OUTBREAK OF INFECTION MANAGEMENT POLICY
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1. INTRODUCTION

An outbreak of infection is defined as the occurrence of two or more related cases of the same infection, or where the number of infections is more than would normally be expected (Wilson, 2001).

The severity of an outbreak is graded according to several factors:

- The number of patients affected
- The type and virulence of the organism
- The endemic status of the organism
- The resources available and necessary to control an outbreak
- The media interest

It is recognised that outbreaks of viral gastroenteritis, which can be common especially during the winter months, are usually managed within existing routine arrangements and could be defined as a minor outbreak.

A situation where a large number of patients are involved, wards closed to all admissions, and other hospitals are required to accept our patients would be considered a major outbreak. This decision is at the discretion of the Infection Control Doctor/ Director of Infection Prevention and Control (DIPC)/Consultant in Communicable Disease Control (CCDC) or Chief Executive (CE).

It is impossible to be prescriptive as to what constitutes a major outbreak, but the examples below, which are not exhaustive, would require convening of the Trust's Major Outbreak Control Team (Appendix 1).

- Viral gastroenteritis which is escalating
- Severe Acute Respiratory Syndrome (SARS) or other Coronavirus
- Influenza

2. PURPOSE

The purpose of this policy is to ensure a rapid, well-co-ordinated response to any outbreak of infection, making efficient use of all health service resources in order to limit the spread of infection and minimise the disruption of clinical services. The policy contents are based on national guidelines.

2.1 Definitions

Gastroenteritis - inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea

Organism - an individual animal, plant, or single-celled life form

Coronavirus - any of a group of RNA viruses that cause a variety of diseases in humans and other animals

Zoonosis - a disease which can be transmitted to humans from animals
3. **SCOPE**

This policy applies to all staff having contact with patients under the care of the Trust, whether in a direct or indirect patient care role regardless of the care environment. Adherence to this policy is the responsibility of all staff employed by the Trust, including agency, locum and bank staff contracted by the Trust. This policy should be read in conjunction with other infection prevention and control policies, particularly Hand Hygiene, Standard Infection Prevention and Control Precautions, Blood and Body Fluid Spillages, Isolation, Waste Management, Decontamination, Cleaning Systems and Processes for the Environment, Patient Equipment and Medical Devices, Collection/Handling and Transportation of Pathology Specimens, Laundry, Decontamination, Diarrhoea and/or Vomiting for Patients and Staff and the Pandemic Flu Plan and Critical Incident Plan.

This policy should be considered and included in services that are contracted and commissioned by the Trust.

This policy applies to both internal outbreaks and outbreaks in the community. Public Health England (PHE) provides public health emergency preparedness, resilience and response leadership. Directors of Public Health in local authorities have the duty to prepare for and lead the local authority public health response to incidents e.g. norovirus/scabies in a care home, norovirus in schools, food outlet poisoning etc.

The Trust may play a role in multi-agency response to an outbreak in the community. This policy describes the internal procedures that facilitate this response and how they link to multi agency plans for outbreaks in the community.

4. **RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES**

4.1 **Board of Directors**

The Board of Directors are responsible for having policies and procedures in place to support best practice, effective management, service delivery, management of associated risks and meet national and local legislation and/or requirements.

4.2 **Chief Executive**

The CE is responsible for establishing and maintaining infection prevention and control (IPC) arrangements across the organisation, but delegates the responsibilities to the Trust Board and the DIPC. The DIPC is the Director of Nursing and Quality.

4.3 **Director of Infection Prevention and Control**

The DIPC directly reports to the CE and the Board:

- Any outbreaks of infection
- The organisations performance in relation to Healthcare Associated Infection’s (HCAI), providing regular reports including an annual report and an annual IPC programme
- Acts on legislation, national policies and guidance ensuring effective policies are in place and audited
- Reports all incidents requiring a post infection review (PIR)

4.4 Infection Prevention & Control Quality & Standards Committee

The main duties of the Infection Prevention & Control Quality & Standards Committee (IPCQSC) are:

- To oversee compliance with national standards/targets in relation to the IPC of HCAIs, including the Health and Social Care Act 2008, NHS Litigation Authority (NHSLA) and the Care Quality Commission (CQC).
- To oversee key IPC issues in regards to:
  - Policy development and review
  - Audit
  - Education & training
  - Communication with staff patients and the public
  - Monitoring of IPC incidents
  - Review of PIR reports, identify lessons learnt, develop and monitor action plans
  - Agreeing the annual IPC report and work programme prior to its submission to Clinical Governance Committee
- To inform the Clinical Governance Committee of clinical risk issues relating to the Trust
- To monitor compliance for IPC training
- To oversee the Trust’s compliance with the CQC Fundamental Standards

4.5 Infection Control Doctors/Consultant Microbiologists

These are medical microbiologists hosted within the provider acute Trusts whose main duties are to:

- Be available for 24 hour access, arrangements made through service agreements
- Provide expert microbiology advice for the management of outbreaks
- Support and provide education to all grades and all disciplines as appropriate
4.6 **Clinical Nurse Specialists (CNS) – Infection Prevention & Control Quality & Standards Team (IPCQST)**

The IPC Clinical Nurse Specialists:

- Provide expert professional advice and education on the prevention and control of infection to other professionals, multi-disciplinary groups, patients and carers
- Report findings to the DIPC
- Give advice on complex issues relating to outbreak management and the control measures, delegating responsibility to Trust staff as appropriate, including the provision of intelligence of possible developing outbreaks to teams that may be required to respond e.g. School Nurses
- Request as a matter of urgency for confirmed outbreaks that an IR1 is completed by the responsible Modern Matron/Service Manager
- In the event of a major outbreak that causes the closure of multiple wards the IPCQST will ensure that the Trust’s Accountable Emergency Officer ((AEO) Director of Children’s and Community Services) is notified
- In the event of the Trust declaring a critical incident the IPCQST will ensure a suitable representative attends meetings of the Emergency Planning Group as requested to advise on IPC matters

4.7 **Consultant Medical Staff/Medical Staff**

Consultant medical staff are responsible for the supervision of junior medical staff and all medical staff must:

- Ensure compliance with IPC policies
- Liaise with the Consultant Microbiologist for advice in relation to the management of outbreaks
- Contribute to and participate in the outbreak report, including attendance at relevant meetings
- Complete relevant actions required from the outbreak report

4.8 **Modern Matrons/Service Managers**

All Service Managers and Modern Matrons are responsible for:

- Membership at the IPCQSC
- On-going compliance with this policy within their clinical areas and reporting non-compliance to the DIPC
• Reporting all matters relating to IPC to the Director of Nursing and Quality
• Facilitating feedback of information related to surveillance data and identified cases of infection/alert organisms and conditions, including outbreaks of infection
• Reporting confirmed outbreaks of infection through the Trust’s IR1 system
• Ensuring that situation reports are completed to deadline as requested

4.9 Staff

All staff must comply with this policy and related guidance.

5. PROCEDURE

Most inpatient area outbreaks are normally managed locally by the IPCQST but at any point if deemed appropriate they can be escalated to a major outbreak.

Community outbreaks are managed by PHE and local authority departments of public health. Intelligence on these outbreaks is communicated to the IPCQST via a daily alert system.

5.1 Inpatient Area Outbreak

Staff who suspect two or more, linked cases of infection and/or clusters of similar infection will:

• Contact the IPCQST at the earliest opportunity to ensure early intervention and risk assessment in order that treatment/outbreak management can be advised and prevalence monitored
• Inform the medic responsible for the care of the affected patients

Out of the IPCQST office hours and at weekends and bank holidays:

• Doncaster and North/North East Lincolnshire staff will contact the Consultant Microbiologist at Doncaster Royal Infirmary on 01302 366666
• Rotherham staff will contact the Consultant Microbiologist at Rotherham Hospital on 01709 820000, via bleep 221 in order that treatment/outbreak management can be advised Doncaster and Rotherham staff will contact PHE on 0114 3211177
• Lincolnshire staff will contact PHE on 01904 687100 in order to inform them of the suspected outbreak and that advice has been sourced from the consultant microbiologists
• All staff will inform the IPCQST at the earliest opportunity
Where possible symptomatic patients must be isolated and appropriate specimens must be obtained for laboratory examination.

During operational hours the IPCQST will liaise with the affected inpatient area twice daily to provide IPC guidance during the outbreak of infection. This guidance will be based on the information provided by the inpatient area staff and it is essential that all information provided is accurate and up to date.

Situation report updates to all relevant personal will be disseminated via email on a daily basis.

The decision to restrict admissions or close an inpatient area will be taken by the Infection Control Doctor/DIPC/CCDC/CE/IPCQST.

It is the responsibility of the DIPC/Consultant Microbiologist to declare a major outbreak in the inpatient setting. If declared a major outbreak the Trust Major Outbreak Control Team will be convened by the IPCQST. Screening, treatments and vaccinations will be undertaken as directed by PHE.

The core function of the Trust Major Outbreak Control Team is to:

- Establish case definitions
- Provide specific IPC guidance
- Meet regularly and review the progress of the outbreak of infection
- Formulate press releases
- Communicate with the following as appropriate:
  - PHE
  - Environmental Health
  - NHS England
  - Department of Health

In the event of a Major Outbreak that causes the closure of multiple wards the IPCQST will notify the Trust’s Accountable Emergency Officer (AEO) Director of Children’s and Community Services) and provide briefing as requested.

If the Trust declares a Critical Incident the Trust Major Outbreak Control Team may be absorbed into the Trusts Gold Command arrangements depending on the rationale decided by the AEO. The Trusts Gold Command provides strategic leadership. Full details of which can be found in the Trusts Critical Incident Plan.

If a Major Incident is declared the AEO will be required to conduct an internal Trust debrief when the incident is over and will liaise with the IPCQST to facilitate a report for presentation to the Trust Board. The debrief will concentrate on the Trust response and how it worked internally and it’s liaison with external agencies. This is to ensure lessons are learned which may inform future actions.

Following a minor outbreak a report will be completed by the IPCQST which is escalated to the Trust Board via the IPCQSC, Clinical Quality and Standards Group (CQ&SG) and Clinical Governance Group (CGG).
5.2 Community Outbreak

The IPCQST receives daily alerts of outbreaks in the community from PHE. This provides intelligence on developing situations and allows preparations to be made in advance of potential outbreaks.

During office hours if the IPCQST become aware that a possible outbreak may exist they will inform:

- PHE
- Local Authority Department of Public Health
- Consultant Microbiologist

The IPCQST will ensure that all appropriate internal teams are informed of any developing situations that may lead to a response from trust community based staff.

During out of hours periods on call staff may receive notification of clusters of cases or an outbreak in the community direct from PHE. In such instances they will ensure they inform the IPCQST at the earliest opportunity.

In the event that a response is needed to an outbreak in the community the IPCQST will ensure staff that respond to patients in the community adhere to the relevant Trust policies.

It is the responsibility of the CCDC/Health Protection CCDC/CHP or senior health practitioner to declare a major outbreak in the community. If declared a major outbreak the Trust Major Outbreak Control Team will be convened by the IPCQST. Where appropriate this will be following consultation with a Consultant Microbiologist or senior Environmental Health Officer (EHO). The core function of the Trust Major Outbreak Control Team is to:

- Establish case definitions
- Provide specific IPC guidance
- Meet regularly and review the progress of the outbreak of infection
- Formulate press releases consistent with PHE and Department of Public Health
- Communicate with the following as appropriate:
  - PHE
  - Environmental Health
  - NHS England
  - Department of Health
  - Clinical Commissioning Groups
  - Local Authorities

In the event of a Major Outbreak in the community the IPCSQT will notify the Trust’s Accountable Emergency Officer ((AEO) Director of Children’s and Community Services) and provide briefing as requested. The decision on whether the Trust Major Outbreak Control Team will be absorbed into the Trust Gold Command arrangements will be made by the AEO.
A representative from the Trust Major Outbreak Control Team may be asked by PHE or Local Authority Department of Public Health to attend the Multi-Agency Outbreak Control Team as described in Appendix 3 of the PHE Communicable Disease Outbreak Management Operational Guidance V2.0 2013.

The Doncaster Multi Agency Outbreak Plan V1.0 contains details of roles and responsibilities for RDaSH in the event of a Multi-Agency Outbreak Control Team (OCT) being convened. This information can be found at appendix 2. Any Trust representative at Multi-Agency OCT should have authority to be able to commit Trust resources if required. Supporting documentation in the form of the Memorandum of Understanding for South Yorkshire Local Health Protection is included in appendix 3.

If a Critical Incident is declared the AEO will be required to conduct an internal Trust debrief when the incident is over and will liaise with the IPCQST to facilitate a report for presentation to the Trust Board. The debrief will concentrate on the Trust response and how it worked internally and it's liaison with external agencies. This is to ensure lessons are learned which may inform future actions.

6. TRAINING ANALYSIS
There are no specific training needs in relation to this policy. All staff that have contact with patients under the care of the Trust, whether in a direct or indirect patient care role regardless of the care environment will need to be familiar with its contents. (And any other individual or group with a responsibility for implementing the contents of this policy).

As a Trust policy, all staff need to be aware of the key points that the policy covers. Staff can be made aware through a number of a variety of means such as:

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<td>Minor Internal Outbreaks</td>
<td>Written report</td>
<td>IPCQST</td>
<td>IPCQSC Clinical Quality &amp; Standards Group Clinical Governance Group Trust Board</td>
<td>Following each minor outbreak. Outbreaks monitored through IPCQSC meetings held bi-monthly</td>
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### 8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on the Equality and Diversity webpage of the RDaSH website [click here](#).

8.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all patients with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

| Indicate how this will be met | No issues have been identified in relation to this policy |

8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

| Indicate how this will be met | All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1) |

9. LINKS TO ANY ASSOCIATED DOCUMENTS

All policies can be found in the Clinical Policies section of the RDaSH Intranet.

10. REFERENCES and BIBLIOGRAPHY
Guidance about compliance: Essential standards of quality and safety (CQC, 2010)
Communicable Disease Outbreak Management - Operational Guidance V2.0 (PHE 2013)

11. APPENDICES

Appendix 1    Trust Major Outbreak Control Team
Appendix 2    RDaSH Action Card from Doncaster Multi Agency Outbreak Plan
Appendix 3    South Yorkshire local Health Protection Memorandum of Understanding (June 2015)
Appendix 1

**RDaSH MAJOR OUTBREAK CONTROL TEAM**

As deemed appropriate by the Chair of the team who will be either the Infection Control Doctor/DIPC/CCDC/CE.

If the Trust declares a Critical Incident this group may be absorbed into Gold Command arrangements as described in the Trust Critical Incident Plan. The rationale for membership of Trust Gold Command is the responsibility of the AEO.

Chief Executive
Consultant Microbiologist
Consultant in Communicable Disease Control (CCDC)
DIPC
Medical Director
Deputy Director of Nursing
Head of Quality and Standards
Assistant Directors of Business Divisions
Clinical Directors of Business Divisions
Head of Facilities
Modern Matron/Service Managers
Infection Prevention and Control Quality and Standards Team
Trust’s Accountable Emergency Officer (Director of Children’s and Community Services)
### Appendix 2
RDaSH Roles and Responsibilities from Doncaster Multi Agency Outbreak Plan

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<th><strong>RDaSH and Representative Role and Responsibilities</strong></th>
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<tr>
<td><strong>Role:</strong> NHS provider organisations may be required to support the response to a communicable disease control incident or outbreak, or may be directly affected by it.</td>
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<td>If a representative from RDaSH is required, the Director of Children’s and Community Services, Director of Mental Health Services or the Deputy Director of Nursing and Standards will represent the organisation on the OCT and will ensure information is cascaded appropriately within the Trust.</td>
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South Yorkshire local Health Protection Memorandum of Understanding (June 2015)

This Memorandum of Understanding (MOU) describes the health protection roles and responsibilities for agencies in South Yorkshire relating to emergencies, incidents and outbreaks, specifically it aims to outline the public health roles and responsibilities of Directors of Public Health, Public Health England, NHS England and Clinical Commissioning Groups.

Governance of health protection
The Director of Public Health (DPH) has a responsibility for the strategic leadership of health protection in their local authority area. The NHS Emergency Preparedness, Resilience and Response (EPRR) is coordinated through the NHS England Accountable Emergency Officer and the Public Health (PH) response via the lead DPH through the Local Health Resilience Partnership.

Overall principles / ways of working
- Collaboration is crucial between the partners, and should be based on this MOU.
- Positive relationship management is essential between both individuals and organisations, so that good will is not lost.
- Provider responsibilities are described as part of the commissioning responsibilities “to ensure”.
- Advice is based on science, i.e. is evidence based, not biased or prejudiced.
- Timely and accurate record keeping is required in all parts of the system.
- In the event of an incident of any type that is a potential or actual threat to local health of the public, the local Public Health England Centre (PHEC) will chair the Incident Control Team, with the DPH chairing if the incident is increasing in complexity, in size or challenges, requiring a wide scope in coordination and the mobilisation of resources outside PHEC, PH and Environmental Health (EH) departments locally and NHS mobilisation.
- In an incident mainstream systems should be used, i.e. do what you usually do.
- Learning should be shared e.g. from incidents of any magnitude.

Assumptions
- The relationships between the DsPHs and PHE, are set out in this MOU. This ensures the DsPHs and PHE can call on the resources of each other to manage health protection emergencies/ incidents/outbreaks. The DsPHs can delegate responsibilities, by mutual agreement.
- In the national NHS mandate, contract and LA regulations there is a requirement on commissioners and providers to mobilise LA and NHS resources as well as PHE, DPH teams in public health incidents funded from baseline. “The provider must at the request of the coordinating commissioner, provide whatever support and assistance may reasonably be required by the
Commissioners and/or Public Health England in response to any national, regional or local public health emergency or incident.”

NHS national contract para 30.12

- Out of hours the PHE Centre for Yorkshire & the Humber will provide 1st on call cover with appropriate arrangements in place to access local authority expertise and resources for public health incidents. Implement the new processes as required.
- DsPH will have slightly different managerial responsibilities in their LA based on local agreement.
- IPC functions are the responsibility of the LA to support local commissioner.
- The DPH needs to be independent of political influence in declaring an incident.
- Strength of delivery in response to incidents has been based on public health services such as school nursing, health visiting. This needs to be retained by the commissioning arrangements.
- Screening and immunisation commissioning is the responsibility of NHS England, with public health advice and support from the Screening and Immunisation Team (SIT) who are employed by PHE but embedded in NHS England.

Some health protection responsibilities are defined nationally e.g. the architecture of ‘command and control’ for public health emergencies, the content of national NHS standard contracts in relation to health protection, the core functions and standards for PHE, and the public health regulations under which local authorities operate.

Issues

- The practical reality of mobilising staff at the request of the DPH, even if enshrined in contracts as the duty to “cooperate”, may be difficult. This will rely on close collaboration between NHS leads and the DsPH, not just the lead DPH in an LRF area. This is especially true for incidents that are of a “slow burn” nature or small, such as many PH events.
- Information governance to ensure links across all parts of the NHS, PHE and LA are required. This will include surveillance as well as other information.

Overall local roles

DPH role is a recognised leadership role. The DPH is:

- The principal adviser to the LA on all matters relating to health
- Responsible for the public health responsibilities of local authorities, including any conferred by regulation
- The chief officer charged with the health protection duty on behalf of the LA
- Of “chief officer” status in LA and appropriately qualified so appointed consistently with the Faculty of Public Health standards and best practice in local government recruitment.
• A statutory member of the health and wellbeing board, alongside the Director of Children Services and Director of Adult Services.

The SY DsPH will:
• Appoint a lead DPH to Co-chair the Local Health Resilience Partnership with an NHS England lead director. The lead DPH will coordinate the public health input into planning and testing for emergencies across the local authorities in the LRF area. The NHS lead director will represent the LHRP on the LRF.

Public Health England Centre Director:
• Has a leadership role in effectively delivering PHE functions, including specialist advice and 24/7 response, to protect the health of the population in the area that the PHEC covers as well as mobilising PHE resources vertically. This role supports that of the DPH in giving expert advice, surveillance of communicable disease and other hazards.

This support includes:
• Attending the local Health Protection Committee, participating in the preparation and agreement of the local Health Protection Agreement. This details multi-agency roles and accountabilities.
• Providing the core functions of the PHEC in respect of health protection across the LA area in accordance with quality standards.
• Providing a named CCDC for each LA area, who can act as proper officer for local authority functions such as notification of communicable disease.
• Attending the LHRP, and the LRF.
• Agreeing with the SY DsPH how this MOU will be implemented.

NHS England
• Directly commission primary medical care services and support CCGs in the co-commissioning of PMS at all levels.
• Can ask CCGs to carry out some commissioning functions in relation to primary medical care on its behalf.
• Commission some services on behalf of CCGs, where this is agreed by both parties.
• Commission defined national and regional specialised services, drawing on engagement with CCGs and LAs. NHS England will commission specialised services on behalf of organisations in Yorkshire and the Humber.
• Have responsibility for health services for those in prison or custody, high security psychiatric services and armed forces and their families.
• Emergency preparedness and response.
  • Secretary of State can delegate powers of direction over NHS providers to the NHS England.
- Ensure that clear arrangements for emergency preparedness, resilience and response are in place, including arrangements for the mobilisation of the NHS in an incident 24/7.

Clinical Commissioning Groups (CCGs) including non-specialist acute and community services
- Commission health care services not commissioned by the NHS England including non-specialist acute services and community services etc.
- Work with EPRR functions of NHS England, LAs and PHE to ensure commissioned healthcare provision is resilient. Ensure representation on LHRP and maintain a 24/7 rota.
- Support NHS England in discharging its EPRR duties at a local level.

SY local authorities
- Commission healthcare services including school nursing services, substance misuse, alcohol and sexual health services.
- Employ the Director of Public Health and supporting PH team.
- Trading Standards Services have statutory public health functions and plans or programmes around animal health and zoonoses, food standards incidents and illicit alcohol.
- Ensure that clear arrangements for emergency preparedness, resilience and response are in place, including arrangements for the mobilisation of the NHS in an incident 24/7.

JSNA=Joint Strategic Needs Assessment
JHWS = Joint Health & Wellbeing Strategy