the post incident report will be produced to reflect the actual events and actions taken throughout the response. This will include:

a. Nature of incident.
b. Involvement of PHE.
c. Involvement of other responding agencies.
d. Implications for public health.
e. Actions undertaken.
f. Future threats/forward look.
g. Chronology of events.

9.4 A separate Lesson Identified report will focus on areas where response improvements can be made in future.

9.5 This report will be submitted to PHEs EPRR Programme Board for approval and progress monitoring.

10. Training and Exercising

10.1 Training and exercising of this CONOPS is detailed in Public Health England's EPRR Training and Exercising programme.

10.2 PHE will ensure that all staff required to respond to incidents receive appropriate training commensurate with the roles they will fulfil.

10.3 Training requirements will be written into Personal Development Plans.

10.4 Depending on service requirements, staff will be expected to participate in training exercises to provide exposure to their response role in a simulated environment.

11. Review and Governance

11.1 This CONOPS will be reviewed;

a. Annually as part of the EPRR business planning process.
b. Post a level 2 or above Incident or exercise.
c. In light of any changes of relevant legislation.

11.2 Public Health England's Executive Management Team will sign off any amendments to this CONOPS.

12. Glossary of Acronyms

BC	Business Continuity
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CCC	Civil Contingencies Committee
CEO	Chief Executive Officer
COMAH	Control of Major Accident Hazards
CONOPS	Concept of Operations
COO	Chief Operating Officer
CRCE	Centre for Radiation, Chemicals and Environmental Hazards
CRIP	Common Recognised Information Picture
DEFRA	Department for Environment Food and Rural Affairs
DH	Department of Health
DsPH	Director of Public Health
DSTL	Defence Science and Technology Laboratory
EA	Environment Agency
ECOSA	Emergency Coordination of Scientific Advice
EPRR	Emergency Preparedness, Resilience and Response
LHRP	Local Health Resilience Partnership
LICC	Local Incident Coordination Centre
LRF	Local Resilience Forum
NHS	National Health Service
NHSCB	NHS Commissioning Board
NICC	National Incident Coordination Centre
PHE	Public Health England
PHEC	Public Health England Centre
SAGE	Scientific Advisory Group for Emergencies

SCG	Strategic Coordinating Group (Gold Command)
SITREP	Situation Report
SOPs	Standard Operating Procedures
STAC	Scientific and Technical Advice Cell
TCG	Tactical Coordination Group

Public Health England Incident Levels

PHE Response Levell	Criteria	Management of the Response
1	Public health impact including public interest or concern is limited to the local population and the response can be managed by one Public Health Centre (PHC) May require liaison internally and with partner organisations. Risk Assessment will be carried out locally and PHE response level declared by PHC.	• Response can be managed within the capacity and resources of a single PHC/PHE specialist service • Directed by senior member of PHC staff • Local PHE plans to be activated • Threat specific plans may need to be activated • Involvement of Specialists from appropriate PHE Services as appropriate • Command, control and coordination at local centre level. • Comms response can be managed within the capacity and resources of a single PHC • Local media handling with partner agencies • Support from Regional Communications Manager and press officer as required • Involvement of specialist communications staff if necessary. The sign off for public advice and/or press releases/statements is the PHC Director/Designate.
2	Public health impact including public interest or concern is limited to the local population but is greater than can be managed by one PHC. It may require regional support and coordination. May require support from PHE specialist service. Risk Assessment will be carried out locally and PHE response level declared by Regional Director or Head of Service as appropriate. May involve a Strategic Coordination Group (SCG) and Scientific and Technical Advice Cell (STAC). Will involve inter-agency working. Expect regional and local media interest.	• Response can be managed within the capacity and resources of the region/PHC Specialist Service • Directed by Incident Director appointed by PHC Director • May require activation of an LICC • PHE plans activated as appropriate • Involvement of specialist services as appropriate • Command and control locally focussed, coordination and overview regionally focussed. • Comms response can be managed within the capacity and resources of the specialist service • Comms response dependent on incident, but may be handled locally with partner agencies (NHS, EA, etc) and support as required or as may be managed by the Regional Communications Manager (RCM) • Involvement of specialist communications staff if necessary • The sign off for public advice and/or press releases/statements is the Incident Director as appointed.

INQ000090415_0031

Level	Description	Response
3	Public health impact including public interest or concern is significant across regional boundaries or nationally. It may require supra regional or central coordination, support and interaction with government departments. Support will be required from PHE specialist service. Risk Assessment will be carried out regionally or centrally and PHE response level and Incident Director appointed by Head of Service and may involve consultation with the Director of Health Protection/Duty Director/CEO. CCC, an SCG and STAC may sit. Possible higher or raised level of media interest.	• Managed by PHE Division/PHE specialist service or HPS Region • Led by an appropriate person appointed as Incident Director by the Director of the PHE division or specialist service responsible for managing the incident and may involve discussion with the CEO or Duty Director. • One or more Incident Co-ordinating Centres may be established to support the response. This will depend on the nature of the incident • NICC may be activated • The sign off for public advice and/or press releases/statements is the Incident Director as appointed.
4	Public health impact including public interest or concern upon the national population is severe. It will require central direction of the PHE response and significant interaction with government/DH. Requirement for cross-agency working. Will require significant PHE resources. CCC/SAGE will sit. One or more SCGs and STACs. PHE National Command and Coordination through NICC.	• May require resources of more than one PHE specialist service • Level and Incident Director appointed by CEO/Director of Health Protection or Duty Executive Director • NICC will be activated • One or more ICCs will be set up to provide support the response • Incident Director to consider implications of escalation in discussion with Director of Health Protection/Duty Executive Director • Comms response may require resources of more than one PHC specialist service • Director of Communications will lead with support from RCMs and Specialist Service press officer • The sign off for public advice and/or press releases/statements is the Incident Director as appointed. National and international media interest.
5	Public health impact including public interest or concern upon the national population is catastrophic. Central direction of the PHE response will be required involving extensive Agency resources and significant interaction with government. PHE National Command and Coordination through NICC. Significant requirement for cross-agency working. CCC/SAGE will sit and potentially multiple SCG	• May require resources of more than one PHE specialist service • Level and Incident Director appointed by CEO. CEO may consult the Duty Executive Director in discharging this action. • NICC will be activated • ICCs will be set up to provide support the response • Comms response may require resources of more than one PHE service • Director of Communications will lead with support from RCMs and specialist service press offices • Possibility of external staff to supplement if required • The sign off for public advice and/or press releases/statements is the CEO or Incident Director as appointed.

Daily Schedule

Incident Insert Title/Reference

Date [00 Month]

Time [00:00]

Time	Event
0800	NICC Teleconference
1000	STAC (Any town LRF)
1100	SAGE
1200	CCC (Officials)
TBN	CCC (Ministers)
1630	SITREP to NICC
1800	NICC Teleconference
1900	SITREP Submitted to DH

INQ000090415_0033

Incident Decision Log

Incident Description:	
Time:	**Date:**
Name:	
Recorded by:	
Problem:	
Options: **A:** **B:** **C:** **D:**	
Outcomes/Actions:	
Rationale:	
Incident Directors Name:	**Signature:**

INQ000090415_0034

PUBLIC HEALTH ENGLAND

Teleconference Protocol

1 Telephone conferences provide an excellent way of rapid sharing of information and agreeing actions. PHE teleconferences can facilitate incident response. They should support those who are representing PHE at COBR, Strategic Coordinating Group (Gold), Tactical (Silver) or rarely at Operational (Bronze) levels. They can also provide a forum for cross sharing of information between levels of response. During an incident or emergency they should be as focused and as short as possible, preferably never more than 60 minutes.

2. Some guidelines for effective teleconferencing:

2.1 Agenda

Where possible, Prepare and circulate an agenda prior to the meeting.

A 'template' agenda for incidents/outbreaks could be prepared for publication on PHEnet for use in sudden and unanticipated teleconferences (see Annex 1).

At the end of each agenda item, the chair should summarise and agree action points before moving on to the next item. These should be noted in the record of the meeting.

Avoid allowing Any Other Business turning into an unlimited discussion by asking that participants notify items for AOB at the start of the meeting.

Establish 'Daily Schedule' such as timing of and participants in teleconferences.

2.2 Record

Ensure that a good note is taken of the teleconference or that it is recorded.

Ensure that action points and who will be responsible for actions is recorded and shared in an agreed and timely fashion.

2.3 Attendance

All those attending the teleconference should confirm their intention to join the meeting or otherwise give apologies no later than by 5 minutes in advance of the start to a designated PHE coordinator.

2.4 Spokespeople

a. Spokespeople for PHE Locations or Services

A lead spokesperson key to the discussion should be identified at each location and they can invite other members of their team to respond on specific issues if required. It is essential to keep as few as possible involved in actively contributing

to a telephone conference as possible. Where appropriate, observers may attend at the discretion of the Chair.

b. Spokespersons External to PHE

Where appropriate, it may be valuable to have contributions from other agencies in the PHE telephone conferences. For example, NHS Operations may be able to provide up to date information on the capabilities of Acute Trusts; an occupational health professional for Police or Fire may be able to confirm health & safety actions for their staff; or the Met Office representative will be in a better position to interpret plume modelling data. Such contributions should be encouraged and supported in a structured manner.

2.5 Behaviours

All those joining the teleconference should identify themselves by name, PHE location, service or other, and function (e.g. supporting STAC at Gold) when joining.

The chair reserves the right to 'lock out' any unidentified participants using the automatic facility to do so (refer to teleconference provider instructions in Annex 2).

The chair should take a roll call at the start of the teleconference. This can be facilitated by use of the appropriate call control code, see Annex 2.

If joining on a mobile phone or otherwise calling in from noisy surroundings (eg station, train, airport, busy road) participants should use their phone mute facility when not speaking (refer to mobile phone provider instructions or call controls, see Annex 2).

No-one should leave the during the telephone conference unless in a real emergency.

All telephone conferences should be targeted and as short as possible.

Emphasis should be placed on keeping teleconferences short, focused and objective. All participants should have the opportunity to speak in turn and not be interrupted.

Patient confidentiality should be strictly adhered to - there should be no sharing of patient names, initials or any other identifiers on teleconferences, especially as there may be other organisations on the conference call who may not be bound by the PHE's legal requirements with regard to patient data. Such information can shared through approved routes, off line, if required.

The general rule is to be specific and stick to the point, but this to be borne in mind:

Keep information as concise as possible –
- A accuracy – ensure information is accurate
- B brevity – keep points and discussion brief
- C clarity – communicate as clearly as possible

Template Agenda for Emergencies

Title of meeting
Date
Time
Venue

Agenda

1. Roll Call

2. Reminder of rules of engagement/teleconference protocol

3. Identification of AOB Items

4. Minutes of the last teleconference and review of actions

5. Feedback from SAGE / COBR

6. Situation reports from relevant sites
   <sites to be added>
   description of incident/incident update
   status of countermeasures
   update
   new issues

7. Media Update

8. Health and Safety

9. New issues and actions not already covered

10. Daily Schedule

11. AOB (previously notified to Chair)

12. Confirm agreed actions, how action points will be shared and by when

13. Details of next teleconference

TELECONFERENCE PROVIDER CALL CONTROLS

Please check your provider before using Call Controls

1. ACT Call Controls

Available to Hosts Only	Available to all Participants
*0 Dial out or Operator Assistance	*0 Operator Assistance
*#2 Conference Recording	*4 Mute/Unmute Individual Line
*#3 Roll Call	*8 Activate Automatic Gain Control
*#4 Conference Lock/Unlock	
*#5 Mute/Unmute All Lines	
*#8 Participant Count	
*#9 Conference Continuation	

2. Meeting Zone Call Controls

Available to Hosts Only	Available to all Participants
#1 Perform Roll Call of Attendees	*0 Call the Operator
#2 Count Number of Attendees	*4 Adjust the Call Volume
*2 Stop Above Audio Message	*6 Mute/Unmute the Line
*5 Lock/Unlock Call for Privacy	
*7 Mute/Unmute all Participants	
#7 Record Conference (follow prompts)	

Revised by CRT, ERD: 07 March 2013

Records Management Policy

Awaited. Under revision

Briefing Note Template for Level 1 and 2 Incidents

This briefing note template is for use during the response to PHE National Incident Response Plan (NIRP) Level 1 and 2 incidents. For PHE NIRP level 3 and above incidents the PHE SitRep template (Annex F, PHE CONOPs) must be used.

Event:

Notified by:

Contact:

PHE Incident Level:

Incident Lead:

Background and Interpretation:

Insert here the background information and details of the incident

---

Implications for PHE Centres:

Implications for PHE sites and services:

INQ000090415_0040

Recommendations to PHE Centres:

Recommendations to PHE sites and services:

References/ Sources of information:

INQ000090415_0041

Public Health
England

PUBLIC HEALTH ENGLAND

SITUATION REPORT (SitRep)

<Insert Name of Incident >

(NB; New information is highlighted in yellow)

SitRep Number <Insert Number>

Date: <Insert Date>

Time: <Insert Time>

Author: <Insert Name of Author>

Incident Director: <Insert Name of Incident Director>

Lead Division <Insert Name of Lead Division>

Introduction

1. This SitRep provides an update using data as at <time> on <date>.

2. This SitRep is PHE's reporting mechanism for level 3 and above incidents and is prepared for the Chief Executive and Directors of PHE to summarise the current situation regarding <insert incident (eg. PHE investigations into potential outbreaks and incidents involving E.coli 0157 in England)>

3. <Insert background information on the incident/outbreak (e.g information on E.coli 0157 infection and control measures)>

4. The briefing will be updated <insert frequency>. All changes from the previous briefing will be highlighted in yellow.

5. <Insert brief summary of the incident/outbreak including an incident timeline.>

Strategic Objectives

6. <Insert brief summary of the strategic objectives of PHE response to the incident. e.g To reduce the harm resulting from the Incident. (e.g. to identify and eliminate / ameliorate the source of / mitigate the effects / to support colleagues from <insert name of agency> in responding to <insert name of incident>)>

PHE Notification Status

7. Using the check boxes, please indicate other organisations that PHE has informed about the incident and whether this is for action or for information only. <If information is for action insert expected actions and outcomes.>

	Action	Information
Department of Health	☐	☐
NHS CB National	☐	☐
Home Office	☐	☐
Foreign and Commonwealth Office	☐	☐
Department for Environment, Food and Rural Affairs	☐	☐
Cabinet Office	☐	☐
Civil Contingencies Secretariat	☐	☐
Devolved Administrations (please state)	☐	☐
European Centre for Disease Prevention and Control	☐	☐
SANCO	☐	☐
Science Partners (please state)	☐	☐
Food Standards Agency	☐	☐
Environment Agency	☐	☐
Nuclear Installations Inspectorate	☐	☐
Other (please state)	☐	☐

Incident Status

8. The incident is declared at level <insert level> and was reported on IRIS on <insert date if applicable>.

9. In this section provide details of whether PHE is the lead for the incident or acting in a supporting role. < Insert any relevant information>
   PHE Leading ☐

   PHE Support to <insert lead agency> ☐

PHE Response

Guidance

10. <Insert Summary/ List if appropriate>

Management Algorithms:

11. <Insert Summary/ List if appropriate>

Countermeasures:

12. <Insert details of countermeasures taken>

Summary of ongoing investigations

13. <Insert Summary if appropriate>

<Insert appropriate data tables>

Example Table 1: Open investigations into cases in England

Incident	Public Health Centres	No. of Cases			Hospitalisations	Deaths	Notes
		Prim.[1]	Sec.[2]	Total			
Incident 1	Public Health Centre 1	#	#	#	# total hospitalisations	#	Additional information/ notes
Incident 2	Public Health Centre 2	#	#	#	# total hospitalisations	#	Additional information/ notes

(1) a primary case is a case directly associated with an identified source
(2) a secondary case is a case of person to person spread usually in a household setting.

Example Table 2: Closed investigations into cases in England

Incident	Public Health Centres	No. of Cases			Hospitalisations	Deaths	Notes
		Prim.[1]	Sec.[2]	Total			
Incident 1	Public Health Centre 1	#	#	#	# total hospitalisations	#	Additional information/ notes
Incident 2	Public Health Centre 2	#	#	#	# total hospitalisations	#	Additional information/ notes

(3) a primary case is a case directly associated with an identified source
(4) a secondary case is a case of person to person spread usually in a household setting.

Legal Issues

14. <Insert Summary if appropriate>

Operational Issues

15. <Insert Summary if appropriate>

Business Continuity Issues

16. <Insert Summary if appropriate>

Forward Look Issues

17. <Insert Summary of strategic issues as appropriate>

De-escalation

18. < Insert Summary of factors/triggers used to establish if/when de-escalation will be appropriate>

Public & Media Communications

19. <Insert Summary if appropriate>

END.