Public Health Scotland

Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams

Scottish Health Protection Network

Scottish Guidance
No 12.1 interim update (2020)

Health Protection Scotland

SHPN

The Scottish Government

Document Amendment Log

Version No.	Date	Page No.	Amendment Summary
Interim update (2020)	July 2020	-	Interim update includes updated legislation for the COVID-19 outbreak plus updating of terminology with reference to HPS and PHS. • Changes throughout Annex A and Annex B (paras 4, 5, 6, 10, 14, 28, 21)

Guidance Owner: This guidance is owned by the Scottish Government and published under the auspices of the Scottish Health Protection Network.

The Scottish Health Protection Network (SHPN) is an obligate (jointly owned) network of existing professionals, organisations and groups in the health protection community across Scotland. The aims of the network are:

- To ensure Scotland has a Health Protection service of the highest quality and effectiveness that is able to respond to short term pressures and to long term challenges.
- To oversee the co-ordination of Scotland's health protection services under a network that promotes joint ownership and equitable access to a sustainable and consistent service.
- To minimise the risk and impact of communicable diseases and other (non-communicable) hazards on the population of Scotland and to derive long term public health benefits (outcomes) through the concerted efforts of health protection practitioners across Scotland.

In line with the above, SHPN supports the development, appraisal and adaptation of health protection guidance, seeking excellence in health protection practice.

Health Protection Scotland

Health Protection Scotland is part of Public Health Scotland, a special health board of National Health Service in Scotland. It provides the national level service for Health Protection dedicated to the protection of the public's health in Scotland.

Public Health Scotland

Public Health Scotland is Scotland's lead national agency for improving and protecting the health and wellbeing of all of Scotland's people. We are building on the firm foundations and the proud legacies of Health Protection Scotland, the Information Services Division and NHS Health Scotland. Our vision is of a Scotland where everybody thrives. Our focus is on increasing health life expectancy and reducing premature mortality. We use data, intelligence and a place based approach to lead and deliver Scotland's public health priorities. We provide advice and support to government and local authorities in a professionally independent manner.

Reference this document as

Scottish Government. Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams Scottish Health Protection Network Scottish Guidance 12.1 interim update (2020). Health Protection Scotland/Public Health Scotland, 2020.

Published by Health Protection Scotland/Public Health Scotland

Meridian Court, 5 Cadogan Street, Glasgow, G2 6QE.

First published June 2017, revised in July 2020.

Health Protection Scotland / Public Health Scotland
Meridian Court
5 Cadogan Street
Glasgow G2 6QE
Tel: +44 (0) 141 300 1100
Email: **nss.hpsenquiries@nhs.net**

Professionals involved in the implementation of recommendations proposed in this document are expected to take them fully into account when exercising their professional judgment. The document does not, however, override the individual responsibility of professionals to make decisions appropriate to the circumstances of the individual cases, in consultation with partner agencies and stakeholders. Professionals are also reminded that it is their responsibility to interpret and implement these recommendations in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this document should be interpreted in a way which would be inconsistent with compliance with those duties.

Table of Contents

Acknowledgements

Health Protection Scotland (HPS)/Public Health Scotland (PHS) wish to express their appreciation to all whose efforts made this guidance possible. In particular, to the members of the Guidance Development Group and their constituencies, PHS Graphics, stakeholders and external reviewers, who contributed and reviewed the content of this guidance.

Comments on the published guidance

Comments on this guidance should be sent to the SHPN Guidance Group by emailing **phs.shpn-pmt-submissions@nhs.net**.

Purpose Statement and Scope

The purpose of this guidance document is to provide support to the NHS boards in preparing for or in response to public health incidents. It is intended to be strategic but not prescriptive and should allow for flexibility so that NHS boards can respond appropriately where necessary.

The main body of this guidance document has also been written purposely generic so that it could be applied to any public health or environmental health incident or hazard. More specific information is detailed in the annexes.

For guidance on the management of all Healthcare Infection Incidents and Outbreaks please refer to **Annex C** and Chapter 3 of the National Infection Prevention and Control Manual (NIPCM): **http://www.nipcm.hps.scot.nhs.uk/**

Abbreviations

APHA	Animal and Plant Health Agency
BCP	Business Continuity Plan
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosives
CJD	Creutzfeldt-Jakob Disease
COBR	Cabinet Office Briefing Room
CPD	Continuous Professional Development
CPH(M)	Consultant in Public Health (Medicine)
CMO	Chief Medical Officer
COPFS	Crown Office and Procurator Fiscal Service
CRCE	Centre for Radiation, Chemical and Environmental Hazards
DIM	Detection Identification and Monitoring
DPH	Director of Public Health
DWQR	Drinking Water Quality Regulator
ECDC	European Centre for Disease Prevention and Control
EHO	Environmental Health Officer
EWRS	Early Warning Response System
FAI	Fatal Accident Inquiry
FSS	Food Standards Scotland
GP	General Practitioner
HAI	Healthcare Associated Infection
HIIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIV	Human Immunodeficiency Virus
HIIAT	Healthcare Infection Incident Assessment Tool
HPS	Health Protection Scotland
HPT	Health Protection Team
HRU	Health Resilience Unit
HSE	Health and Safety Executive
HSWA	Health and Safety at Work Act 1974
ICD	Infection Control Doctor
IEM	Integrated Emergency Management
IHR	International Health Regulations
IMT	Incident Management Team
IPCT	Infection Prevention and Control Team
LA(s)	Local Authority
LDCC	Local Disease Control Centre

LRP	Local Resilience Partnership
MIP	Major Incident Plan
MOU	Memorandum of Understanding
NFP	National Focal Point
NHS	National Health Service
NMC	Nursing and Midwifery Council
NSS	National Services Scotland
PSoS	Police Service of Scotland (legal term, also referred to as Police Scotland)
PAG	Problem Assessment Group
PHE	Public Health England
PHEIC	Public Health Emergency of International Concern
PHI	Public Health and Intelligence (business unit of NSS which includes HPS)
PHS	Public Health Scotland
PII	Personal Identifiable Information
RAG	Recovery Advisory Group
RRP	Regional Resilience Partnership
SARS	Severe Acute Respiratory Syndrome
SAS	Scottish Ambulance Service
SBAR	Situation, Background, Assessment and Recommendation
ScoRDS	Scottish Resilience Development Service
SEPA	Scottish Environment Protection Agency
SFRS	Scottish Fire and Rescue Service
SG	Scottish Government
SGHSCD	Scottish Government Health and Social Care Directorates
SGORR	Scottish Government Resilience Room
SHPIR	Scottish Health Protection Information Resource
SHPN	Scottish Health Protection Network (previously HPN)
SMO	Senior Medical Officer
SORT	Special Operations Response Team
STAC	Scientific and Technical Advice Cell
TB	Tuberculosis
UK	United Kingdom
WHO	World Health Organization
XDR-TB	Extensively Drug-resistant Tuberculosis

Foreword

This 2020 revision of the MPHI Guidance has been produced as a rapid update to bring the 2017 edition in line with organisational changes since 2017 and is therefore labelled an 'interim' revision.

The rapid update has been required due to the 2020 pandemic outbreak of COVID-19 infection. Where appropriate, specific information relating to the management of the COVID-19 pandemic has therefore been added to relevant sections (e.g. new legislation). Due to time constraints however, this version has not followed the full standard SHPN guidance revision process. It does not therefore incorporate a review of relevant new scientific evidence. The technical and professional advice in the 2020 interim update therefore remains the same as before. A full scale SHPN guidance review will be carried out when time and circumstances permit in future.

The main organisational change since 2017 relates to Health Protection Scotland, the successor organisation to a series of national health protection organisations in Scotland: initially founded as the Communicable Diseases (Scotland) Unit (CD(S)U) in 1969, then renamed the Scottish Centre for Infection and Environmental Health (SCIEH) and finally re-established as Health Protection Scotland (HPS), a part of NHS National Services Scotland (NSS). On 1 April 2020, HPS was transferred to the new national organisation for public health in Scotland; Public Health Scotland (PHS). HPS now operates as the national level health protection organisation in Scotland, within Public Health Scotland.

Where HPS was used as an abbreviation for Health Protection Scotland in the 2017 edition, HPS/PHS is now used in this version to denote the transfer of HPS to PHS. While PHS becomes fully established and until the eventual migration of the HPS website and all HPS publications to PHS is completed, the name HPS, as a long identified and recognised brand, will continue to be used on external publications and communications of the Health Protection Service of PHS.

1. Introduction

1. When individuals find themselves in situations that may cause them harm they may be able to take action to protect themselves. However, circumstances can arise when the health of the population may be at risk because groups of individuals are exposed, or at risk of being exposed, to infectious disease, high levels of a hazardous substance or adverse environmental conditions. These situations are public health incidents and NHS boards and HPS must take action to protect public health.

2. This document provides generic guidance for the NHS in preparing for, and managing public health incidents in collaboration with partners, especially the local authorities (LAs). It is not intended to be prescriptive and should allow for flexibility so that NHS boards can respond appropriately where necessary.

3. The vast majority of public health incidents do not require an escalated response. However, if an incident escalates and it is deemed appropriate, a co-ordinated response through Resilience Partnerships (RP) may ensue. This response should be based on the guidance provided in '**Preparing Scotland**' which reflects current legislation with regards to the Civil Contingencies Act 2004 (the Act) and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 (the Regulations). As amended in The Civil Contingencies Act 2004 (Contingency Planning)(Scotland) Amendment Regulations 2013.

4. NHS boards are accountable to the Scottish Government Health and Social Care Directorates (SGHSCD) for protecting and improving the health of people living within their geographic areas. NHS boards act to protect human health during incidents within the context of shared responsibility for improving health with LAs and within the multi-agency emergency planning structures. Territorial NHS boards, the Scottish Ambulance Service (SAS) and LAs are Category 1 responders under the Civil Contingencies Act 2004 and the Civil Contingencies Act (Contingency Planning) (Scotland) Amendment Regulations 2013. Health Protection Scotland (HPS) is part of NHS National Services Scotland (NSS) which is the common name for the Common Services Agency for the Scottish Health Service and designated a Category 2 responder. HPS role is to coordinate national health protection activity. Further detail is provided at **Annex B, paragraph 14-16**. NHS boards are encouraged to use the Integrated Emergency Management (IEM) cycle, working together with multi agency partners via Regional and Local Resilience Partnerships.

5. The Public Health (Scotland) Act 2008 provides clarity over the roles and responsibilities of NHS boards and LAs and provides extensive powers to protect public health. Broadly, NHS boards are responsible for people, and LAs are responsible for premises. NHS boards and LAs have a duty to co-operate in exercising their functions under the Act, and to plan together to protect public health in their area. This includes the production of a Joint Health Protection Plan every two years.

2. Background

2.1 Versions and updates

6. The first version of this guidance 'Managing incidents presenting actual or potential risk to the Public Health: Guidance on roles and responsibilities of NHS led Incident Control Teams' was published in 2003 and was revised in 2011 and 2017.

7. This 2020 interim update is not a full revision of the guidance but brings the document up to date in terms of organisation titles and other non-technical issues. The professional guidance content of the document remains largely unchanged since the 2017 updated version.

N.B.: This update was completed in July 2020 at the time of the COVID-19 epidemic. Additional legislation relevant to this outbreak is listed in **Annex A**.

8. The 2017 revision took into account changes in legislation including:

- Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Amendment Regulations 2013;
- International Health Regulations 2005 (IHR);
- Establishment of the European Centre for Disease Prevention and Control (ECDC) in 2005 and public health duties placed on member states through EC Directives including notification of outbreaks likely to cross borders;
- Establishment of Health Protection Scotland (HPS) in 2005;
- Public Health (Scotland) Act 2008;
- Health and Social Care Act 2012 and the establishment of Public Health England with responsibilities related to Scotland especially on chemicals, poisons, and radiation.
- Public Bodies (Joint Working) (Scotland) Act 2014

N.B. See **Annex A** for new legislation relating to the pandemic of COVID-19 infection, added in the 2020 interim revision.

9. Significant incidents and major planned exercise events in Scotland since 2012 included:

- Outbreak of Legionnaires disease in Lothian in 2012;
- Public health incidents planning for Olympics, London, 2012 and Commonwealth Games, Glasgow, 2014;
- Planning and management of the response to Ebola 2013-2015;
- Outbreak of botulism in Scotland in people who inject drugs (PWID), Scotland, 2014-2015;
- Exercise Silver Swan, 2015.

10. To inform the development of the 2017 guidance version, a review of evidence from the above events was undertaken in collaboration with the Scottish Health Protection Network (SHPN).

11. For the 2020 interim update (version 12.1), due to time and resource constraints, no updated review of evidence was carried out and consequently there have been no changes to the technical content or professional advice.

12. This guidance is owned by the Scottish Government but is overseen, coordinated and maintained by SHPN and published by Health Protection Scotland (HPS)/Public Health Scotland (PHS).

2.2 Aim of the Guidance

13. This guidance document aims to provide information that NHS boards and LAs can refer to when preparing for or in response to public health or environmental health events or incidents. It is not intended to be prescriptive and does not replace risk assessment and professional judgement.

14. From this, local and integrated public health incident response plans and procedures should be drawn up under the general direction of the NHS board in close collaboration with Health and Social Care Partnerships and other partners, where appropriate. These should include consideration of topics such as workforce planning, administrative support, capacity and mutual aid.

15. The main body of this guidance document has been written purposely generic so that it could be applied to any incident. More specific information is detailed in the annexes.

16. This document also outlines the roles and responsibilities of Incident Management Teams (IMTs). It covers both planning and response based on a set of key principles and key functions. The guidance does not replicate that found elsewhere but sets out a hierarchy of existing guidance. It also illustrates how the response to an incident will change depending on the level and scale of that incident. It covers single and multi-board incidents and incidents where a national response is required. **Further detail on statutory responsibilities and roles and responsibilities of the various agencies that lead and/or contribute to managing public health incidents, where appropriate, can be found at Annex A and Annex B respectively.**

3. Definitions

3.1 Hazards and Exposures

17. The broad categories of agents which endanger health (hazards) and how we come into contact with them (exposures) are presented below with examples:

Hazards:

- Biological: infectious agents (e.g. bacteria, viruses, parasites, fungi), allergens (e.g. pollen), biological warfare agents;
- Chemical: natural or man-made (e.g. industrial, domestic, chemical warfare agents);
- Physical: radiation - ionising (e.g. radioactive); non-ionising (e.g. UV); emissions from natural sources (e.g. radon); or man-made (e.g. deliberate release);
- Physical: natural particulates and man-made pollution, extreme weather events (e.g. floods, heavy snow) and natural disasters (e.g. volcanoes, tsunamis), forest fire combustion products, hydrocarbons.

Exposures and pathways:

- Person-to-person (via direct contact with individual or indirectly from an individual's immediate care environment (including equipment);
- Food;
- Water;
- Air;
- Animal (including vectors, e.g. insects);
- Environmental.

3.2 Incidents

18. For simplicity throughout this framework, the terms incident and Incident Management Team (IMT) are used as generic terms to cover both incidents and outbreaks.

19. A **public health incident** may arise in the following situations:

- a single case of a serious illness with major public health implications (e.g. botulism, viral haemorrhagic fever, XDR-TB) where action is necessary to investigate and prevent ongoing exposure to the hazardous agent;
- two or more linked cases that could indicate the possibility that they may both be caused by the same known or unknown agent or exposure i.e. an outbreak;
- higher than expected number of cases or geographic clustering of a serious pathogen;
- a high likelihood of a population being exposed to a hazard (e.g. a chemical or infectious agent) at levels sufficient to cause illness, even though no cases have yet occurred (e.g. contamination of the drinking water supply).

20. **The Public Health (Scotland) Act 2008** provides a legal definition of a public health incident that can be summarised as follows:

- if a person has an infectious disease or there are reasonable grounds to suspect that a person has such a disease; or
- a person has been exposed to an organism that causes an infectious disease or there are reasonable grounds to suspect that a person has been exposed; or
- a person is contaminated or there are reasonable grounds to suspect that a person is contaminated; or
- a person has been exposed to a contaminant or there are reasonable grounds to suspect that a person has been exposed; or
- any premises or anything in or on premises is infected, infested or contaminated, or there are reasonable grounds to suspect it; **AND**
- there are reasonable grounds to suspect that the circumstance is likely to give rise to a significant risk to public health.

21. An **Incident Management Team (IMT)** is defined as a multi-disciplinary, multi-agency group with responsibility for investigating and managing the incident.

3.3 Emergencies and Major Incidents

22. The Civil Contingencies Act 2004 defines an **emergency** as an event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. The definition is concerned with consequences rather than the cause or source.

23. Major incident is a widely accepted term used to describe any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the LA. Major incidents are events that may severely disrupt health and social care and other functions (power, water etc) and may exceed even collective capability within the NHS or LA. The response to these events will be co-ordinated through the RRP / LRPs, Scottish and UK arrangements as described in '**Preparing Scotland**' (see **Annex D**), and should be led by police or other agency as appropriate.

4. Tiered Response and Associated Incidents

24. This section describes the level of response required depending on the scale of the incident and the threat to the public health. However, the need to escalate the response may also be influenced by the capacity of the NHS board, LA and partners to respond. The classification of public health incidents and suggested response is outlined in **Table 1**.

25. Where an incident is being led by one NHS board or where two or more NHS boards are involved but with no major disruption of services, **this** guidance is to be used supplemented with any issue-specific guidance. Links to sources of guidance are available in **Annex D**.

26. Where an incident is Scotland or UK wide, with some but no major disruption of services, HPS/PHS will coordinate the incident in Scotland following the principles set out in this guidance.

27. When a Major Incident has been declared (an incident with major disruption of services and/or either affecting Scotland or UK wide), NHS boards, HPS/PHS and the Scottish Government will be working to the local plans based on the principles set out in '**Preparing Scotland**'. Preparing Scotland is the Scottish Government's guidance on responding to emergencies and brings together the guidance on implementation of the Civil Contingency Regulations, good practice and the integration of national and local planning for emergencies. A suite of guidance is available within '**Preparing Scotland**' including specific guidance to be followed by NHS boards, LAs and other agencies on the role of Scientific and Technical Advice Cells (STACs).

28. An incident that takes place in a single NHS board or LA might also escalate sufficiently to necessitate declaration of a Major Incident and the consequent need to invoke the NHS Board Major Incident Plan and/or the RRP / LRP plans including arrangements for a STAC.

29. In addition to '**Preparing Scotland**', the SGHSCD has published NHS Scotland Resilience ' Preparing for Emergencies' - Guidance for Health Boards. This guidance is designed to help NHS boards across Scotland be prepared when problems arise. The document also outlines specific types of incidents and sets out requirements for Boards e.g. chemical, burns and communicable diseases.

30. Further detailed explanation of roles and responsibilities appears in **Annex B** and this includes a full explanation of how NHS board, LA and other agency roles will change as an incident escalates.

31. **Table 1** below provides guidance on the suggested level of response to an incident depending on the threat to the public health, with detail provided in subsequent sections for illustration. It should be noted that Table 1 is intended as a guide only and the response taken may vary depending on the individual circumstances and risk assessment carried out by the IMT managing the incident.

Table 1: Classification of public health incidents and suggested level of response.

Level	Actual or potential impact of incident	Response - Management	Response - Resources	Response - Briefing during incident	Post-incident Reporting
0	**Initial identification of potential incident** - significance in public health terms not clear	NHS board led Problem Assessment Group (PAG)	Local HP team and LA staff	Consider HPS/PHS Consider SGHSCD according to protocol[1] HIIAT assessment required in a healthcare infection incident[2]	Consider hot debrief template if any significant learning identified[3]
1	**Limited local impac**t - no significant risks to public health beyond the immediate group/setting affected in a single NHS board area	NHS board led IMT	Local NHS Board and LA staff as required Support from HPS/PHS and other agencies as required	HPS/PHS Consider HPS/PHS Alert[4] DPH and senior managers in NHS board and LA as appropriate HIIAT assessment required in a healthcare infection incident[2] SGHSCD according to protocol[1] Consider briefing LRP if appropriate	Hot debrief template[3] SBAR[5] to HPS/PHS and NHS board/LA

Level	Actual or potential impact of incident	Response - Management	Response - Resources	Response - Briefing during incident	Post-incident Reporting
2	**Significant local impact** - significant risk to public health beyond group/ setting affected mainly in single NHS board area	NHS board led IMT with links to other NHS boards as required Consider need for Resilience Partnership co-ordinated response if wider consequences	Local HP team and LA staff Consider need for corporate response and/ or mutual aid Support from HPS/PHS and other agencies as required.	HPS/PHS Consider HPS/ PHSAlert[4] HIIAT assessment required in a healthcare infection incident[7] DPH/senior managers in NHS/LA; SGHSCD according to protocol; Consider briefing RRP/ LRP partners & elected members	Hot debrief template[3] SBAR[5] or full incident report for NHS board/ LA and HPS/ PHS
3	**Significant wider impact** - significant risk to wider public health affecting more than one NHS board	NHS board or HPS/PHS-led IMT with input from affected NHS boards as required[6] Consider need for RP co-ordinated response if wider consequences	Local HP Team and LA staff Support from other agencies as required Consider need for corporate response and/ or mutual aid Consider need to activate Business Continuity Plan (BCP) or Major Incident Plan (MIP)	HPS/PHS Alert[3] HIIAT assessment required in a healthcare infection incident Consider UK / EWRS / IHR alert[7] DPH/senior managers in NHS/LA; SGHSCD according to protocol[1] Consider briefing RRP/ LRP partners and elected members	Hot debrief template[3] Full incident report for NHS board/LA and HPS/PHS

Level	Actual or potential impact of incident	Response - Management	Response - Resources	Response - Briefing during incident	Post-incident Reporting
4	**Severe local or wider impact** - major ongoing risk to wider public health affecting one or more than one NHS board with significant disruption of services	NHS board led Civil Contingencies response RP if impact in one NHS board area. or SG led RP response if more than one NHS board area is involved	All available public health resources in the NHS board(s) and LA staff deployed. Request mutual aid Consider HPS/PHS Activate BCP and/or MIP	HPS/PHS Alert[4] UK / EWRS / IHR alert as appropriate[6] DPH/senior managers in NHS/LA SGHSCD according to protocol[1] RRP/LRP partners elected members	Hot debrief template[3] Full Incident report for NHS board/LA and HPS/PHS
5	**Catastrophic impact** - major ongoing impact on public health with major disruption of normal societal functions	SG led RP	All available public health resources in the NHS board(s) and LA staff deployed MIP activated	HPS/PHS Alert[4] UK / EWRS / IHR alert as appropriate[6] DPH/senior managers in NHS/LA; RRP/LRP partners; SGHSCD according to protocol;[1] elected members	Hot debrief template[3] Full Incident report for NHS board/ LA and HPS/PHS

1 See **Annex B** for information on the SGHSCD communications protocol.

2 Levels 0-3: The Healthcare Infection Incident Assessment Tool (HIIAT) should be used to assess every healthcare infection incident i.e. all outbreaks and incidents (including decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services and private providers of healthcare). See **Annex C**.

3 See **Annex K** for hot debrief template.

4 Alert issued by HPS/PHS to NHS boards, SGHSCD and other partner agencies as appropriate (see **paragraph 100** for details).

5 SBAR - Situation, Background, Assessment and Recommendation.

6 Where HPS/PHS is leading the IMT, NHS boards retain responsibility for the local operational management of the incident.

7 HPS/PHS will liaise with PHE to consider and issue UK alert, Europe-wide EWRS (Early Warning Response System) or IHR (International Health Regulations) notification as appropriate. See **Annex A**.

5. Key Principles

32. The key principles of Incident Management are:

- A state of preparedness;
- Clarity of purpose and integrated working;
- An early and effective response;
- Effective communication with the public and among agencies;
- Learning from experience; and
- A prepared workforce.

5.1 A state of preparedness

33. The management of public health incidents should not be regarded as an activity relevant exclusively to an emergency response, but should be integrated into an NHS board's overall health protection arrangements. Effective day-to-day working in the surveillance, prevention, treatment and control of illnesses related to exposure to hazards or disease, coupled with sufficient capacity in these services to respond to unforeseen increases in need, will enable an effective response to an incident.

5.2 Clarity of purpose and integrated working

34. Public health incidents usually require an integrated response from more than one organisation. NHS boards must work jointly with LAs and other partners to draw up co-ordinated incident response plans, protocols and procedures, which should be regularly updated. These should include the capability of involving other neighbouring and national agencies should this be necessary. Some NHS boards have mutual aid arrangements with other NHS boards and the Director of Public Health (DPH) / Consultant in Public Health Medicine (CPHM) and other staff should be familiar with local arrangements. Plans should be cross-referenced to Joint Health Protection Plans as required by the Public Health (Scotland) Act 2008.

5.3 An early and effective response

35. The prompt detection of and response to an actual or potential public health incident is crucial. Front-line medical and laboratory staff should be aware of and competent to diagnose illnesses likely to present immediate public health risks and notify Public Health. Epidemiological systems should be capable of distinguishing clusters of cases requiring further investigation and control. Systems for monitoring water and air quality should be able to detect the presence of hazards likely to endanger public health. NHS boards and HPS/PHS should ensure that mechanisms are in place to collect, collate and continually review information from these sources, to take prompt decisions on the nature and levels of risks to public health, and to co-ordinate action from a range of agencies to reduce these.

5.4 Effective communication with the public and among agencies

36. Where appropriate the NHS boards should keep the public informed about public health incidents as widespread public anxiety can occur as a result of outbreaks and incidents. Where appropriate, NHS boards must brief the Scottish Government, HPS, local health care staff, and partners in local and national agencies. They must work effectively with the media. Systems should be in place to enable the rapid transfer of information on public health incidents. Those charged with managing incidents should regularly report on progress to the agencies to which they are accountable.

5.5 Learning from experience

37. Those involved in managing incidents are expected to evaluate and report on the effectiveness and efficiency of their efforts. NHS boards, LAs and national agencies should share information on public health incidents with interested parties, so that the whole service can learn from the experience of others. The SHPN has a key role in promoting best practice and lessons learned amongst NHS boards and HPS following public health incidents (**Annex F**).

38. The SHPN will maintain a central repository of Incident Learning collected from incident meetings relating to IMTs, Problem Assessment Groups (PAG) or debriefs for public health incidents through the existing Scottish Health Protection Information Resource (SHPIR) web site. Learning can be disseminated through the routine work of the SHPN and symposium.

39. Multi-agency debriefs can also be accessed on each of the RRP Resilience Direct pages and National Lessons Quarterly Reports are issued by the Scottish Resilience Development Service (ScoRDS).

40. The IMT chair is responsible for identifying and following up key learning points.

5.6 Prepared Workforce

41. To help support the implementation of this guidance in the workplace, staff from all agencies who may contribute to managing public health incidents should be offered appropriate workforce education development opportunities (including CPD activities) on an on-going basis. HPS/PHS and NHS Education for Scotland strategically lead on national health protection workforce education initiatives including the development and delivery of quality assured educational resources and training events in relation to incident management. This work is guided and prioritised by the SHPN Workforce Education Development Group and related national groups.

42. In addition, it is recommended that all staff who may be required to contribute to a resilience multi-agency group in response participate in the ScoRDS core-learning programme so as to develop and maintain their knowledge and skills for effective resilience multi-agency working.

6. Organisational Arrangements

6.1 Accountability and reporting arrangements

43. NHS boards and HPS/PHS share responsibility for improving and protecting public health with LAs. In addition, representatives from other statutory agencies will be involved in planning for and managing public health incidents, each agency fulfilling a remit on behalf of their own organisation and being responsible to it for actions taken in this regard. Each will have its own statutory duties to fulfil with regard to protecting public health. NHS boards, as the lead agency for protecting health, are responsible for the overall integrity of the arrangements for planning for public health incidents, and for the effectiveness of the incident response. See **Annex A** and **Annex B** for more information on roles and responsibilities.

44. NHS boards should reach agreement with their partners, especially LAs, on:

- Developing, training and testing joint plans for managing public health incidents. Normally this will be through Joint Health Protection Planning arrangements. Most public health incidents **do not** require a LRP co-ordinated emergency planning response;
- Reviewing and approving incident plans. Members of the NHS board and where appropriate, political or appointed representatives of other organisations should be involved in this process;
- NHS boards and /or HPS/PHS should:
  - Follow up the recommendations made in IMT reports;
    - Decide where the IMT report should be shared. The IMT group should discuss and make a recommendation on how to share the report. The IMT Chair should then recommend the sharing procedure to DPH and / or NHS board Chief Executive.
    - Follow up on lessons learned (this guidance recommends that this should be the responsibility of the IMT chair);
    - Support a central repository for IMT and SBAR reports and/or debriefs for public health incidents through the existing Scottish Health Protection Information Resource (SHPIR) web site. Learning points will be extracted and collated nationally from submitted reports/debriefs to inform future guidance and service design as continuous improvement, resourced through the SHPN Portfolio Management Team which encompasses HP Service Delivery Managers, Healthcare Scientists and Project Support Officers;
    - Liaise with SGHSCD and other national agencies in developing national plans and procedures and reviewing the overall effectiveness of public health incident management in Scotland.

45. NHS boards should appoint a lead officer to be responsible for putting these arrangements in place and updating them as appropriate. Normally this will be the Director of Public Health. He/she is responsible for ensuring that the NHS board has sufficient resources to discharge the functions detailed in this guidance.

46. Occasionally there will be indications that the IMT is not working as effectively as required. In such instances, the lead NHS board officer (usually the DPH) for assessing IMT performance should take steps with senior management counterparts in the other agencies participating in the IMT, to assess and remedy any shortcomings.

6.2 Joint planning for public health incidents

47. NHS boards should draw up co-ordinated incident plans with LAs and these should be formally endorsed by agencies involved. These plans should be kept under review and jointly exercised at least every three years unless a significant incident has occurred. The plans should outline a generic approach to managing incidents and be suitable to address the investigation and management of incidents resulting from exposure to scenarios involving microbiological, chemical, radiation and other hazardous agents.

48. It is essential that arrangements for handling incidents are integrated with overall wider multi-agency arrangements for emergency response. This is particularly important if there is any question of any criminal activity being involved in the causation of the incident e.g. the illegal supply of drugs and sale of food unfit for human consumption. However, the control of the incident and prevention of further illness must remain the priority. The IMT Chair must consider an early meeting with Police Scotland and other key partners to agree the most effective forensic recovery plan if the police are not members of the IMT.

49. Personal Identifiable Information (PII) may be shared with IMT members on a need to know basis with the agreement of all IMT members to enable taking appropriate control measures to protect public health. If any members of the IMT representing one of the participating agencies have any objections to PII data sharing, then the chair of the IMT should discuss this issue with the Caldicott Guardian of the agency concerned to resolve this matter as soon as possible so that appropriate and timely investigations and control measures can be taken without delay. Further information is given in **Annex E**.

50. NHS boards and HPS/PHS should reach agreement with their emergency planning partners, and in particular Police Scotland, about emergency response arrangements in the circumstances when criminal activity is implicated and consideration should be given to developing memorandums of understanding.

51. In certain incidents, e.g. those involving the deliberate release of a chemical or biological agent, the NHS board, while retaining its own responsibilities, will be required to play a key part in the overall response led by the Resilience Partnership (RP) of the area in which the incident occurs and to have regard to the potential requirement to protect the crime scene in order to avoid prejudicing prosecutions.

52. When incidents involve, or have the potential to involve, criminal proceedings, it is important that the local Crown Office and Procurator Fiscal Service (COPFS) office is kept informed. COPFS has an interest in any deaths which are sudden, unexpected, unexplained or potentially suspicious (giving rise to potential criminal prosecutions).

53. NHS boards, HPS and LAs must ensure that adequate resources are made available from the outset to investigate and manage the incident including the provision of suitable accommodation, facilities and sufficient experienced administrative support, particularly in the case of prolonged investigations. An inadequate initial response may have serious consequences for the wider public health. Investigations should never be delayed for financial or contractual reasons. Representatives of agencies on the IMT should have sufficient devolved authority to commit agency resources required to investigate and control an incident. These issues should be discussed among agencies as part of the arrangements for formally agreeing joint plans.

6.3 The Incident Management Team (IMT)

6.3.1 Arrangements for Leading the Team

54. It is the responsibility of the NHS board to call an IMT. In public health incidents, a Consultant in Public Health (CPH(M)) or Specialist in Public Health will lead the investigation and management of the incident on behalf of the NHS board, chair the IMT and co-ordinate the multi-agency IMT response. Usually this will be a CPH(M) with responsibility for Health Protection who will be acting with the delegated authority of the Director of Public Health. The CPH(M) will be responsible for initial action in response to the incident and convening an IMT. The size and nature of the incident will determine the exact arrangements and the IMT Chair can delegate some of the assigned tasks as necessary.

55. In a healthcare setting, the CPH(M) or the Infection Control Doctor (ICD) will chair the IMT depending on the circumstances and this should be agreed in advance and documented in the local plan. The ICD will usually chair the IMT, lead the investigation and management of incidents limited to the healthcare site, where no external agencies are involved and where there are no implications for the wider community. The CPH(M) would normally chair the IMT where there are implications for the wider community e.g. during TB or measles incidents. For rare events, or where there is doubt about who should lead the investigations, the CPH(M) and ICD should discuss and agree who should chair the IMT e.g. during CJD or hepatitis B/HIV look backs. Where there is an actual or potential conflict of interest with the hospital service, it may be preferable for the CPH(M) to chair the IMT in discussion with DPH and HAI Executive lead (if necessary).

6.4 Problem Assessment Group (PAG)

56. In some circumstances where it is unclear if there is a threat to the public health, the CPH(M) may choose to convene a Problem Assessment Group (PAG) to undertake an initial assessment and determine if an IMT is required.

57. Outcome of the initial assessment may be one of the following:

- No significant risk to the public health - continue to monitor and PAG stands down;
- Potential/actual significant risk to the public health or environment and/or media interest - IMT required;
- Potential for significant public and/or media interest - IMT required;
- Not possible to determine if there is significant risk with current information - further investigation required. PAG or delegated member of PAG continues to review but no IMT at this stage.

58. The PAG should not delay definitive action and would normally only meet on one occasion to assess the situation.

6.5 Membership of the IMT

59. The membership of the IMT will vary depending on the nature of the incident. The IMT Chair will decide on the composition of the IMT and invite members to attend. The IMT would **normally** include:

- NHS board chair (usually a CPH(M));
- Health Protection Nurse Specialist;
- Local authority Environmental Health Officer;
- Specialist with expertise in the detection and characterisation of the hazardous agent involved in the incident e.g. a consultant microbiologist, public analyst;
- Infection Control Doctor and Infection Prevention and Control Team representative, if appropriate;
- Appropriate Health Protection Scotland/Public Health Scotland representation;
- Corporate communications officer;
- Administrative support;
- SGHSCD representative (e.g. Senior Medical Officer or policy officer) may attend in an observer capacity;
- Others, as appropriately identified by other IMT members.

60. The IMT may include primary care representatives, senior management, managers of affected care areas, clinicians, pharmacists, estates and occupational health as required.

61. It is recommended that the following remain standing agenda items at IMT meetings:

- Membership – Assess if the membership structure is appropriate and remains appropriate throughout an incident. It should be determined locally, be fit for purpose and remain flexible. Roles must be appropriate and members may feed into or integrate with LRP to work together. In particular, STACs may be operational during major public health incidents;
- Resourcing;
- Framework (incident management structure);
- If work escalates or goes beyond the scope of the IMT, consider seeking support through LRP/ RRP / Regional Resilience Coordinator and other personnel.

62. The IMT may also contain officers from other relevant agencies e.g. Scottish Ambulance Service, APHA, Scottish Water, SEPA, FSS etc whose input is essential to manage the incident. This could also include Third Sector organisations where appropriate, e.g. Scottish Drugs Forum. However, it is important that the IMT does not become too large as it may lose focus.

63. Sometimes a Scottish Government official will attend the IMT to facilitate liaison between the IMT and SG. In such instances, unless otherwise indicated, his/her status on the team will be as an observer.

64. The status of IMT members should be clarified at the first meeting i.e. full members, in attendance or observers. Prospective members of the IMT should declare any potential conflict of interest as individuals or on behalf of their organisations. Where a declaration of potential conflict of interest is made, it should be recorded and a decision made on the individual's status. Individuals who are not full members may continue to attend the IMT by invitation, but should not expect to have equal rights in terms of determining the conduct of the investigation, the advice given to the public, the content of press statements, or the final IMT report.

6.6 Role of the IMT

65. The IMT is an independent, multi-disciplinary, multi-agency group with responsibility for investigating and managing the incident. The IMT provides a framework, response and resources to enable the NHS board and other statutory agencies to fulfil their remits which are:

- To reduce to a minimum the number of cases of illness by promptly recognising the incident, defining how cases have been exposed to the implicated hazard, identifying and controlling the source of that exposure, and preventing secondary exposure;
- To minimise mortality and illness by ensuring optimum health care for those affected;
- To inform the patients, actually or potentially exposed groups, staff, clinical and management colleagues, public, their representatives and the media of the health risks associated with the incident and how to minimise these risks; and
- To collect information which will be of use in better understanding the nature and origin of the incident and on how best to prevent and manage future incidents.

66. In carrying out this remit, the IMT should assist the relevant statutory organisations, in a timely manner to:

- ensure that systems are in place to collect and collate all relevant information and verify, review and interpret its significance;
- carry out a risk assessment and decide on courses of action necessary to protect the health of the public;
- co-ordinate the investigation and management of the incident within the protocols and codes of practice of the agencies involved and having regard to extant legislation;
- liaise with HPS/PHS, SGHSCD and other relevant agencies to share information, draw on their expertise and ensure the agencies implement the actions that they are responsible for. See **Annex E** for more detail on sharing personal/patient information;
- co-ordinate the issuing of advice and information to the public directly and through the media, liaising as necessary with the SGHSCD communications team;
- ensure arrangements for the care of patients are in hand, and keep all relevant clinical professionals updated;
- agree criteria for standing the IMT down and declaring the end of the incident; and
- produce a full IMT report or SBAR for the NHS board Clinical Governance Committee normally within three to six months of the debrief. The report should be shared with SHPN if appropriate to ensure lessons identified are captured and shared (see **Table 1**).

67. The IMT may require to set up subgroups to consider specific aspects of the incident within their remit e.g. care of people, clinical care, communications etc. RPs can be used to add value by managing wider aspects of the response, removing them from the IMT. Details of these can be found in '**Preparing Scotland**'.

68. All members of the IMT must have due regard to the confidentiality of information discussed in the IMT meetings. However, the IMT must also bear in mind the need to demonstrate openness and transparency when reporting the facts to the public, and the possibility of records being released under the terms of the Freedom of Information Act. All agencies represented in the IMT must ensure that relevant staff within their own organisations are regularly briefed about the incident.

69. Representatives from the individual agencies involved in an IMT should normally only carry out investigations, assess risk to the public health, take control measures, and make public statements after full discussion and agreement within the IMT, or, if that is not practical, with the IMT Chair. The IMT should bear in mind that some agencies i.e. the FSS and HSE are not bound to seek agreement from the IMT Chair or IMT itself, however the normal expectation would be that they would act in accord with the IMT.

70. Meetings should be kept to a minimum and be as short and efficient as possible without compromising safe working. Careful consideration should be given to the composition of the agenda, the timing, duration and frequency of meetings. Attention should be paid to the context of public concern in which an incident may be taking place, the different information requirements of the print and broadcast media, and the crucial issue of timing, to ensure optimal dissemination of information. Responsibility for this should be clearly assigned. Facilities should be in place to support the IMT i.e. identified room with the appropriate technology which can be commandeered immediately. A draft IMT agenda is included in **Annex G**.

6.7 Administrative support

71. NHS boards and HPS/PHS must ensure experienced administrative support is provided to support the IMT and is available in and out of hours. Accurate records must be kept of all IMT meetings and audio recordings should be considered. Provision must be in place to support good record keeping throughout the incident from the initial notification to the completion of the report. All discussions held, including phone and email, decisions made, and actions taken should be recorded. Agencies should ensure that administrative support is available at all times as required, including after the IMT has stood down for the production of a final report or any possible Freedom of Information Requests. In large or complex incidents, senior administrative support must be available and may need to include loggists and action chasers.

72. The IMT Chair should ensure that the findings of the initial investigation; timing and content of communications; outcome of initial risk assessment; decisions taken and all other relevant matters are carefully documented. This documentation should also include reasons why certain actions were not taken/appropriate as well as why actions were taken/appropriate. A formal Decision Log that records options considered and decision taken should be used to facilitate this process (template attached at **Annex H**).

73. Support for the IMT: In some situations, pressures may be brought to bear on the IMT, which could distract it from its core purpose of managing the public health aspects of the incident for example when there is a sustained, large volume of enquiries about the incident from the public, media and politicians. In large and/or lengthy incidents, the IMT may require to consider the activation of Major Incident Plans and wider aspect of Business Continuity Plans both internally and across the member organisations. In addition, the IMT Chair may require to discuss with the Director of Public Health the need for a corporate response by the NHS and partners to provide additional support within the locally agreed structures, for example an Incident Management Support Team or where necessary Resilience Partnership. Very large incidents can have secondary impacts on a range of services e.g. hospital care, food and water supply and may lead to the need for increased expenditure with money being reallocated from existing budgets. In large and/or lengthy incidents, there will be a need to make appropriate provisions for relieving IMT members who may become fatigued. In such instances, the IMT Chair should discuss with the Director of Public Health the need for a corporate response by the NHS and partners to provide additional support within the locally agreed structures, for example an Incident Management Support Team. In some circumstances, it may be necessary to consider activating Business Continuity and/or Major Incident Plans.

74. The IMT chair and the DPH should consider whether the incident can continue to be dealt with by the Health Protection Team or whether the incident requires a wider Public Health and/or NHS board response. It may be necessary to reprioritise the activity of the public health department and this should be done in a planned way. Shift systems should be implemented if it is anticipated that an incident may be large or protracted. These issues should be documented in Business Continuity Plans.

75. The LA and other agencies involved in the IMT should also consider the impact of the incident on their resources and consider the need to activate their own Business Continuity Plans.

76. LRPs and RRPs will work with the IMT to provide support as required.

The support required from other NHS board staff or partners could include:

- supporting the IMT by providing additional information and resources needed for its effective functioning;
- if necessary, acting as an alternative resource to help deal with certain external factors, including aspects of media enquiries;
- making tactical/strategic decisions on the wider impact of the incident on services not directly implicated in the incident;
- mobilising additional resources to aid the management of the incident; and
- responding to requests from the IMT for additional help required to resolve problems which may compromise the function of the IMT.

6.8 Decision making by the IMT

77. The IMT is not simply an advisory group but an independent group set up specifically to investigate and manage the response to a public health incident. The IMT Chair's leadership role is delegated by the DPH on behalf of the NHS board Chief Executive and the NHS board, as the lead agency for protecting public health. The IMT Chair, therefore, has overall responsibility for managing a public health incident. As such the leadership of an IMT is invested in the IMT Chair and he/she will co-ordinate the activities of the other agencies. Where consequences arise as a result of the incident but not directly related to public health issues, Resilience Partnerships may be established involving the necessary multi-agency representation to manage these consequences.

78. It is expected that the IMT will reach collective decisions but it may be necessary for the IMT Chair to make difficult decisions if the IMT cannot resolve an issue by consensus or if urgent decisions are required between IMT meetings. The final decision on action rests with the IMT Chair. However, in some circumstances it may be necessary for emergency action to be taken to protect the public health e.g. under the Use of Hygiene Emergency Prohibition procedures. The LA should advise the IMT chair that emergency action has been taken as soon as possible.

79. All members of the IMT must recognise their individual roles as a member of the IMT and that they should be in a position to commit to act on behalf of their organisation.

80. Usually all members of the IMT will commit to collective decisions. In the rare event that a member is not supported by his/her organisation to a collective agreement to act, and this cannot be resolved by the IMT Chair, then the issue must be resolved at a higher executive level in both organisations. The DPH of the NHS board should work to achieve this in the first instance, and only if this does not achieve resolution should the Chief Executives of both organisations work to resolve the issue. Escalation to Scottish Government would not normally be envisaged, as issues of significant public health risk should be given priority by all organisations involved.

81. In some incidents, the IMT Chair may be required to contribute to a Scotland wide IMT led by HPS/PHS. In this situation, the IMT Chair retains responsibility for the investigation and management of the local public health response to the incident.

82. If the RP requests that the DPH convene a STAC, this response will be based on the '**Preparing Scotland STAC guidance**'. In this situation, the NHS board still retains the responsibility for the investigation and management of the public health aspects of an incident, accountable to the NHS board, irrespective of an RP led response. There is still a need for the NHS board to ensure that the public health tasks associated with an incident are addressed in line with this guidance.

83. Depending on the situation there are various options:

- If an IMT has already been set up, it could carry on as an NHS board led IMT and the IMT Chair could agree with the RP chair that the IMT would act as the nominal STAC. In this case the focus of an IMT/STAC would remain primarily the investigation and public health management but additional members (e.g. SEPA, Scottish Water etc) could be invited to ensure that any other scientific or technical issues raised during the incident could be addressed if requested by the RPs.
- The alternative model recognises that, in view of an outbreak being primarily a public health incident, there is an overriding need for the NHS board resources to be focussed on maintaining the IMT and addressing the incident from the public health perspective. Hence the IMT should remain intact and separate but as a sub-group of a STAC, itself chaired by the DPH or CPH(M). In this alternative option, the IMT (as a STAC sub-group) should continue to deal with all issues pertinent to the public health response (as per this guidance) and should maintain contact with the STAC but via a liaison representative; the IMT is then free to leave any other scientific or technical advice issues to the rest of the STAC.
- The first option is likely to be preferable where NHS resources are limited. If NHS resources are particularly stretched, there is also the option for the STAC to be chaired by a non-NHS board agency.
- The structures implemented in any incident should be kept under review and essentially must address the needs of the particular situation and will also be influenced by the resources available.

84. In the hospital setting, the Infection Control Doctor (ICD) will usually chair the IMT and lead the investigation and management of healthcare infection incidents. Where there are implications for the wider community e.g. TB or measles, or rare events such as CJD or a Hepatitis B/HIV look back, or where there is an actual or potential conflict of interest with the hospital service, the DPH/CPHM may chair the IMT.

85. In LA premises, the LAs should recognise the potential for conflict of interest and ensure that measures are in place to manage such conflict.

6.9 External Advice

86. There may be circumstances when the IMT needs to seek external expert advice beyond what can be provided by member agencies. This should be discussed and agreed at the IMT.

6.10 After the incident

87. The IMT must decide when the public health response to an incident is over and, if it is appropriate, make a statement to this effect for release to the general public and other interested parties. It is suggested that this would come following formal assessment and report that there is no longer a significantly increased risk to the public health. However, it should be borne in mind that IMT members could be required to give evidence to any future inquiry.

88. The IMT should document the incident to ensure lessons learned are identified and shared. More detail on debriefs and IMT reports is provided in **section 7.8** on evaluation and documentation.

7. Key Functions of Incident Management

7.1 Introduction

89. Local incident management plans should describe how the key functions in managing incidents will be implemented in each NHS board area. These include the following and are described in more detail below:

- Surveillance, notification and reporting;
- Identification and initial response;
- Investigation;
- Risk assessment;
- Risk Management;
- Risk Communication;
- Audit, evaluation and documentation.

7.2 Surveillance, notification and reporting

90. An essential part of incident management is the recognition of a change in the distribution of illness or the occurrence of an illness of major public health significance. To this end surveillance, i.e. the timely collection and collation, analysis and dissemination of information for action, is a vital tool. Following the implementation of the Public Health (Scotland) Act 2008, all registered medical practitioners have a statutory responsibility to notify NHS board Health Protection Teams of any of the specified diseases or health risk states where there may be a significant risk to public health. These should be reported by telephone on the basis of reasonable clinical suspicion rather than awaiting laboratory confirmation. The telephone call should be followed up by written notification using the electronic system, Scottish Care Information (SCI) Gateway, within three working days or by written notification. (Schedule 1 of Public Health (Scotland) Act 2008 **http://www.legislation.gov.uk/asp/2008/5/schedule/1**)

91. Local diagnostic laboratories are also required under the Act to notify specified organisms within the same working day, followed by written/electronic notification within ten days. (Schedule 1 of Public Health (Scotland) Act 2008, **http://www.legislation.gov.uk/asp/2008/5/schedule/1**)

92. NHS boards and HPS should have in place systems which enable them to analyse and interpret information collected through surveillance and identify:

- an increase in the incidence of a communicable disease, or of an illness which may be due to an environmental hazard, over that expected for a specific person, place or time;
- the clustering of cases, in person, place or time, of communicable disease or illnesses which may in part be due to environmental hazards;
- the occurrence of a single case of a serious infection with significant public health implications;
- the occurrence of a novel pathogen;
- a clustering of cases of severe illness which have an unusual clinical presentation;
- a clustering of unexplained illnesses; and
- the occurrence of an event which has led or has the potential to lead to a community or significant proportion of the population, being exposed to a hazardous agent.

93. NHS boards and HPS/PHS should agree with their partners reporting mechanisms which include criteria ('triggers') for notification of certain types of potential incidents (such as water failures) requiring further investigation and risk assessment. The Public Health Act has established a framework and timeframes for registered medical practitioners and diagnostic laboratories to notify the Health Protection Team (HPT) of diseases, organisms or health risk states. However, NHS boards and HPS/PHS should also have plans in place requiring that partner agencies report incidents when:

- Statutory agencies responsible for monitoring air, food and water quality, have information that indicates there may be a risk to public health; and
- Emergency services reporting incidents in which the public may be/have been exposed to harmful agents such as chemical spills.

94. In addition to the formal notifications system described above early identification of a threat to the public health may be identified through informal epidemiological intelligence based on excellent working relationships with local partners e.g. EHOs, GPs, clinicians but also with care homes, schools etc. This facilitates the possibility of early intervention and prevention of illness.

7.3 Identification and initial response

95. The occurrence of one or more of the events indicated above should alert the NHS board and in particular the CPH(M) to the possibility of an incident. Incidents, particularly those involving more than one NHS board area, may be recognised through the national surveillance system operated by HPS/PHS. In certain circumstances e.g. an immediate response to a chemical incident, one or more agencies may have to take urgent action to protect the public before notifying the NHS board. However, the NHS board must be notified as soon as the initial control steps have been taken. This will allow the NHS board to activate a multi-agency response to implement further measures to protect the public.

96. On recognition of one or more of these events, the NHS board should ensure that:

- all relevant agencies with a responsibility for the investigation and management of the incident are informed;
- steps are taken to gather further information about the cases and how they may have been exposed to the hazardous agent;
- an initial risk assessment is undertaken;
- if possible, a working hypothesis as to the cause of the incident is formulated;
- urgent control measures are put in place to protect public health (if necessary).

97. If the initial risk assessment indicates that there are cases of an illness which have significant public health implications and/or there is a probability of the public continuing to be exposed to an infective or other hazardous agent, steps should be taken to convene an IMT. Based on an initial risk assessment, the NHS board should reach a view in conjunction with the partners about the need for specific control measures. These should be instituted as soon as possible and should not necessarily await the convening of an IMT if there is an urgent need to protect public health.

98. Some incidents may be over by the time they are reported or discovered. In this case the focus of the investigation will be on identifying the cause and on the prevention of a future episode. An incident may be limited in terms of size and clinical significance, e.g. an outbreak of norovirus in a care home. In such instances, it may not be necessary to convene an IMT. However, should the outbreak escalate or be a cause for concern, an IMT may be required.

99. Once the initial risk assessment has been carried out (see also **Paragraph 118**), a decision should be made on how the risk is likely to be perceived by the public; how and when it should be communicated and the best medium for doing so. In exceptional circumstances, if there is a need for urgent preliminary communication, it is not necessary to wait for the IMT/PAG to meet. There may also be a need to involve the Scottish Government communications team depending on the nature and scale of the incident.

100. NHS boards, once they have assessed that an incident is or may be occurring, should contact HPS/PHS and the appropriate team within the Scottish Government who will alert appropriate Ministers if appropriate. On receipt of an alert, HPS/PHS should agree with the notifying NHS board whether agencies other than those immediately engaged in the management of the incident, should receive an appropriate alert. This assessment should be based on the likelihood of the incident spreading to other NHS boards, of it receiving extensive media coverage likely to cause public concern or of it being of such a scale that mutual aid may be requested. HPS/PHS should indicate in the alert the level of response required by the receiving agencies:

- for noting - no action required;
- for action - monitoring only;
- for action - monitoring and wider dissemination to NHS; or
- for action - monitoring, wider dissemination and specific measures to be taken by recipient.

101. When appropriate, HPS/PHS will decide, in conjunction with SGHSCD and PHE, if an Early Warning Response System (EWRS) or International Health Regulations (IHR) notification may be required (**Annex A**). HPS/PHS should also record details of the incident received from the notifying NHS board in an Incident Surveillance System developed to monitor the overall number of these types of events occurring in the country, to facilitate assessing their overall impact and the best means of managing them.

7.4 Investigation

102. From the information gathered from the initial investigation, it may be possible to form a working hypothesis about the route of exposure to the infective agent or the environmental hazard involved, the source and level of that exposure, the nature and size of the population exposed or likely to be exposed, and the degree of risk to the public health. The IMT will then decide how to progress a fuller investigation to test the hypothesis. NHS Boards and HPS/PHS should have a clearly defined pathway to define costs for additional work required to access expertise and pay the associated costs.

103. The investigation should usually consist of three elements:

- an epidemiological investigation;
- an investigation into the nature and characteristics of the implicated hazard (in communicable disease incidents, this would be a microbiological investigation); and
- a specific investigation into how cases were exposed to the infective agent or other hazard (e.g. food supply and hygiene, hygiene in healthcare settings) to inform control measures.

104. Most incidents merit detailed description, and a descriptive epidemiological study of cases should be carried out. The IMT should agree a case definition for the purpose of the incident and regularly review and revise this definition, as appropriate, throughout the incident investigation. Standard surveillance forms should be available prior to the incident under investigation, and should be modified for the purposes of the incident. Information from individual cases should be collated preferably using an appropriate computer software package. Line listings and standard epidemiological output, e.g. epidemic curve, incidence rates and exposed populations, time line etc should be presented to the IMT. The working hypothesis may then need to be reviewed. Based on the outcome of the descriptive epidemiological investigation, the IMT may decide to carry out an analytical epidemiological study. HPS/PHS is a resource which can provide expertise and support. It is essential to involve scientific, especially diagnostic laboratories, as early as possible in the investigation of an incident. The scientific specialist on the IMT should advise on the taking of appropriate specimens and arrange for relevant investigations. This should include liaison with the relevant reference laboratory in Scotland, or other specialist laboratories in the UK if necessary. The public analyst should arrange for appropriate investigation of non-human samples e.g. food samples. It is essential that accurate results of tests are available as rapidly as possible to the IMT. The IMT should therefore consider carefully the best use of laboratory resources available, taking into consideration turn-around times for testing and reporting. The laboratory may need to prepare for a substantial increase in samples and plan for surge capacity. Guidance on the submission of clinical samples should be a high priority and should be communicated to all relevant clinicians. As part of the incident investigation, the specialist should advise on the information required by the laboratory to ensure prompt identification of such samples and to distinguish them from other samples.

105. Specific investigations should be undertaken into the reasons for and circumstances in which cases were exposed to the hazardous agent implicated in the incident. This will often involve the taking of appropriate samples for microbiological or other laboratory testing. It also may involve tracing the likely passage of the agent causing illness from the most probable source of contamination or infection to the specific circumstances in which the case was exposed to it. NHS boards and HPS/PHS should liaise with LAs and other agencies in ensuring that relevant protocols for this type of investigation are in place.

106. In the early stages of an investigation, the IMT members should consider whether a criminal investigation is likely to ensue. If so, the Crown Office should be consulted to provide appropriate guidance on evidential procedures required to enable progress but without jeopardising the investigation or control measures.

107. The IMT Chair and others within the IMT who have powers to conduct investigations with a view to potential future criminal proceedings should individually and collectively consider the implications of any potential criminal investigation at the outset. It is therefore essential that all IMT members and their respective organisations record and keep detailed and accurate records from the outset of any investigation. Instigating critical control measures should initially be the objective of the IMT collectively. The results of the epidemiological, microbiological and environmental investigation must be considered together before reaching a conclusion as to their significance to the control of the incident. This should be linked to previous knowledge of the illness involved and local circumstances. Considering the findings from each investigation singly may be misleading. IMTs should take care to assess where the findings may be coincidental. In particular the IMT should review associations which may be considered causal and assess whether there is evidence of bias in the investigation and/or the strength of a specific association.

7.5 Risk Assessment

108. Based on the findings from the investigation and an assessment of the effectiveness of control measures taken, the IMT should assess the ongoing risk to the public from exposure to the hazardous agent involved in the incident. The IMT may wish to reflect on principles within HIIAT for a risk assessment. The purpose of this assessment is two-fold, to assess:

- Whether exposure is ongoing, and
- the impact of exposure (numbers affected and severity).

109. Risk assessment essentially entails appraising the balance of evidence collected in the incident investigation and reaching a view as to whether it indicates that there is an ongoing significant threat to public health. The risk assessment should be dynamic and regularly reviewed e.g. at each IMT.

110. Points to consider in risk assessment:

- **Severity:** Dynamically assessed risk of the degree of foreseeable harm that may be caused to individuals or to the population and possible issues with recovery.
- **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 media interest, public concern and attitudes, expectations, pressures, strength of professional knowledge and external factors including political decisions.

111. Conclusions derived from this process are principally a matter of professional judgement. However, for reasons of public accountability and understanding, it is essential that this process is as transparent as possible. The IMT should discuss and record the outcome of the risk assessments. Once the risk has been assessed, a decision should be made on how the risk is likely to be perceived by the public. This should inform the development of specific communications to the public about the risk and how it is being reduced.

7.6 Risk Management

7.6.1 Control measures to prevent further exposure

112. The principal objective of control measures is to reduce the risk to public health. Control measures may be directed at the source of the exposure and/or at affected persons to prevent secondary exposure to the agent.

113. Specific control measures will vary according to the type of incident. In summary they may include the following:

- advising specific groups or the general public on how to avoid and minimise risks e.g. advising condom use, preventing needle sharing, promoting safe food handling, avoid contaminated sites;
- delivering healthcare interventions to prevent the transmission or development of illnesses or their complications e.g. antibiotics, chemical antidotes, immunisation;
- implementing hygiene measures which reduce or eliminate contamination with hazards e.g. respiratory and hand hygiene, environmental decontamination, dust control measures;
- review the current standards of practice to identify areas for immediate improvement;
- curtailing normal daily activities or services e.g. excluding from school or nursery, closure of food preparation or retail premises, either through voluntary agreement or enacting regulatory powers, closing wards/care homes to admissions, limiting public access, identifying circumstances in which usual practices (agricultural, industrial, commercial) should be modified;
- food withdrawals or food warnings; and
- providing alternative arrangements for normal services e.g. drinking water supplies.

114. A range of agencies may be involved in controlling an incident. Many of the measures taken have to be carried out within a legal or statutory framework. At times voluntary agreements will be sought with a range of parties implicated in the incident e.g. food business operators. Wherever possible these voluntary agreements should be recorded and if possible signed by both parties. It is important that professionals and the general public are provided with relevant information on the control measures being taken so that they can understand their relevance to their own safety/practice.

115. Control measures taken by one agency will have implications for those taken in another therefore it is essential that the IMT maintains an overview and co-ordinates such measures. When controls involve or have the potential to involve criminal proceedings, it is important that the local Procurator Fiscal's department is kept fully informed. The agency responsible for a specific control measure should check that the measure is being put in place in the time required and is having the desired impact as defined by the IMT, then report on this to the IMT.

7.6.2 Patient Assessment and Care Measures

116. A major public health incident can lead to significant pressure being placed on primary care and hospital services. It is important that in such instances the IMT establishes effective liaison with senior managers of the NHS board, hospitals, pharmacists, GPs, Primary Care and Community Health services.

117. The IMT should request advice from clinical colleagues on the appropriate management of patients directly involved in the incident. Guidance on the clinical management of patients should be provided to Primary Care, Out of Hours Services, NHS 24 and hospital doctors.

118. The IMT may also need to consider the need to develop plans for the enhancement of specialist hospital based services; support arrangements for GPs and other primary care services; mechanisms to coordinate services between primary care and between and among different hospitals (if more than one is involved). The plan should also indicate arrangements for the admission of patients; the content of communications to professionals, patients and relatives; contact points for enquiries and infection control measures to prevent transmission in healthcare settings.

7.7 Risk Communication

7.7.1 General

119. NHS boards and HPS/PHS should use the Health Protection Network guidance 'Communicating with the Public about Health Risks' to inform their risk communication strategy (see **Annex D**) for links to guidance.

120. Risk communication is an essential part of the process of managing public health incidents. As the main issues to be covered in these communications generally concern hazards to public health, NHS boards should take the lead in decision making on risk communication.

- Decision-making about communication of public health risks should be based on a presumption of openness. Not being open puts at stake the perceived trustworthiness of the agencies involved in managing risks.
- When communicating about risks, health agencies should be clear about the objectives they are pursuing, and identify any key issues which will influence the impact on the public from the communication.
- Plans for public health incidents should contain clear procedures for risk communication. **Paragraph 129** below gives examples.
- Communications should contain messages that are clear, relevant and timely, acknowledging uncertainties and should explain as far as possible the risk to the public in terms of probabilities and by comparing the current risk to others.
- The IMT should keep in mind the particular need for specific communications aimed at defined risk groups (e.g. people who are immuno-compromised, pregnant women), those with reading difficulties or hearing or vision deficits. In addition, the IMT should consider the need for advice to be available in different languages for ethnic minority groups.
- Mechanisms should be in place to monitor the impact of communication on public perception e.g. monitoring the number and nature of calls to a helpline and the extent, content and tone of media coverage.

121. Decisions on risk communication should be recorded. Decisions not to communicate about actual or potential risks to the public health even when these are uncertain should be justified and recorded.

122. If an incident escalates significantly and there is a national response or SG emergency procedures are invoked it is likely that communication and handling will be discussed and agreed with SG.

7.7.2 Communications Plans

123. NHS boards and HPS/PHS should have a communications plan which indicates how they will provide information about the incident and its control to the following key groups:

- the key agencies involved in managing the incident;
- professionals involved in diagnosing, treating, or advising patients who are, or could be cases of infection or toxic exposure;
- the general public and in particular the community directly affected by the incident;
- HPS/PHS and SGHSCD; and
- Contribute to multi-agency response via LRP/RRP structures, if appropriate

7.7.3 Intra and inter agency communications

124. If time allows the CPH(M) should brief the relevant agencies likely to be involved in responding to the incident prior to the first IMT meeting. Information should be regularly updated as appropriate. As part of their emergency plans, NHS boards and HPS/PHS should maintain a contact list (including out of hours arrangements) for representatives for all key agencies. NHS boards and HPS/PHS should ensure that there are procedures to ensure that on notification, information is passed to Director of Public Health, senior management and the communication team. The relevant LA and HPS/PHS should be informed about suspected incidents. CPH(M)s should be informed of all hospital infection incidents (and will report to DPH), regardless of whether chaired by ICD or CPH(M). The IMT should discuss and agree the level to which briefings should be escalated within each relevant agency.

125. NHS boards and HPS/PHS must notify suspected public health incidents to the SGHSCD, if possible prior to the first meeting of the IMT. Notifications should be made to a SGHSCD representative (e.g. SMO or policy officer) in line with the protocol agreed with Scottish Government Ministers in 2007 (excluding all infection incidents and outbreaks in any healthcare premise for which separate arrangements apply, see **Annex C**). The IMT should agree clear channels of communication and reporting lines at the first meeting. This should include a single channel of reporting in to SG. If the incident is thought to be the result of foodborne exposure, Food Standards Scotland (FSS) should be notified. SGHSCD should receive regular updates on the progress of the incident during working hours and out of hours. If the incident is related to a public drinking water supply, Scottish Water should notify the Drinking Water Quality Regulator (DWQR). SGHSCD and the DWQR should liaise to ensure a consistent message from the SG.

126. During an incident, a range of professionals working in diagnostic laboratories or clinical services will require information about the nature of the hazard, care arrangements, diagnostic testing, advice to the public, the scale of the incident and steps taken to control it.

127. NHS boards and HPS/PHS should have mechanisms in place for the effective and timely sharing of information while applying methods in-line with the Caldicott Guardian encompassing information management principles. Where e-mails are used, it should be ensured that secure email addresses are used for sensitive or patient identifiable data and alternative routes of communication are used for those e-mails which do not fulfil these criteria. However, it is important to appreciate that when investigating and managing an incident, colleagues may not be at their base so any urgent communication should still be by telephone. A loggist should be used to record all decisions, actions and communications.

128. Where deaths have or may have arisen as part of an incident, the IMT Chair should ensure that the Procurator Fiscal has been informed.

7.7.4 Communications with the public

129. To help allay any unnecessary public anxiety, communications should be made as early as possible in the management of the incident. This requires tested systems capable of rapid deployment that are ready for use prior to any incident occurring. The following mechanisms should be considered:

- face to face communication with affected individuals or groups e.g. patients, staff, general public at public meetings;
- the establishment of a special helpline provided by NHS 24;
- letters or fact sheets provided directly to patients, staff, members of the public in an affected healthcare setting or community;
- information in the form of statements, press releases, interviews and briefings for the print and electronic media (see section below);
- specially designed information leaflets to be distributed at appropriate points;
- social media can be used as a monitoring tool as well as for distributing messages;
- briefing key members of the public such as head teachers, MSPs, councillors, members of local health council.

130. Wherever possible standard templates for communicating with the general public and the media should form part of planning for more common or potentially dangerous types of incidents. They should include standard press releases and ‘question and answer’ information sheets. These should require minimal customisation during incidents to facilitate speedy communication. Examples of documentation used in previous incidents may be available on the SHPIR website under Incident Learning.

131. In addition, each Regional Resilience Partnership has a multi-agency communications and media plan which fulfils statutory duty to warn and inform the public. During incidents and emergencies, partner agencies are used to working together and these networks and arrangements should be utilised to support public health led response.

132. NHS 24 can provide a range of services to support NHS boards which should be actively considered. NHS 24 may be able to provide more extensive support in a major public health incident, based on the organisation's contact centre network, technology, voice infrastructure and contingency arrangements. Please refer to **Annex B, paragraph 26**.

133. In some types of incident, private or public sector organisations implicated as probable sources of the exposure to a hazard will have existing lines of communication to their customers, clients or patients. At times, the organisation may form part of the IMT e.g. Scottish Water as described in the Scottish Waterborne Hazard Plan. Use of these lines of communication can often facilitate advising the public on how to reduce risks and to implement control measures to prevent exposure e.g. not drinking the water. In these circumstances, the IMT should liaise with the organisation in employing its knowledge and resources to communicate with public about risks. The IMT should co-ordinate the content and tone of any messages and how these should be disseminated.

134. NHS boards and HPS/PHS should have in place mechanisms to establish special helplines promptly e.g. via NHS 24. In some incidents, the public will look to contact a specific company or agency to obtain information about their services or products. In these instances, the IMT should liaise closely with the organisation about the measures it is taking to deal with customer enquiries while recognising that the mechanisms for doing so are best left to the company involved. It should be made clear however that the central public health message is the responsibility of the IMT.

135. The IMT should maintain an overview of all communications to ensure that there are no contradictions in their content or tone, or alternatively may set up or delegate a sub-group to manage the communication messages. The IMT Chair, or delegated deputy, has overall responsibility and should agree any suggestions/changes to external communications prior to their being distributed for comment or release.

7.7.5 Media handling

136. The considerable extent of public, press and political interest in recent incidents highlights the importance of paying careful attention to this aspect of incident management. There is a need, in large-scale incidents, for a clear and proactive approach to media management and public relations especially by NHS boards. In view of the crucial interface with the media, media management should form an essential part of incident plans. Actively engaging with the media and providing accurate and timely information may prevent inaccurate reporting and negative outcomes. Early implementation of RRP communication and media plans will assist effective coordination of media resources and messaging.

137. For all national and large-scale incidents, NHS boards and HPS/PHS should bear in mind that there will be a need to co-ordinate media activity closely with the Scottish Government communications team and partner agencies. SGHSCD will often refer media to the local NHS board for detailed information but it is important that key messages are co-ordinated.

138. There are two important roles that require to be fulfilled, that of media liaison and that of acting as spokesperson for the IMT.

139. To fulfil the first role, a member of the NHS board's communications team should liaise with the media to ensure that the information communicated to them is consistent and to organise arrangements for press briefings, interviews etc. He/she should be the identified communication team member acting in this capacity on behalf of all organisations involved in the IMT. The IMT Chair, or delegated deputy, would usually fulfil the second role i.e. be the 'public face' of the IMT. There may be situations when the communications team fulfils both roles. If other professional opinions are sought from individual IMT members, these should not be given without the agreement of the IMT Chair and full liaison with the communications team. Whenever possible those from other organisations answering media enquiries should be members of the IMT.

140. In some instances, it may be desirable for other organisations represented on the IMT to respond to press enquiries which specifically relate to their operations or legal responsibilities. Arrangements should ensure that such organisations can respond promptly to such enquiries without straying from, or indeed contradicting the core message about the public health risks and the measures being taken to reduce them.

141. To avoid confusion, a common data set (e.g. on number of cases and their clinical status) and a timetable for its compilation and issue to the media should be agreed by the IMT. Decisions about media briefing, and the issuing of press statements, should be made at each IMT meeting. In doing so, careful consideration should be given to:

- background briefing material, e.g. role of the IMT, the general nature of the hazard or threat, what is known, and important facts which may not be known;
- the implications of releasing the information;
- the implications of the timing of the release;
- the importance of presenting complex information in simple language;
- and the different requirements of the print and broadcast media; and
- consideration given to use of more immediate social communication tools.

142. All press statements issued should be copied to the press offices of all organisations represented on the IMT, the SGHSCD and other relevant organisations.

7.8 Incident evaluation, documentation and lessons learned

143. A recurrent theme with public health incidents is the need to learn from experience. This involves three key components:

- A formal IMT debriefing on the management of the incident with a view to including lessons learnt in an IMT report. The debrief should take place as soon as possible after the incident. (If required/requested, the RRP can assist in facilitating the debrief process via the Learning & Development Coordinator, however as sponsor, the IMT remains the owner of the information and responsible for any further actions that may arise);
- An assessment of the performance of statutory agencies in managing public health incidents; and
- An evaluation of the effectiveness of incident management arrangements in protecting the public health.

144. Organisations' emergency planning / civil contingencies officers may be able to advise and assist with a multi-agency debrief for multi-agency incidents. The report resulting from the debrief would be handed over to the IMT chair. The IMT chair would retain ownership of the debrief report including lessons learned.

145. IMTs both during and in the debriefing following an incident should use criteria jointly agreed with their partners (**Annex I**) to assess and report on their own performance to the NHS board clinical governance committee in managing the incident and the appropriateness of current plans. Recommendations on how these can be improved should be included in a report prepared by the IMT for which the IMT Chair has the overall responsibility for producing.

146. The IMT should prepare a report and the IMT Chair has the overall responsibility for its production as illustrated in **Table 1**. The IMT report should be the product of agreement of all full members of the team. If this is not possible, the report should note areas of disagreement. A template for the report is provided in **Annex K**. The report should, in addition to describing the incident, consider the effectiveness of the investigation and the control measures taken. The report should include recommendations to prevent further incidents and improve the handling of further incidents and may include an identified need for further research.

147. Based on the results of the investigation, risk assessment and debriefing, the IMT should formulate targeted recommendations with timescales. The IMT Chair should ensure that the report and specifically the section dealing with the recommendations, is communicated to the targeted organisation. NHS boards and HPS/PHS are responsible for monitoring whether IMT recommendations are followed up. The NHS board to which the IMT is accountable should ensure that there is a response to the recommendation from that organisation for its implementation. If it has statutory responsibilities, it must reply to the NHS board laying out its response to the recommendation.

148. In some instances, it may be necessary to delay or limit the circulation of the final report pending legal action. In such cases, appropriate legal advice should be sought.

149. The IMT Chair, in discussion with the IMT, should determine the most appropriate format for reporting the incident, e.g. full IMT report, SBAR, or hot debrief paper should also be completed for incidents where learning or recommendations have been identified for national consideration (see **Annex I**).

150. A full IMT report (a suggested template is provided in **Annex L**) should be considered in the following situations:

- Significant lessons identified that should be shared locally or nationally;
- Actions required by other agencies to address problems identified;
- Novel infection, sources or pathways of infection;
- High mortality or morbidity;
- Changes required in guidance; or
- Significant public or political interest.

151. If the IMT Chair does not consider a full report is necessary then a summary of the incident should be provided in an SBAR (Situation, Background, Assessment, Recommendations) format. SBAR template is provided in **Annex J**. The SBAR format can also be used for updates during the incident.

152. IMT reports should be sent for approval and endorsement to the relevant NHS board meeting or a NHS board Committee e.g. Clinical Governance Committee. They may then decide who to share the report with e.g. SHPN, local authorities, SGHSCD etc. The reports should then be sent to the SHPN and made available to appropriate individuals, the LA, and the SGHSCD or other SG Directorate with responsibility for aspects of the outbreak/incident. Other relevant regulatory agencies should receive a copy.

153. The SHPN has agreed to maintain a central repository for IMT and SBAR reports and/or debriefs for public health incidents through the existing Scottish Health Protection Information Resource (SHPIR) website. The repository would be populated with new reports as they are published and IMT Hot Debrief reports as they are received. The latter shall be used by NHS boards and HPS/PHS for any future outbreak/incidents in order to capture initial lessons learnt immediately as a 'hot debrief' recognising that some IMT reports take months/years to be published.

154. The NHS board is responsible for approving an action plan to follow up the recommendations contained in the report, (where this is required). The action plan should be appended to the copies of the report submitted to SGHSCD. If a recommendation has major policy implications or if the response from the agency to which an action is recommended is deemed by the NHS board to be inadequate, the NHS board should inform SGHSCD who will review the issue further.

155. In addition to an IMT report, all relevant incidents should be summarised in the appropriate standard summary form for submission in timely fashion to HPS/PHS for the purposes of incident surveillance.

156. The role of SHPN in supporting collation of lessons learnt and sharing is described in **Annex F**.

List of Annexes

Annex A: Statutory Responsibilities and Legislation

International Obligations

1. The International Health Regulations, 2006 are a legally binding international instrument to: 'prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international trade and traffic'.

2. The IHR define a list of diseases that must always be reported to WHO. These include:

    - Smallpox;
    - Poliomyelitis due to wild-type poliovirus;
    - Human influenza caused by a new subtype; and
    - Severe acute respiratory syndrome (SARS).

3. In addition, the UK has an obligation to assess other events using an IHR tool and to notify the WHO of those events that may constitute Public Health Emergencies of International Concern (PHEICs). This can include non-infectious events (chemical/radiological).

4. The UK Governments (including the devolved administrations) have designated Public Health England (PHE) to act as the National Focal Point (NFP) for all of the UK and only PHE should communicate directly with the WHO on IHR matters

5. The European Commission established the Early Warning and Reports System (EWRS) in 1999. The EC Decisions on it have been updated on a number of occasions, most recently Commission Decision 2009/574/EC. The Decision sets out obligations on Member States to report specified threats to public health to each Member State so that they can determine if measures may be required to protect public health in their country. The information is transmitted by specified competent bodies through an accredited structure and process managed by the European Centre for Disease Prevention and Control (ECDC). The Competent Body for the UK is PHE. HPS/PHS liaises with PHE if there is need to send out or respond to an EWRS relevant to Scotland. EWRSs originating from the UK are approved by the relevant Health Departments.

6. **Events to be reported within the Early Warning and Response System are:**

    - Outbreaks of communicable diseases extending to more than one Member State.
    - Spatial or temporal clustering of cases of disease of a similar type, if pathogenic agents are a possible cause and there is a risk of propagation between Member States.

- Spatial or temporal clustering of cases of disease of a similar type outside the Community, if pathogenic agents are a possible cause and there is a risk of propagation to the Community.
- The appearance or resurgence of a communicable disease or an infectious agent which may require timely, coordinated community action to contain it.

7. The Surveillance and Response Support Unit of ECDC aims at ensuring the timely detection of communicable disease threats, their assessment and the provision of support to enable Member States to control and mitigate them. As such it develops and maintains ECDC data bases and communication platforms including EWRS and the European Surveillance System (TESSy). The latter collects, validates, analyses and disseminates data and produces outputs for public health action. All EU Member States must report their available data on 49 communicable diseases to TESSy as described in EC Decision 2119/98/EC.

The Civil Contingencies Act 2004

8. The Civil Contingencies Act 2004 and Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Amendment Regulations Scotland 2005 and 2013, delivers a single framework for civil protection in the United Kingdom. The Act is separated into two substantive parts: local arrangements for civil protection (**Part 1**) and emergency powers (**Part 2**). Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each. Those in Category 1 are those organisations at the core of the response to most emergencies. This includes NHS boards as well as emergency services and LAs.

9. Category 1 responders are subject to the full set of civil protection duties. They will be required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency; and
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (LAs only).

10. Category 2 organisations (e.g. NHS National Services Scotland, transport and utility companies) have lesser obligations placed on them but will be heavily involved in incidents that affect their sector. They should be engaged in discussions where they can add value and they must respond to all reasonable requests.

11. Category 1 and 2 organisations will come together to form Regional Resilience Partnerships (RRPs) and Local Resilience Partnerships (LRPs) which will co-ordinate activities at a local level.

The Public Health etc (Scotland) Act 2008

12. The Public Health etc (Scotland) Act was passed in 2008 and sets out the public health duties of Scottish Ministers, NHS boards and LAs. Scottish Ministers have a duty to protect public health i.e. to protect the community from infectious disease, contamination and any other hazards that constitute a danger to human health. This includes the prevention of, control of, and provision of a public health response to such disease, contamination or other hazards. Under the Act 'contamination' means contamination with biological, chemical or radioactive substance; 'infectious disease' means an illness or medical condition caused by an infectious agent (including notifiable organisms).

13. Where a NHS board or LA, in the view of Scottish Ministers, is considered to be failing to exercise a function under the Public Health Act or to exercise it acceptably, then Scottish Ministers have a power to issue a direction to the NHS board or LA. This would require the function to be exercised and in the manner directed. In addition, the Scottish Ministers may require another party to exercise the function. These powers would be expected to be used rarely.

14. Under the Act, NHS boards and LAs have a duty to protect public health. They also have a duty to co-operate which is enshrined in the 1978 NHS (Scotland) Act which also outlines the requirements on Education Authorities. This is complemented by the 2003 duty of wellbeing placed on local authorities. (See **Annex B, paragraph 23**). In addition, each NHS board and LA must designate a 'competent person' or persons who have the necessary qualifications and experience to enact specific powers under the Act.

15. The split of responsibilities under the Act between NHS boards and LAs essentially falls into a responsibility of NHS boards in relation to 'people' and of LAs in relation to 'premises'. The Act also requires NHS boards and LAs to co-operate with each other and with the Common Services Agency (essentially National Service Scotland (NSS) and Health Protection Scotland (HPS)/ Public Health Scotland (PHS) and the Scottish Ministers (Scottish Government)).

16. The Act also requires each NHS boards to work with partner LAs to prepare a biennial Joint Health Protection Plan and must consult the LAs on that plan. The joint plans will set out the overall health protection priorities and out of hours arrangements of the NHS board and LA taking into account the local geography and infrastructure of the population served.

17. The Act sets out a new list of notifiable diseases (duties on registered medical practitioners),notifiable organisms (duties on laboratories) and how and where notifications have to be made. In addition, it sets out a new category of 'health risk states' to be notified where a registered medical practitioner has grounds to suspect that a patient has been exposed to a 'health risk state'. 'Health Risk state' is not specifically defined in the Act but will allow the powers under the Act to be used for new and emerging organisms and other unanticipated health hazards.

18. Further information about the Act and accompanying Guidance can be found at the following link - **http://www.legislation.gov.uk/asp/2008/5/pdfs/asp_20080005_en.pdf**

Other legislation

19. In addition, LAs have a range of duties and powers which they may invoke to protect the public health during an incident. These include those under the terms of:

- The Food Safety Act 1990 (as amended)
- The Food (Scotland) Act 2015;
- The Health and Safety at Work etc. Act 1974;
- The Environmental Protection Act 1990;
- The Public Health etc. (Scotland) Act 2008;
- International Health Regulations, 2006;
- The Public Health (Ships) (Scotland) Regulations 1971-2007;
- The Public Health (Aircraft) (Scotland) Regulations 1971-1978
- The Food Hygiene (Scotland) Regulations 2006 (as amended).

The Coronavirus Act 2020

20. The Coronavirus Act 2020 was passed on 25 March 2020. The legislation is initially time limited for two years (but could be temporarily extended). The Act puts in place new powers specifically for dealing with the Coronavirus pandemic.

21. Schedule 21 provides public health officers, constables and immigration officers with new powers in relation to individuals who are considered to be potentially infectious. The powers are only available during a "transmission control period", which is a period during which a particular statutory declaration made by Scottish Ministers is in force.

22. The Schedule gives "public health officers" (these are health board competent persons, or other people who may be designated by Scottish Ministers) powers to require potentially infectious persons to go to, and remain in, a suitable place to undergo screening and assessment. These powers can be used where there is a

reasonable suspicion that the person has or may have COVID-19, or has been in an infected area within the 14 days preceding that time. (Such persons are referred to in the provisions as 'potentially infectious' persons.)

23. There are additional powers for public health officers, including powers to impose other appropriate restrictions and requirements upon potentially infectious persons where necessary and proportionate, such as a requirement to remain in isolation, restrictions on travel, activities and contact with others.

24. The Schedule also confers certain powers on constables and immigration officers – allowing them to direct, remove or keep a person at a place for the purpose of assessment.

25. The Act also gives powers to Scottish Ministers. These include powers in Schedule 22 to issue directions relating to events, gatherings and premises which could, for example, be used by Scottish Ministers to close particular premises where there is an outbreak.

26. The Act also gives Scottish Ministers powers to make Regulations for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in Scotland (Schedule 19). If you want to find the latest coronavirus Regulations that are in force, then they will be available at **www.legislation.gov.uk**.

Annex B: Organisational Roles and Responsibilities

Scottish Government Health and Social Care Directorates

The Scottish Government's roles include the following:

- Strategic and Policy role (including CMO letters and HDLs);
- Performance management role - NHS territorial and special Health Boards

Performance Management Role

1. NHS boards and HPS/PHS are accountable to the Scottish Government (SG). Performance management of territorial NHS boards is handled by the Directorate for Health Performance and Delivery who has a range of formal procedures in place agreed with Scottish Ministers. This includes an interim performance review and an end year review, which is held in public by the Cabinet Secretary for Health. NHS boards work to an agreed set of indicators which are now managed under the auspices of the Quality Strategy.

Strategic and Policy Role

2. The SG is responsible for setting policy and strategic direction and this includes policy and strategy issues that arise during the course of or because of an incident. The extent of the SG's involvement will depend on the scale of the incident - far less active involvement will be expected for a smaller single NHS board incident than a national incident in which civil contingency procedures may be engaged. This section explains the SG's role in various different scenarios.

Notification

3. For many incidents, regardless of scale, the SG will, as a minimum, require notification as early as possible so that Ministers can be informed.

4. The Directorate for Population Health is the main point of Government contact for public health incidents (excluding all infection incidents and outbreaks in any healthcare premise, for which separate arrangements apply. See **Annex C**).

5. If required, the Directorate for Population Health or the Directorate for Covid Public Health will follow the 'Protocol for informing Ministers about significant public health incidents and outbreaks' and a decision will be taken on the need to inform and brief the duty Scottish Government press officer.

N.B. For the Covid-19 pandemic response, the main point of Government contact for public health incidents related to Covid-19 is the Directorate for Covid Public Health.

Food Incident Notifications

6. The SG has a Concordat with Food Standards Scotland (FSS). Both parties will ensure immediate communication on matters relating to outbreaks and incidents of foodborne or potentially foodborne disease and will establish lines of communication for the duration of the incident or outbreak.

Communications with the CMO Team

7. Clear channels of communication will be established between the Chief Medical Officer's team and the IMT. This will be the sole line of communication in terms of the progress of the public health incident. It is useful for the IMT chair to agree times for updating the Senior Medical Officer on a regular basis. This can, for example, be agreed to be 30 minutes following the IMT meeting. It is important to avoid the risk of conflicting data being provided via multiple briefings. It will also be important for the IMT Chair to contact the Senior Medical Officer (SMO) if there are significant events of which the SG should be aware (excluding all infection incidents and outbreaks in any healthcare premise, for which separate arrangements apply, see **Annex C**). Speed is essential in communicating important information to Ministers, particularly if it is likely to be of interest to the media.

8. In the majority of public health incidents in Scotland the response of SMOs and the policy team would be all that is necessary.

An incident affecting two or more NHS boards with no major disruption of services or a Scotland or UK-wide outbreak or incident with some but no major disruption of services

9. In this scenario, the SG is likely to liaise more proactively with HPS/PHS, particularly if they are managing the incident on behalf of SG. They will seek to work with HPS/PHS to identify and resolve any policy or handling issues at an early stage and to communicate proactively with NHS boards involved. If the incident involves another country within the UK, the policy team would establish links with opposite numbers in e.g. the Department of Health and set up a regular channel of communication. They would also liaise proactively with SG communications team and provide regular updates to Scottish Ministers. For a major incident, arrangements are in place to allow the relevant Scottish Government Division to draw on additional health directorates resources.

10. The role of the SG team supporting the response can be summarised as follows:

- providing regular and timely advice to Scottish Ministers;
- providing regular information and agreeing public lines with the Health Communications Team;
- providing information and advice to any other relevant area of health directorates and other Government directorates as required;
- liaising with other devolved administrations and UK Government as required;

- liaising with HPS/PHS;
- liaising with any other relevant agency in Scotland; and
- assessing the effectiveness of the local or national response (with HPS/PHS and NHS Boards) and considering resource impact on national policy or strategy.

Incidents with major disruption of services requiring the mobilisation of significant surge capacity and the establishment of regional or national multi-agency strategic, tactical and operational management arrangements (e.g. pandemic flu)

11. In the circumstances of a national level emergency, SG emergency planning procedures may be implemented including establishment of the SG Resilience Room (SGoRR) with regular meetings of officials and Ministers. A lead SG department (and lead Minister) is likely to be designated according to the nature of the emergency. There may also be SGoRR Officials meetings which will support the Ministerial meetings.

12. If this becomes or is part of a UK Major Incident then the Cabinet Office Briefing Room (COBR) may be established, and SG will link into COBR at officer and Ministerial level. The UK Government would convene their Civil Contingencies Committee and Civil Contingencies Committee (officials). There may also be circumstances where an emergency in Scotland relates to an area of responsibility reserved to the UK Government (in which case a UK Govt department would be in the lead and would liaise with the Scottish Government).

13. All Scottish Government activity in a national level emergency is co-ordinated through the SGoRR supported by relevant Directorates and Resilience Partnerships. The SGHSCD Health Resilience Unit (HRU) is likely to produce regular situation reports (SitReps) which cover all aspects of an incident. It is likely that the Resilience Team would request information from the relevant Health Board/s for inclusion in the report. This would be in addition to the ongoing liaison between the NHS board and the SMOs in SG. All relevant Scottish Government Directorates will work closely together when managing an incident of this scale.

Health Protection Scotland

14. As of 1 April 2020 Health Protection Scotland (HPS) operates as part of Public Health Scotland (PHS). Its aim is to work, in partnership with others, to protect the Scottish public from being exposed to hazards which damage their health and to limit any impact on health when such exposures cannot be avoided. It seeks to achieve this aim by:

    - promoting a consistent, efficient and effective approach in the delivery of health protection services by NHS and related agencies;
    - co-ordinating the efforts of public health agencies in Scotland in health protection especially when a rapid response is required to a major threat;
    - helping increase the public understanding of and attitudes to public health hazards and facilitating their level of involvement in the measures needed to protect them from these;
    - being the source in Scotland of expert advice and support to government, NHS, other organisations and the public on health protection issues;
    - helping develop a competent health protection workforce;
    - improving the knowledge base for health protection through research and development.

15. The key functions of HPS in PHS are:

    - Monitoring the hazards and exposures affecting the people of Scotland and the impact they have on their health;
    - Co-ordinating national health protection activity;
    - Facilitating the effective response to outbreaks and incidents;
    - Supporting the development of good professional practice in health protection;
    - Monitoring the quality and effectiveness of health protection services;
    - Research and development into health protection priorities;
    - Providing expert impartial advice on health protection;
    - Promoting the development of a competent and confident workforce in health protection; and
    - Commissioning national reference laboratories.

16. HPS in PHS has the following responsibilities for facilitating the response to incidents:

A localised incident affecting a single NHS board with no major disruption of services

- Maintain communication with and provide access to expert advice to the NHS board;
- Liaise when necessary with the Scottish Government and/or Food Standards Scotland;
- If available, provide additional personnel to facilitate the management of the incident who will be managed for the relevant period by the NHS board; and
- Work with the NHS board to assure the quality and effectiveness of the steps taken to manage the incident and in particular help ensure that there is a structured debrief.
- Health alerts arising from an incident
    - distribute information to relevant staff in the NHS and LAs, if appropriate;
    - copy information to SG; and
    - respond to queries concerning the subject matter of the alert.

An incident affecting two or more NHS boards with no major disruption of services

- agree with the NHS boards the appropriate management arrangements (i.e. a single IMT or two or more IMTs). This may include as an option HPS/PHS assuming responsibility for leading the overall management of the incident on behalf of an NHS board;
- on behalf of the parties to the joint arrangement, co-ordinate surveillance, investigation, risk assessment and management and risk communication; and
- operational management locally will remain the responsibility of NHS boards.

A Scotland or UK-wide incident with some but no major disruption of services (e.g. a foodborne outbreak associated with a nationally distributed foodstuff)

- lead the management of the incident in Scotland and establish appropriate arrangements on behalf of SGHSCD;
- with regard to an incident affecting one or more of the countries in the UK, lead Scotland's participation in UK-wide management arrangements. This may involve leading in certain circumstances the UK response;
- co-ordinate surveillance, investigation, risk assessment and management and risk communication; and
- operational management locally will remain the responsibility of NHS boards.

Any of the above incidents with major disruption of services requiring the mobilisation of significant surge capacity and the establishment of regional or national multi-agency strategic, tactical and operational management arrangements (e.g. pandemic influenza)

- When an incident requires the activation of the RP (based on the current emergency planning arrangements set up with Police Scotland), HPS/PHS will support the NHS board in discharging its functions regarding health protection advice to the SCG. As with an IMT, HPS/PHS will advise and support the Scientific Technical Advice Cells (STACs) on the health protection response with NHS boards co-operating with, and taking advice from, HPS/PHS.
- When an incident requires the establishment of a national strategic multi-agency group by the SG, HPS/PHS will support SG (and in particular the CMO) in discharging its functions regarding health protection advice to the strategic lead. HPS/PHS will be responsible for coordinating the tactical health protection response by the NHS boards (e.g. surveillance, investigation, risk assessment and management and risk communication). NHS boards will remain responsible for the operational health protection response.

NHS boards

17. Under the terms of the National Health Service (Scotland) Act 1978, the NHS in Scotland is charged with two statutory duties:

    - securing improvement in the physical and mental health of the people of Scotland;
    - securing the prevention, diagnosis and treatment of illness.

    NHS boards, as the lead agency for protecting health, are responsible for the overall integrity of the arrangements for planning for public health incidents and for the effectiveness of the incident response, including leading the response and the related IMT. Where the IMT is being led by HPS/PHS, e.g. in a Scotland-wide incident, NHS boards will contribute to the IMT as required. Operational management locally will remain the responsibility of NHS boards.

18. Under the terms of the Public Health (Scotland) Act 2008, NHS boards have a duty to ‘continue to make provision, or secure that provision is made, for protecting public health in its area, without prejudice to its general duty to promote the improvement of the health of the people of Scotland’ and a duty to ‘co-operate with any relevant person who appears to have an interest in or a function relating to the protection of public health’.

19. NHS boards have a range of powers available to them under the Act which can be exercised by their designated 'competent person':

- receive notification of a disease or health risk state from a registered medical practitioner either orally or in writing, relating to a patient who usually resides within that area and a duty to send a return in writing to Public Health Scotland;
- receive notification from the director of a diagnostic laboratory, where the laboratory identifies a notifiable organism no later than 10 days after identification;
- undertake public health investigations including powers for investigators to enter premises, ask questions etc.;
- apply to a Sheriff to have a person medically examined;
- make an 'exclusion order' which will exclude a person from any place or type of place specified in the order, and impose such conditions (if any) on the person as is considered appropriate;
- make a 'restriction order' which will prohibit a person from carrying on any activity specified in the order, and impose such conditions (if any) on the person as is considered appropriate; and
- apply to a Sheriff for an order to require a person to be quarantined in their home or other setting, other than a hospital or to have a person detained in hospital.

N.B. For the COVID-19 response, under the Coronavirus Act 2020, Health Board Competent Persons also have powers that allow them to impose certain measures when there is a reasonable suspicion that a person has Coronavirus (see **Annex A**).

20. In addition to the above, a SEHD/CMO (2007) is available setting out NHS boards' Health Protection remit. The CMO letter clarifies that the operational responsibility for health protection services lies primarily with NHS boards. Health Protection Scotland / Public Health Scotland has a role in helping to ensure a consistent, efficient and effective approach in the delivery of these arrangements. The role of NHS boards will always focus on operational management of an incident, but the paragraphs above indicate how the lead role will change during escalation of an incident and in relation to the roles of HPS/PHS and the SGHSCD.

Diagnostic Microbiology Laboratories

21. The director of a diagnostic laboratory must ensure the appropriate authorities are informed of notifiable organisms as described in the Public Health etc. (Scotland) Act 2008. It is expected that diagnostic microbiology laboratories will support as appropriate and as able with the investigation of Public Health incidents.

Microbiology Reference Laboratories

22. As described in the ECDC TECHNICAL REPORT 'Core functions of microbiology reference laboratories for communicable diseases', June 2010, the functions of the microbiology reference laboratories include provision of reference diagnostics, support with monitoring for developing infectious public health threats and provision of specialist scientific and clinical advice.

Local authorities

23. Under the terms of the Public Health (Scotland) Act 2008, LAs have a statutory duty to 'continue to make provision, or secure that provision is made, for the purpose of protecting public health in its area' and 'co-operate with any relevant person who appears to have an interest in or a function relating to the protection of public health.' Similarly to NHS boards, LAs also have a duty to designate a sufficient number of persons who can exercise functions under the Act.

24. Under the terms of the Act, LAs have powers to:

- undertake public health investigations including powers for investigators to enter premises, ask questions etc;
- serve a notice on the occupiers of any premises in its area if anything in or on such premises is infected, infested or contaminated and in order to prevent the spread of infectious disease, or contamination, disinfection, disinfestation, or decontamination of the premises or things in or on the premises, the destruction of a thing, or other connected operations is necessary;
- to order a range of public health measures in relation to premises and things, including disinfection, disinfestation and decontamination, in order to prevent the spread of infectious disease or contamination.

25. Environmental Health Officers constitute the prime LA resource in health protection. They also have the principal local responsibility for reducing the risks from many environmental hazards. They liaise closely with their NHS colleagues in the investigation and control of outbreaks of infections, often being the enforcement arm of the teams set up to manage these incidents.

N.B. For the COVID-19 response, Local authorities have also been given a role in enforcing Regulations relating to Coronavirus. Under the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020 local authorities can designate people to enforce requirements relating to the closure of premises and businesses. The Regulations relevant to Coronavirus are subject to change at short notice and so it is always necessary to check the current Regulations in force.

NHS 24

26. NHS 24 is responsible for the delivery of clinical triage, health advice and information services providing the population of Scotland with access to care 24 hours a day, 365 days a year. Within Public Health emergencies, the role of NHS 24 is to:

- triage calls, assess patients' symptoms and refer patients to the most appropriate healthcare professional within an appropriate timescale based on clinical need;
- work in partnership with local health systems provided by NHS boards, NHS staff organisations and local communities through integration with other parts of the NHS - in particular, the GP Out-of-Hours Services provided by NHS boards throughout Scotland, the Scottish Ambulance Service and the Acute Hospitals' Accident and Emergency Departments;
- provide other telephone-based and online services:
  - A Special Helpline service to support public health related alerts that generate a large volume of calls/interest from the general public, either locally or nationally. The helpline should only be used for the acute phase of the emergency (the first 5-7 days) to manage the peak in activity. A line can be set-up within 6 hours, if required, to address an emergency situation. Basic statistics can be generated around numbers of calls to the line and additional reporting can be negotiated depending on the nature of the situation. IMT must be able to provide detailed content and support to the Helpline as required.
  - Delivery of digital content to provide the public with information on **NHS24.scot** and/or **NHSinform.scot** and linking through to source content on relevant websites e.g. WHO, HPS/PHS etc. Utilisation of social media to support and share messages from initiating organisation, providing consistent information to the public.

Scottish Ambulance Service (SAS)

27. The Scottish Ambulance Service (SAS) provides an emergency, unscheduled and scheduled service to people across mainland Scotland and its island communities. As a national Board, they offer a vital link for patients and the wider NHS. Their core function is to respond to patients when they need them, provide clinical treatment and care, and ensure patients are routed quickly and efficiently to the care they need. To deliver this they have established strong links across the NHS and with other key partners, have higher skilled staff than ever before, and have invested in leading-edge technology.

28. SAS operate specialist retrieval services both through the air ambulance and on road vehicles.

29. SAS have three Emergency Medical Dispatch Centres (EMDCs) based in Glasgow, Edinburgh and Inverness which handle in excess of 800,000 calls for help each year from public, GPs, police, NHS 24 and other NHS partners, ranging from life-threatening heart attacks requiring an immediate response to requests from NHS partners to transfer patients between hospitals.

Special Operations Response Teams (SORT)

30. The SAS has developed three Special Operations Response Teams (SORT) in Edinburgh, Glasgow and Aberdeen, comprising 106 specially trained paramedics and ambulance technicians. The teams are trained and equipped to work inside the inner cordon alongside police and fire and rescue services at large scale hazardous incidents. They have all completed an intensive training course that enables them to operate in chemical, biological, radiological, nuclear and explosives (CBRNE) incidents and other accidents that involve hazardous materials. The training includes additional clinical skills, risk assessment, forensic awareness and decontamination procedures. It covers the use of specialist personal protective equipment including self-contained breathing apparatus. Additional training in water rescue techniques means that ambulance staff can play a key role in flooding incidents.

Other agencies

31. Other agencies have statutory responsibilities which overlap with those of NHS boards and LAs and may come into play in the investigation and control of communicable diseases and environmental hazards. These include:

- Food Standards Scotland (FSS);
- Animal and Plant Health Agency (APHA);
- Scottish Water (SW);
- Drinking Water Quality Regulator (DWQR);
- Police Scotland;
- Scottish Fire and Rescue Service (SFRS);
- Health and Safety Executive (HSE);
- Scottish Environment Protection Agency (SEPA);
- PHE Centre for Radiation, Chemicals and the Environment (CRCE);
- Crown Office and Procurator Fiscal Service (COPFS);
- Care Inspectorate;
- Foreign and Commonwealth Office.

32. Public Health England (PHE), The European Centre for Disease Control (ECDC) and the World Health Organization (WHO) also have significant overall responsibilities through PHE acting as the nominated UK body for the ECDC, and the use of the International Health Regulations (IHR).

The responsibilities of these agencies are detailed below.

Food Standards Scotland (FSS)

33. Food Standards Scotland (FSS) is the public sector food body for Scotland. They ensure that information and advice on food safety and standards, nutrition and labelling is independent, consistent, evidence-based and consumer-focused.

34. FSS' primary concern is consumer protection – making sure that food is safe to eat, ensuring consumers know what they are eating and **improving nutrition**. Their vision is to deliver a food and drink environment in Scotland that benefits, protects and is trusted by consumers.

35. FSS develops policies, provides policy advice to others, is a trusted source of advice for consumers and protects consumers through delivery of a robust regulatory and enforcement strategy.

36. FSS was established by the Food (Scotland) Act 2015 as a non-ministerial office, part of the Scottish Administration, alongside, but separate from, the Scottish Government. They are mainly funded by government but also charge fees to recover costs for regulatory functions.

37. FSS uses the following definitions of food hazards:

- **Localised food hazard** - one in which food is not distributed beyond the boundaries of the Food Authority and is NOT deemed to be a serious localised food hazard;
- **Serious localised food hazard** - one in which food is not distributed beyond the boundaries of the Food Authority but which involves *E. coli* O157, other VTEC, *C. botulinum, Salmonella typhii or Salmonella paratyphi* or which the Food Authority considers significant because of, for example, the vulnerability of the population likely to be affected, the numbers involved or any deaths associated with the incident;
- **Non-localised food hazard** - one in which food is distributed beyond the boundaries of the Food Authority.

Serious localised food hazards and non-localised food hazards should be reported to FSS at the earliest opportunity. FSS will handle food related incidents in accordance with the **FSS Incident Management Framework**.

Animal and Plant Health Agency (APHA)

38. The APHA, formerly known as the Animal Health & Veterinary Laboratory Agency, covers England, Wales and Scotland but not Northern Ireland. It is the lead agency responsible for animal health delivery by implementing the policies of Chief Veterinary Officers in Defra and the Devolved Administrations. It exercises the Scottish Government's statutory responsibilities for responding to notifiable diseases in animals including some which can be transmitted between animals and humans (zoonoses), working closely with veterinary and policy colleagues in the Scottish Government Animal Health and Welfare Division and the Scottish Government's Rural Payments and Inspections Directorate (SGRPID).

Drinking Water Quality Regulator (DWQR)

39. The role of DWQR was created in 2002 by the Water Industry (Scotland) Act 2002 to monitor and regulate the quality of public water supplies in Scotland, and to supervise the discharge of LA duties with respect to private water supplies. The work of the DWQR is supported by a small team of technical staff within the Drinking Water Quality Division of the Scottish Government. The DWQR's primary role during incidents is to brief Scottish Ministers and provide advice on technical matters to other stakeholders such as EHOs and CPH(M)s. Following conclusion of the incident, DWQR's focus shifts to investigating the cause of the incident and actions taken to prevent a recurrence, and would include the use of enforcement powers if appropriate.

Scottish Water

40. Scottish Water was created in 2002 to provide water and sewerage services throughout Scotland. Its general responsibilities and powers are set out under the Water Industry (Scotland) Act 2002. Scottish Water has a duty under the Water (Scotland) Act 1980 to provide a supply of wholesome water. The Water Supply (Water Quality) (Scotland) Regulations 2001 define what is meant by wholesome by setting the quality standards for a number of different parameters and also define the monitoring frequency to establish the quality of all supplies.

Police

41. The Police and Fire Reform (Scotland) Act 2012 established a single police force, the Police Service of Scotland (PSoS), also operationally known as Police Scotland, (functional from April 2013), abolishing the existing territorial police forces and their governing bodies. The PSoS has a range of responsibilities which overlap with NHS boards in managing public health incidents. The police will normally coordinate the activities of those responding at and around the scene of a land based sudden impact emergency. They liaise with NHS boards in managing the coordinated provision of essential services to protect the public from exposure to hazards in chemical incidents and other public health emergencies.

Scottish Fire and Rescue Service (SFRS)

42. The Police and Fire Reform (Scotland) Act 2012 established a single fire and rescue service, the Scottish Fire and Rescue Service (SFRS) (functional from April 2013), abolishing the existing fire brigades along with their governing bodies, in April 2013. The main purpose of the SFRS is to work in partnership with communities and with others in the public, private and third sectors, on prevention, protection and response, to improve the safety and wellbeing of people throughout Scotland. The SFRS is also empowered to use their personnel and equipment for purposes other than fire fighting. The management of operations within the inner cordon is normally delegated to the SFRS, including the safety of all personnel working within it. Recovery or rescue from within the inner cordon will, in all but exceptional circumstances, be the responsibility of the SFRS.

43. The SFRS, where appropriate, and working in collaboration with the relevant specialist advisors, will take principal responsibility within the inner cordon for detecting, identifying and monitoring the hazardous substance(s) involved in the incident.

44. In close consultation with other Emergency Services and scientific support, the SFRS will take appropriate steps to identify the hazardous substance(s) involved in the incident (including Detection, Identification and Monitoring (DIM) equipment, and where appropriate, on-site collection of environmental samples for analysis). This relates particularly to matters of safety and operations at the scene and environmental protection. The Scottish Ambulance Service (SAS) will contribute to hazard identification by making an assessment of casualty symptomology in particular regard to NHS Scotland responsibilities.

45. The SFRS will provide the LRP and the local NHS board Health Protection team with relevant information on the nature of the incident including, where possible, the type of hazardous substance(s) involved.

Scottish Environment Protection Agency (SEPA)

46. SEPA is a non-departmental public body, accountable through Scottish Ministers to the Scottish Parliament. Their main role is to protect and improve the environment, by being an environmental regulator, helping business and industry to understand their environmental responsibilities and helping customers to comply with legislation. SEPA protect communities by regulating activities that can cause harmful pollution and by monitoring the quality of Scotland's air, land and water. The regulations they implement also cover the keeping and use, and the accumulation and disposal, of radioactive substances. SEPA are responsible for delivering Scotland's flood warning system, helping to deliver Scotland's Zero Waste Plan and controlling, with the Health and Safety Executive, the risk of major accidents at industrial sites.

Health and Safety Executive (HSE)

47. The HSE is a non-departmental public body with Crown status. The Chair and members of HSE's Board are appointed by the Secretary of State to provide strategic direction for Great Britain's health and safety system. The Board reports to the Secretary of State for Work and Pensions, and to other Secretaries of State.

48. HSE's primary function is to secure the health, safety and welfare of people at work and to protect others including members of the public from risks to health and safety from work activity in accordance with the Health and Safety at Work etc Act 1974 (HSWA) and regulations made under it. HSE does this in partnership with LAs by applying an appropriate and proportionate mix of intervention techniques such as inspection, communication campaigns, advice and support and, where necessary, enforcement action. If a public health incident arises as a result of work activity, HSE could have a role in investigating the matter under HSWA and reporting its findings to the Crown Office and Procurator Fiscal Service (i.e. criminal investigations, e.g. unexplained deaths, infectious disease).

49. Health and safety matters dealt with by HSE have not been devolved to the administrations in Scotland and Wales. Effective working arrangements have been developed, however, between HSE and the devolved administrations to ensure that areas of 'common and close interest' are managed appropriately.

Public Health England Centre for Radiation, Chemical and Environmental Hazards (PHE CRCE)

50. CRCE provides a wide range of radiological protection services to industry, research, the medical sector, Government Departments and the public. These services include the provision of training courses, personal monitoring of occupational exposures, radiological protection advice, radiochemistry, radon assessments, instrument testing, dose assessments and specialised services covering medical and dental radiology. These services are provided across the UK from three CRCE locations: CRCE Chilton, CRCE Scotland (based in Glasgow) and CRCE Leeds. The provision of these services provides a benchmark for the standards of practical radiation protection in the UK and contributes to the restriction of exposure to workers, medical patients and members of the public.

51. Public Health England (PHE) replaced the Health Protection Agency (HPA) in April 2013 and now provides support to the Scottish Government on incidents involving Radiation and Chemical hazards.

Radiation

52. The Health and Social Care Act 2012 and related legislation made statutory provision for PHE to provide advice and support to Scotland for incidents involving radiation. This advice and support is available through PHE's Centre for Radiation, Chemical and Environmental Hazards (CRCE), based in Chilton, Glasgow, and Leeds. The CRCE also provides training courses, related to emergency planning and response in these areas.

53. In the event of a radiation incident in Scotland, PHE would provide advice to the Scottish Government and other responding organisations, including Health Boards, the emergency services, the SEPA, HPS/PHS and the LAs.

54. PHE expert advice would be available to the Scientific and Technical Advice Cell (STAC) and the Recovery Advisory Group (RAG) located at the strategic co-ordination centre.

55. Depending on the incident, PHE staff would be deployed to a number of key locations including:

- The Strategic Co-ordination Centre (SCC);
- The Media Briefing Centre (MBC);
- Scottish Government Resilience Room (SGoRR);
- The scene of the incident or at survivor reception centres or decontamination facilities to assist in the coordination of radiation monitoring and decontamination provisions.
- PHE CRCE is the coordinating body for the National Arrangements for Incidents involving Radioactivity (NAIR)

Chemicals

56. HPS/PHS provides the first line of support to NHS boards and other agencies in Scotland in relation to risk assessment and advice on risk management of chemical exposures and incidents. PHE provides support to HPS/PHS on request for more specialist aspects of public health toxicology and resilience for response to any major level incidents.

57. PHE provides an online information resources for the public and for responding agencies including a **'Compendium of Chemical Hazards'**. This provides information on a wide range of hazardous substances including their physicochemical properties, health effects, and recommended methods of decontamination, and a 'Chemical Action Card' for use by on-call or public health staff faced with a chemical emergency.

National Poisons Information Service (NPIS)

58. The National Poisons Information Service (NPIS) is a national service organised and co-ordinated by PHE that provides expert advice on all aspects of acute and chronic poisoning. The NPIS Scottish Base at the Royal Infirmary of Edinburgh manages TOXBASE, a clinical toxicology database which is specifically designed to provide healthcare professionals with information on clinical management of individuals who have been exposed to chemicals.

The Crown Office and Procurator Fiscal Service (COPFS)

59. The COPFS is responsible for the prosecution of crime in Scotland, and the investigation of sudden, unexpected, accidental, unexplained and suspicious deaths, which occur in Scotland.

60. The dedicated Health and Safety Division is responsible for overseeing the investigation of offences arising specifically from contraventions of the Health and Safety at Work etc Act 1974. Where such allegations of offences are received, COPFS is committed to ensuring that they are investigated thoroughly, sensitively, and prosecuted appropriately, where there is sufficient evidence and it is in the public interest to do so.

61. The principal aims of death investigation are to:

- minimise the risk of undetected homicide or other crimes;
- determine whether a death has resulted from the criminal actions of another and to take appropriate action in relation to such deaths;
- eradicate dangers to health and life in pursuance of the public interest;
- allay public anxiety;
- preserve evidence;
- determine whether a Fatal Accident Inquiry (FAI) or any other form of Public Inquiry is to be held;
- ensure that the nearest relative of the deceased is kept advised of the progress of the investigation;
- ensure that full and accurate statistics are compiled.

The Care Inspectorate

62. The Care Inspectorate, formally known as Social Care and Social Work Improvement Scotland (SCSWIS), is an independent public body set up following the Public Services Reform (Scotland) Act 2010 to scrutinise and regulate social care and social work services across Scotland. The Care Inspectorate replaced the Care Commission, the Social Work Inspection Agency (SWIA) and child protection unit of Her Majesty Inspectorate for Education (HMIe) in these functions.

63. The Care Inspectorate's statutory duties include the registration, inspection, complaint investigation and enforcement in relation to social care services; inspection of LA social work services; joint inspection of integrated health and social care services, scrutiny of and improvement in strategic commissioning, and is also responsible for the scrutiny of children service as set out in the Public Services Reform (Scotland) Act 2010. The Care Inspectorate has general duty of furthering improvement in the quality of social services. Scrutiny by The Care Inspectorate should be proportionate and risk based. In carrying out its statutory functions, The Care Inspectorate will take into account the National Care Standards, which are developed and published by the Scottish Government, and will set out what people using care services can expect from their service provider.

64. The Care Inspectorate will advise care service providers which incidents need to be notified or reported to The Care Inspectorate, for example, outbreaks of any infectious diseases, deaths of people using the service and other serious incidents. This information will be used by The Care Inspectorate to inform risk-based and intelligence-led scrutiny of care services.

Regional Resilience Partnership (RRP)

65. In Scotland, following the principle of subsidiarity, the response to emergencies that require multi-agency management is achieved by convening Resilience Partnership(s) at the most suitable level and attended by appropriate representatives to deal with the incident. Ordinarily, Resilience Partnerships are convened at local level i.e. 'Local Resilience Partnership (LRP)' but may be broadened to contend with the same incident impacting across a wider area i.e. 'Regional Resilience Partnership (RRP).' There are some emergencies such as Public Health or Animal Health indents where specific structures are used requiring the establishment of IMTs or LDCCs (Local Disease Control Centre) which would be set up initially to respond to the incident. These should work in tandem with the RPs as and when they are set up. Emergencies will have significant health implications (e.g. accidents or hostile acts resulting in trauma) and some of these will be specifically relevant to public health (e.g. contamination hazards following a major industrial accident, deliberate release of pathogens).

66. The Civil Contingencies Act 2004 (CCA) and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Amendment Regulations Scotland 2005 and 2013 provided the context for the organisation and operation of Resilience Partnerships. The legislation defines two categories of responders: Category 1 responders are the organisations that provide vital services in an emergency, including the emergency services, LAs, territorial NHS boards and the Scottish Environment Protection Agency (SEPA); Category 2 responders are organisations that provide infrastructure services, including NHS National Services Scotland, the utilities, transport operators, telecommunication companies and the Health and Safety Executive.

67. Legislation places the following duties on Category 1 responders to:

- co-operate with other Category 1 & 2 local responders;
- share information with other local Category 1 & 2 responders;
- assess the risk of emergencies occurring;
- maintain business continuity plans;
- maintain emergency plans;
- maintain arrangements to make information available for the public before, during, and in recovering from, an emergency; and
- provide advice and assistance on business continuity management for businesses and voluntary organisations (LAs only).

68. Regional Resilience Partnerships (RRPs) are required to meet twice per year to fulfil planning and preparation responsibilities and comprise representatives from all Category 1 agencies. Although the Partnership meeting is not a statutory body in its own right, and does not have powers to direct members, they provide a strategic forum to allow members' duties under the CCA to be carried out, including information sharing, multi-agency resilience planning as well as coordination of the emergency response. RRPs therefore form the focal point for local and regional resilience building.

69. Each member of the RRP should be prepared to lead the multi-agency response according to the nature of an emergency, although most scenarios indicate a Police lead. Any RRP/LRP member can activate the RP and, during a health emergency of sufficient severity, where a multi-agency response was required, the RRP could be activated by the NHS board representative.

70. RPs often require expert advice on a range of public health, environmental, scientific and technical issues, in order to deal effectively with the immediate and longer term consequences of an emergency. This advice is normally provided and co-ordinated by a Scientific and Technical Advice Cell (STAC). Often this will relate to issues of public health, in which case the NHS board should provide a chairperson for the STAC, normally the Director of Public Health, or their deputy.

71. The STAC operates as an advisory group and is not an operational group. It may link with other structures at Scottish and UK national levels as well as advising local area strategic and tactical coordinating groups. Communication with national and local strategic levels will usually be through the STAC chair, facilitated via the Resilience Partnerships.

72. Where there is a major or widespread emergency, this can lead to the establishment of multiple Resilience Partnerships and their associated STACs. However, it is not practical for national agencies (SEPA, HPS/PHS, FSS, HSE, etc) to support multiple STACs in such a multiple location incident, and so a primary STAC will be designated by agreement between Resilience Partnership chairs to coordinate and disseminate advice from the national agencies to the other established STACs, referred to as secondary STACs.

Annex C: Healthcare Infection Incident Assessment Tool (HIIAT)

The Healthcare Infection Incident Assessment Tool (HIIAT) should be used by the Infection Prevention and Control Team (IPCT) or Health Protection Team (HPT) to assess every healthcare infection incident i.e. all outbreaks and incidents (including decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services and private providers of healthcare).

The HIIAT has two parts/functions:

Part 1: Assesses impact of a healthcare infection incident/outbreak on patients, services and public health.

The HIIAT should:

- be utilised to assess the initial impact and monitor any ongoing impact (escalating and de-escalating the incident/outbreak until declared closed).
- remain assessed **'Amber'** or **'Red'** only whilst there is ongoing risk of exposure, new cases, or until all exposed cases have been informed.

An individual member of the IPCT or HPT may undertake the initial assessment. If a PAG/IMT is established then further assessments will be led by the chair of the PAG/IMT.

Part 1: Assessment.

Impact	Severity of illness	Services	Risk of transmission	Public Anxiety
Minor	Patients require only minor clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	No or minor impact on services.	Minor implications for Public Health. Minor risk or no evidence of cross transmission or exposure	No or minor public anxiety is anticipated. No, or minimal, media interest: no press statement.
Moderate	Patients require moderate clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	Moderate impact on services e.g. multiple wards closed or ITU closed as a consequence of the control measures	Moderate implications for Public Health. Moderate risk or evidence of cross transmission or ongoing exposure	Moderate public anxiety is anticipated. Media interest expected: prepare press statement
Major	**Patients require major clinical interventional support as a consequence of the incident and/ or** **Severe/life threatening /rare infection and/or** **there is associated mortality***	**Major impact on services e.g. hospital closure(s) for any period of time as a consequence of the control measures**	**Major implications to Public Health or Significant risk of cross transmission, of a severe/life threatening / rare infection or significant ongoing exposure**	**Major public anxiety anticipated.** **Significant media interest: prepare press statement**

Calculate the Impact:

All Minor = **GREEN**; 3 Minor and 1 Moderate = **GREEN**;

No major and 2-4 Moderate = **AMBER**;

Any Major = **RED**.

Part 2: Supports a single channel of infection incident/outbreak assessment and information reporting both internally within a NHS Board area and externally to Health Protection Scotland (HPS) and Scottish Government Health and Social Care Department (SGHSCD).

Part 2: Communication.

GREEN	AMBER	RED
Complete mandatory HIIAT Green reporting template and attach any prepared press statements. http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-15-mandatory-healthcare-infection-incident-and-outbreak-reporting-template-hiiort A HIIORT is only required when HPS support is requested Follow local governance procedures for assessing and reporting.	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS. Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT assessment as agreed between IMT and HPS (**at least weekly**) The HIIAT should remain Amber only whilst there is ongoing risk of exposure to new cases or until all exposed cases have been informed	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT daily or as agreed between HPS and IMT (**a minimum of weekly**). The HIIAT should remain Red only whilst there is significant ongoing risk of exposure to new cases or until all exposed cases have been informed.

The final decision to release a press statement irrespective of HIIAT assessment (colour) is the responsibility of the IMT chair.

*** Only HAI deaths which pose an acute and serious public health risk must be reported to the Procurator Fiscal (SGHD/CMO(2014)27).**

The full manual is available at **www.nipcm.hps.scot.nhs.uk/**.

Annex D: Other related guidance and further information

Guidance that may be useful in the management of public health incidents may be published on a variety of websites but links to the key sources are provides below.

Scottish Health Protection Information Resource (password protected)

Scottish Health Protection Information Resource (SHPIR) is intended to provide a distillation of the most current and relevant health protection advice and guidance material available for use in dealing with Health Protection issues and enquiries encountered both in daily practice and in an out-of-hours setting for Public Health/Health Protection staff involved in on-call work. The essential purpose of SHPIR is to provide a reliable and quality assured resource of first resort, for Health Protection staff in Scotland, particularly when rapid access is required to key documentation, advice, guidance and other information on Health Protection topics.

http://www.shpir.hps.scot.nhs.uk

Scottish Health Protection Network

Please refer to **Annex F**.

Incident Learning

Please refer to **paragraph 37**.

Click 'Incident Learning' on the SHPIR homepage to access the repository **http://www.shpir.hps.scot.nhs.uk**.

Scottish Government contact (non HAI incidents)

Office Hours: Senior Medical Officer on call **0131 244 2804**.

Out of Hours: on call mobile number **07824 087787**.

Healthcare Infection Incidents and Outbreaks

Please refer to Chapter 3 of the National Infection Prevention and Control Manual (NIPCM) **http://www.nipcm.hps.scot.nhs.uk/**.

The purpose of Chapter 3 is to support the early recognition of potential infection related issues, to minimise the risk of cross-transmission of infectious agents within health and other care settings; and outline the incident management process

Civil Contingencies

The Civil Contingencies Act

Preparing Scotland

Food Standards Scotland

Food (Scotland) Act 2015

A Strategy for reducing foodborne illness in Scotland

FSS incident Management Framework (2018)

Public Bodies Act 2014

http://www.legislation.gov.uk/asp/2014/9/contents/enacted

NHS (Scotland) Act 1978

http://www.legislation.gov.uk/ukpga/1978/29/contents

Public Health (Scotland) Act 2008

http://www.legislation.gov.uk/asp/2008/5/contents

Communicating with the Public about Health Risks – HPN document

https://www.hps.scot.nhs.uk/web-resources-container/communicating-with-the-public-about-health-risks

Annex E: Sharing Personal/Patient Information in the context of the Public Health Incident Response

1. Building up the overall picture of a public health incident normally requires collated information from individuals. Personal health information is integral to effective investigation of the cause and development of effective control measures. Personal health information is recognised as particularly sensitive within the Data Protection Act.

2. In an incident with significant risk to the wider population, there remains a duty both to protect and minimise the personal health information used and also a duty to share information with other agencies if required to determine the cause and enable effective control of the incident. Police officers may be members of an IMT and police action may be essential to control the incident and reduce harm to the wider population. Some Resilience Partnerships also have specific information sharing agreements. The Data Protection Act and other guidance can enable the sharing of personal health information when there is significant risk to the broader public.

3. There may therefore be duties in any incident to both protect and to share personal health information. Decisions should be guided by the Data Protection Act principles and the guidance highlighted in paragraphs 2 and 3. Those leading the IMT should be able to justify decisions made and to record the reasons for such decisions.

4. The IMT chair must base the final decision on all the available information and balance the duty to share data with the duty to keep personal data confidential.

5. The Data Protection Act and the 'Caldicott Rules' provide a clear framework within which we are all required to work. More specifically, the following material is available in relation to information sharing in the context of public health incidents:

    - Preparing Scotland (2016) provides guidance on the need to share information generally. **http://www.readyscotland.org/ready-government/preparing-scotland** / **Freedom of Information (Scotland) Act 2002**.
    - CEL (13) 2008 Information Sharing between NHS Scotland and the Police describes the protocols to be followed by the NHS and the Police Service on the sharing of information between the two services and is viewable at: (**http://www.sehd.scot.nhs.uk/mels/CEL2008_13.pdf**).
    - CMO letter of 28 January 2010 on the OUTBREAK OF ANTHRAX IN HEROIN INJECTING DRUG USERS - Confidentiality and Data Sharing Requirements reminds NHS boards of the existing policy agreements on information sharing with the police and the broader guidance on duties related to sharing and protecting personal health information: (**https://www.sehd.scot.nhs.uk/cmo/CMO(2010)03.pdf**).

- Memorandum of Understanding for Public Health Intelligence (PHI) processing of personally identifiable information (PII) provided by microbiology laboratories, NHS Board Health Protection Teams and Infection Prevention and Control Teams, approved in October 2016.
- CMO letter of 17 November 2016 on sharing of personal Sensitive Information (medical / clinical records) for Court proceedings: (**http://www.sehd.scot.nhs.uk/cmo/CMO(2016)20.pdf**).

6. The General Medical Council guidance 'Confidentiality: disclosing information about serious communicable diseases' (September 2009) provides guidance to doctors responding to public health incidents. It is important to read this guidance as a whole but the following are important elements of the guidance:

   - 'Personal information may therefore be disclosed in the public interest without the patients' consent and in exceptional cases where patients have withheld consent if the benefits to an individual or to society as a whole outweigh both the public and patient's interest in keeping the information confidential.'
   - 'Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to risk of death or serious harm.'
   - 'You should pass information about serious communicable diseases to the relevant authorities for the purpose of communicable disease control and surveillance. You should use anonymised or coded information if practicable and as long as it will serve the purpose.'

   The Nursing and Midwifery Council (NMC) provides guidance for nurses in the NMC.

   Standards of conduct, performance and ethics for nurses and midwives (2008).

Annex F: Planned activities of the SHPN in relation to the implementation of the Framework for the Management of Public Health Incidents

Introduction

The SHPN was conceived to improve health protection in Scotland, by bringing together those working in this field to share good practice in a network. As such, the SHPN is the appropriate platform to support further development of a number of actions suggested in the Management of Public Health Incidents guidance.

Proposal

The SHPN will support the implementation of the key principles of Incident Management that relate to education, promotion of best practice and curatorship of the reports (**paragraph 37**).

The SHPN is proposing to take forward the above by:

1. Making sure an appropriate framework to support effective incident management is in place, monitored and regularly reviewed by:
    - developing the system to produce IMT reports as indicated in the Management of Public Health Incidents guidance so that NHS boards and other agencies agree on what is required to report and is of the highest quality possible
    - making sure there is an appropriate and fit-for-purpose system to log, store and share reports across Scotland;
2. Supporting the work of the SHPN Workforce Education Development Group in relation to incident management workforce education development relating;
3. Making sure there are regular forums to help facilitate sharing and learning from experience.

Annex G: Draft Agenda for IMT

1. Introduction (Reminder of confidentiality and need for accurate records)
2. Declarations of conflicts or vested interests
3. Items not on the agenda
4. Minute of last meeting (if applicable) including review of actions agreed
5. Incident/Outbreak Resume/Update:
    - General situation statement;
    - Patient report;
    - Microbiology/Toxicology report;
    - Environmental Health report;
    - Other relevant reports.
6. Risk Assessment:
    - **Severity:** Dynamically assessed risk of the degree of foreseeable harm that may be caused to individuals or to the population and possible issues with recovery.
    - **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 media interest, public concern and attitudes, expectations, pressures, strength of professional knowledge and external factors including political decisions.
7. Risk Management/Control Measures:
    - Patients;
    - General;
    - Public Health;
8. Care of Patients - Hospital and Community

9. Further Investigation:
    - Epidemiological;
    - Environmental;
    - Microbiological / Toxicological.
10. Risk Communication:
    - Agree common data set;
    - Advice to public (letters, printed materials, media, social networking, websites, helplines etc);
    - Advice to professionals (GPs, clinical staff, other NHS boards, partners);
    - Media (print, radio, TV, websites, social networking sites);
    - Elected members;
    - Inform other authorities e.g. Procurator Fiscal.
11. Review (standing agenda items):
    - Appropriate membership;
    - Resourcing;
    - Framework (incident management structure); consider need to seek support through LRP/RRP / other personnel;
    - Obtain contact details of all key personnel within and outwith hours;
    - Assess effectiveness of action;
    - Other resilience management groups formed or required;
    - Need to escalate (refer to **Table 1**).
12. Future activity (final meeting only - collation of documentation, possibility of future inquiries)
13. AOCB
14. Action list with timescale and allocated responsibility
15. Date and time of next meeting

Annex H: IMT Decision Log

Decision log
Time:
Date:
Name:
Recorded by:
Problem:
Options: **A:** **B:** **C:** **D:**
Outcome / actions:
Rationale:
Signature:

Annex I: Incident evaluation and reporting

Incident Preparedness

- Incident plans have been reviewed annually by NHS boards and their partners, especially LAs.
- Incident plans dealing with a major exposure to hazard e.g. food, waterborne, HAI, chemical and radiological incidents have been tested within a 3-year cycle i.e. utilised in an actual major outbreak or tested in an exercise. Such testing should include dealing with the deliberate release of hazardous agents
- Incident plans include up to date contacts for liaison out of hours, available expertise and possible IMT members - as related to incident, whether full members, co-opted or advisory level.
- Incident plans include an aide-memoir of the outline of the role of IMTs.
- The NHS board has documented systems and agreed criteria for being notified of and detecting potential or actual incidents.

Incident management

- In the event of an incident, the NHS board has undertaken an initial risk assessment and recorded:
    - whether there is a significant risk to public health;
    - scale of problem;
    - severity of problem;
    - possible cause of incident/outbreak;
    - initial actions to be taken and why.
- The IMT has kept records of decisions made about incident control measures and documented:
    - whether these measures have been applied; and
    - if not, the reason why;
    - if yes, by whom, when and where they have been carried out;
    - any further action arising from above.
- The IMT has reviewed the impact of control measures at each IMT meeting and documented its view on this.
- The IMT has reviewed the risk to public health arising from the incident and the likely overall impact of control measures on it.

- The IMT Chair has ensured that there is a check maintained on the above aspects of incident management and that this is recorded in the IMT minutes.
- The IMT Chair has regularly reported on the incident to relevant senior management of the LA and NHS board.
- The IMT has agreed a single press spokesperson and press officer who have regularly reported to the IMT on the tone and content of communications and responses to them.

After the incident

- The IMT Chair has conducted a hot debrief immediately at the conclusion of the response phase.
- The IMT Chair has arranged for a full debrief to be carried out and submitted the final IMT report to the NHS board or NHS board committee
- The IMT Chair has forwarded the report to SHPN and relevant organisations with responsibility for taking forward its recommendations.

Annex J: SBAR Report

A tool to assist NHS boards and HPS/PHS report incidents not requiring Full Incident Report.

Issue	Statement
Situation • Causative agent • When and where incident detected and ended • Number of people involved • Organisation • Impact of health	
Background • How recognised • Context to Incident • Guidance	
Assessment • Descriptive epidemiology • Exposures and sources • Risks to public health • Control Measures • Communications	
Recommendation • What, who and when: • Prevention of similar events • What went well • What needs improved	
Name:	**Designation:**
Email:	**Tel:**

Annex K: Hot debriefing template

The Scottish Government 'Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams for the Management of Public Health Incidents', specifically highlights the need to learn from experience. A central repository for Incident Management Team (IMT), Problem Assessment Group (PAG) and Situation, Background, Assessment and Recommendation (SBAR) Reports and a mechanism to capture and share learning nationally will be established through the Scottish Health Protection Network (SHPN). New reports will be collated as they are published to populate the repository.

This document should be completed by IMTs chair as soon as possible following the end of an incident in the interim before the full IMT report is produced. This is to capture initial lessons learnt immediately (a 'hot debrief'), recognising that some IMT reports take months/years to be published.

Incident reference
Please provide a reference/title for this incident (e.g. Legionnaires outbreak in Lothian, 2012; or Outbreak of E. coli O157, Rose Lodge nursery, Aboyne)
Details of incident
Please provide a brief summary of incident:
What went well?
Please list aspects of the incident that were managed well.
What did not go well?
Please list aspects of the incident that were not managed well.
Lessons Learned
Please provide details of any learning or recommendations for national consideration:

IMT lead details	
Name:	Email:
Job Title:	Address:
Contact number:	Contact number (mobile):
Date:	Signed:

Completed templates to be returned to: phs.shpn-pmt-submissions@nhs.net

Annex L: IMT Report template

The following is a suggested template for an IMT Report. However, other report formats are also acceptable.

1. Introduction
    - Brief summary of the incident and setting the scene.
2. Background
    - Information on features of cases, incubation period, dose, source and modes of exposure, diagnosis and treatment, and if relevant, prevalence of the relevant disease locally, nationally and globally.
3. Investigation
4. Epidemiological investigation and results
    - Descriptive: description of initial cases, case definition and hypothesis generation, enhanced surveillance
    - Analytical: description of any case control and/or cohort studies
5. Environmental investigation and results
    - Details of investigation/detection of main routes of exposure, sources of these, if possible levels of exposure and circumstances leading to exposure
6. Microbiological/Toxicological investigations and results
    - Clinical, food/water and environmental sampling undertaken
7. Risk Management
8. Prevention of further exposure to hazardous agent including details of relevant enforcement/regulatory action
9. Care of cases
10. Risk Communication
11. Discussion and conclusions
12. Lessons identified and recommendations
13. Appendices (if necessary)

Full Incident Management Team Report Proposed Standardised Dataset

*A suitable method will be developed for reporting this proposed dataset. It is expected that when completed, it will be attached to a suitable narrative on the incident. The dataset and methods of reporting will be piloted and suitably revised. There will be a final consultation on reporting method. It is intended that the narratives and completed datasets will be held by the SHPN to facilitate on-going work to help prevent similar incidents and improving practice in incident management.

1. Incident Management

Key fields	Details (to complete)
Incident Management Team (IMT) lead	Name and job title, Board
Agencies represented on IMT:	
Date of first IMT meeting:	
Date of last IMT meeting:	
Number of IMT meetings held:	
Guidance used by IMT:	
Please record any other points on IMT:	

2. Incident Detection and Initial response

Key fields	Details (to complete)
Date of first notification of case(s)	
Date incident detected	
Description of how the incident was detected	
Description of the initial risk assessment response and communications:	

Key fields	Details (to complete)
Please note any other points on Incident detection and initial response	

3. Type of Incident

Key fields	Details (to complete)
Causative Agent*	
Main presenting illness	
Main Primary Exposure(s)**	Food Water Air General Environment (i.e. when a hazard, usually chemical or radioactive, is widely dispersed e.g. in soil, water, in living matter and it is difficult to discern a specific exposure pathway). Person to person type e.g. sexual, respiratory, contact) Zoonotic Other (please describe)
Source(s) of exposure***	
Duration Of Incident	From: To:
Please note any other points on the type of incident	

*Causative Agent refers to the hazard (biological, chemical or radiological) which has been absorbed into and/or entered the cases and is prime cause of their illness.

**Exposure is used to describe the pathway through which a person/group/population has come into contact with the hazard which is the of disease or health state of interest. The main types of exposure are: food, water, air, person to person, zoonotic and general environmental. Exposure can be primary i.e. the original exposure leading to the hazard entering into or being absorbed by the index case or secondary i.e. consequential further exposures which are related to but may be different to the original

***Source of exposure relates to where the exposure has originated from.

4. Investigation

A. Epidemiological Investigation

Key fields	Details (to complete)		
Type(s) of Epidemiological investigation			
Final Case Definitions	Confirmed Probable Possible		
Number of cases by definition and sex			
Number of cases by definition and age			
Clinical status	Admitted:	ITU:	Deaths:
First and last date of onset by definition Epidemic curve appended?	Yes/No		
Areas of incident occurrence Mappings of cases appended?	Yes/No		
Primary Exposures investigated	Food Water Air General Environment Person to person(type) Zoonotic Other (please describe)		
Source(s) of exposures			
Secondary exposures investigated			
Other risk factors for illness			
Underlying medical conditions			
Further epidemiological investigations Report appended?	Yes/No		

Key fields	Details (to complete)
Key findings:	
Main conclusions	
Please note any further points on the epidemiological investigation	

B. Human Laboratory Investigation

Key fields	Details (to complete)
Diagnostic laboratories involved	
Reference laboratory involved	
Sampling and testing strategy Report appended	 Yes/No
Causative Agent	
Strain/Genotype of micro-organism	
Dates of first and last positive results in confirmed cases by laboratory	
Further microbiological investigations Report appended	 Yes/No
Key findings:	
Main conclusions	
Please note any further points on the laboratory investigation	

C. Environmental Investigation

Key fields	Details (to complete)
Agency leading investigation	
Other agencies	
Laboratories involved	
Investigation Strategy (including sampling & testing) Report appended	 Yes/No
Main exposure(s)	
Source and vehicle of exposure(s)	
Further epidemiological investigations Report appended?	 Yes/No
Key findings:	
Main conclusions	
Please note any further points on the environmental investigation	

D. Overall Summary from Investigation

Key fields	Details (to complete)
Key findings:	
Main conclusions	

5. Control Measures

Key fields	Details (to complete)
Objectives	

A. Prevention of primary exposure

Exposure	Measure	Onset and duration	Agency responsible

B. Prevention of secondary and further exposure(s)

Exposure	Measure	Onset and duration	Agency responsible

C. Prevention of ill health in those exposed

Exposure	Measure	Onset and duration	Agency responsible

D. Treatment and care of cases

Services	Measure	Onset and duration	Agency responsible
Primary care			
Secondary care			
Other			
Criteria for cessation of main control measures			

E. Summary

Key fields	Details (to complete)
Enforcement of compliance issues	
Evaluation of impact and achievement of objectives	
Main conclusions	

6. Communications

A. Strategy

Key fields	Details (to complete)
Objectives	
Audience(s)	
Key content: Assessed risk to health	
Key content: Advice on risk reduction	
Main spokesperson(s)	
Method of assessing impact	

B. Communications made - service

Key fields	Details (to complete)
Public Health (Scotland)	
Public Health (UK & Europe)	
Scottish Government	
General Practice	
NHS 24	
Out of hours & A&E	
Local authorities	
Secondary Care	
Others	

C. Communications made - public

Key fields	Details (to complete)
Cases and Contacts	
Affected communities	
Local Media	
National Media	
Helpline	
Publicity and specific health information	
Others	

D. Summary

Key fields	Details (to complete)
Evaluation of impact and achievement of objectives	
Main conclusions	

7. Antecedants of Outbreak

Key fields	Details (to complete)
What occurred to precipitate the outbreak?	
Were there any system failures which contributed to this?	
Were there any organisational or cultural issues contributing to these?	
What is the likelihood of a similar event occurring?	
What needs to be done to prevent this?	

8. Learning from Experience

A. Learning Points

Key fields	Details (to complete)
Organisational Arrangements	What worked well?
	What could be improved?
Investigation	What worked well?
	What could be improved?
Control measures	What worked well?
	What could be improved?
Communications	What worked well?
	What could be improved?
Please identify any updates to guidance that should be considered as a result of the incident	
Please identify any research that should be considered as a result of the incident	
Please identify any Workforce/ Education/Development priorities to arise as a result of the incident	

B. Recommended Actions Arising from the Incident

Recommended Actions should be set out as objectives using the `SMART` approach i.e. Specific, measurable, achievable, realistic, timed:

- **Specific** – Be precise about the objective to be achieved.
- **Measurable** – Quantify the extent of the action.
- **Achievable** – Actions should not be an excessive burden on owners.
- **Realistic** – Sufficient resources should be available to complete actions.
- **Timed** – State the expected completion date.

Action No.	Description of action	Action owner	Complete by date

9. Report Approval

For completion by the Chair of the Incident Management Team	
Name:	**Designation:**
Signature:	**Date:**
Email:	**Tel:**

Annex M: Membership of Working Group for 2017 review

Name	Remit on Group	Role /Job Title	Organisation
Henry Prempeh	Chair	Consultant in Public Health Medicine	NHS Forth Valley
Alex Sanchez-Vivar	SHPN-Guidance - Healthcare Scientist	Senior Healthcare Scientist	HPS
Alison Potts	Representative – NSS PHI (HPS)	Epidemiologist	HPS
Allan Moffat	Representative – Scottish Government Response & Communication, Resilience Division	Unit Head, Response & Communication	Scottish Government
Bruce Farquharson	East of Scotland Regional Resilience Partnership	Group Manager	Scottish Fire and Rescue Service
Cheryl Gibbons	SHPN-Guidance - Healthcare Scientist	Healthcare Scientist	HPS
Clive Murray	Representative – North of Scotland Regional Resilience Partnership		Police Scotland
Colin Ramsay	Representative – NSS PHI (HPS)	Consultant Epidemiologist	HPS
Darren Ross	Group Administration	Service Delivery Manager	HPS
Fiona Browning	Representative – Health Protection Nurse Specialists	Health Protection Nurse Specialist	NHS Grampian
Gareth Brown	Representative – Scottish Government Health Protection Team	Head of Health Protection	Scottish Government
Gillian Hawkins	Representative – NSS PHI (HPS)	Consultant in Health Protection	HPS
Helen Ewing	Representative – NSS PHI (HPS)	Resilience Manager	HPS
Joe Graham	Representative – West of Scotland Regional Resilience Partnership		Police Scotland
Josephine Pravinkumar	Representative – SHPN Coordination Group	Consultant in Public Health Medicine	NHS Lanarkshire

Name	Remit on Group	Role /Job Title	Organisation
Lindsey Meechan	Group Secretariat	Administrative Support Officer	HPS
Lisa Ritchie	Representative – NSS PHI (HPS)	Nurse Consultant Infection Control	HPS
Martin McNab	Representative - Society of Chief Officers of Environmental Health in Scotland	Health Protection Manager	Inverclyde Council
Michael Healy	Representative – Health Resilience Unit	Head of Health Resilience Unit	Scottish Government
Nicola Rowan	Scottish Health Protection Network Manager	Service Manager	HPS
Syed Ahmed	Chair of the Health Protection Coordination Group	Clinical Director	HPS

Annex N: 2020 interim review

The 2020 interim update was undertaken by Colin Ramsay (deputy Clinical Director, HPS/PHS) with contributions from Andrew Reilly/SMO with Scottish Government Health Protection Directorate and other colleagues.