Bracknell Forest Council

'Be Prepared'

A review of Preparedness for Public Health Emergencies by a Working Group of the Health Overview & Scrutiny Panel

June 2010

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Acknowledgements

The Working Group would like to express its thanks and appreciation to the following people for their co-operation and time. All those who have participated in the review have been thanked for their contribution and received a copy of this report if wished.

Angela Snowling	Public Health Consultant and former Acting Director of Public Health, NHS Berkshire East
John Pullin	Deputy Director of Commissioning (Strategy and Planning), NHS Berkshire East
James Amos	Emergency Preparedness Manager, South Central Ambulance Service
Alyson Smith	Consultant in Health Protection, Emergency Planning Lead, Thames Valley Health Protection (HP) Unit, HP Agency

The following from Bracknell Forest Council:

David Steeds	Head of Environmental Health and Safety
Louise Osborn	Emergency Planning Manager
Richard Beaumont	Head of Overview and Scrutiny
Andrea Carr	Policy Officer (Overview and Scrutiny)
Victoria Bale	Former Overview and Scrutiny Support Officer

1. Executive Summary

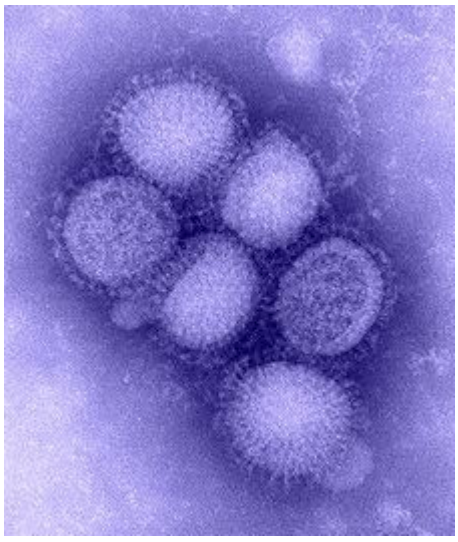
1.1 Wishing to review an aspect of health services from the patient's perspective, the Health Overview and Scrutiny Panel established a Working Group to pursue this task. From a lengthy list of possible review topics, the Working Group identified preparedness for public health emergencies as the theme of the review as it was felt that a significant number of occupants of the Borough would view it as being relevant and important to them in the light of growing threats to human health such as influenza pandemics and terrorism.

1.2 Although preparedness for and response to public health emergencies is seen largely as a function of health services, other bodies such as the ambulance service, fire service and local authority can become involved as a multi-agency approach is often required. Accordingly, the Working Group met representatives of and researched the role and responsibilities of numerous relevant agencies during the course of its review as part of the evidence gathering process.

1.3 This report describes the work of the Working Group and sets out its findings. Members hope that the report will be well received and look forward to receiving responses to their recommendations.

1.4 The Working Group comprised:

Councillor Burrows (Lead Member)
Councillor Mrs Angell
Councillor Thompson
Local Involvement Network Representative Mrs Mattick



Electron microscope image of the Swine Flu virus.

2. Background

2.1 In October 2007, a working group of the Health Overview and Scrutiny Panel commenced a patient focus review. Although this review was discontinued in August 2008, a patient focus on local health services was felt to remain relevant and a new working group with different membership was established to undertake more work in this area from a different perspective.

2.2 The new working group selected the preparedness of the Council and its partners for public health emergencies as the theme for its review which was timely and relevant as it coincided with the outbreak of Swine Influenza A/H1N1 (Swine Flu). The Working Group felt that the review theme met the criteria of being relevant to a sizeable number of residents, not over-complex, open to carrying out some original work which had the prospect of adding value and making worthwhile recommendations.

2.3 The key objectives of the review were to:

- Examine the arrangements for identifying risks of public health emergencies;
- Establish the respective roles of the Council, NHS Berkshire East (the local Primary Care Trust) and other partners;
- Review the plans and resources for responding to public health emergencies;
- Compare the plans and arrangements to any national requirements and best practice; and
- Recommend improvements as appropriate.

2.4 The scope of the review consisted of the arrangements of the Council and other public bodies to prepare for public health emergencies in Bracknell Forest.

2.5 Specific questions identified for the Working Group to address were:

- What are the respective roles of the World Health Organisation (WHO), the Health Protection Agency (HPA), the Council, NHS Berkshire East and other partners relating to preparing for public health emergencies in Bracknell Forest?
- What are the national requirements relating to preparing for public health emergencies, and how does Bracknell Forest measure up to these?
- What examples are there of best practice relating to preparing for public health emergencies, and how does Bracknell Forest measure up to these?
- What are the arrangements for identifying risks of public health emergencies, and what is on the list for Bracknell Forest? How frequently is that list reviewed?

- What detailed plans exist, and what resources have been made available for responding to public health emergencies?
- Have these plans been tested in practice? If so, what issues arose?
- How did the arrangements work in practice in relation to the Swine Flu pandemic in 2009?
- Are any improvements needed to existing policies and practices?

Flooding Emergency

3. Investigation, Information Gathering and Analysis

3.1 Having met on two instances to agree the theme and scope of the review, the Working Group met on six further occasions to gather information from representatives of organisations identified as playing a significant role in emergency preparedness and response in Bracknell Forest. The review also included ascertaining the role of the WHO in public health and researching the role of other organisations, particularly the Royal Berkshire Fire and Rescue Service (RBFRS), in preparing for and responding to emergencies. The structuring of General Practitioner (GP) surgeries to respond to health emergencies and offer support was also looked at. Research undertaken by the Working Group to inform the review included consideration of the NHS Berkshire East Influenza and Emergency Response Plans, Bracknell Forest Council's Influenza Pandemic Response Plan, the Thames Valley Health Protection Unit's (TVHPU's) Joint Outbreak / Incident Control Plan and the Berkshire Major Incident Protocol.

3.2 Public health emergencies fall within the remit of the health profession to lead the response and other agencies, including the Council, are involved in a co-ordination and support role. The Council's main partners in preparing for and responding to public health emergencies are NHS Berkshire East, the HPA, South Central Ambulance Service NHS Trust (SCAS), Thames Valley Police, RBFRS and the Environment Agency. Their related roles and responsibilities are outlined in Appendix 1 and elaborated upon below. Slides included in Appendices 2 and 3 indicate how they interlink at different command levels and their responder categories. The voluntary sector also provides support in response to public health emergencies.

3.3 Owing to the amount of time required for the Working Group to complete its review together with the fluid and rapidly changing nature of the Swine flu pandemic which is cited in this report as an example of a potential public health emergency, the information gathered by the Working Group in the earlier stages of the review reflect the development of the pandemic at that time and not necessarily the outcomes.

Meeting with the Former Acting Director of Public Health

3.4 The Working Group met Dr Angela Snowling, a public health consultant and Acting Director of Public Health at NHS Berkshire East at the time of the meeting with 'on call' responsibilities depending upon whether an operational or public health response to an incident or emergency was required. In addition to giving a presentation in respect of Swine Flu and NHS Berkshire East's Influenza Pandemic and Emergency Response Plans, Dr Snowling described Scientific and Technical Advice Cells (STACs), the roles and responsibilities of local agencies and the role of the WHO in public health.

3.5 Dr Snowling advised that the WHO had redefined the phases of Influenza pandemics (global and rapidly spreading virus) which were now categorised into three stages, namely, Inter-pandemic, Pandemic alert and Pandemic. There were six Alert Levels within these stages and the United Kingdom (UK) was at Level 5 at the time of the meeting in an extended pre-surveillance stage where there was evidence of significant human-to-human transmission. Influenza Pandemic Plans, which had been tested nationally, became operational at Level 6 (efficient and sustained human-to-human transmission). Whilst recognising the international alert system, the UK operated a separate

alert level plan where Levels 2 to 4 would trigger action. When assessed in March 2009, NHS Berkshire East's Influenza Pandemic Plan received a success rating of 89%. The 11% gap related to dealing with vulnerable groups and development work to close this gap was being progressed by Bracknell Forest's Emergency Planning Team. This involved working with the British Red Cross voluntary organisation to establish a 'flu friends' process (people that could collect anti-virals for sufferers who were vulnerable and did not have a support network around them). As Swine Flu did not ultimately have the expected impact and the number of symptomatic vulnerable people was less than anticipated, the system developed with British Red Cross was not activated and small numbers of vulnerable people were accommodated by NHS Berkshire East. There was also some discussion nationally to provide a centralised process.

3.6 The Plan was sufficiently flexible to change if needed and it was recognised that there was always scope for improvement. Dr Snowling felt that the voluntary sector was overstretched and assistance from organisations such as the Women's Royal Voluntary Service and British Red Cross would be sought when serious alert levels were reached and they were able to assist. In the worst case scenario of up to a 50% mortality rate, the army could become involved in a theoretical response. Although serving officers were catered for by international medical teams, NHS Berkshire East remained responsible for the health of their family members. Military hostel accommodation for those who had become infected with flu was a possibility depending on the army's level of preparedness.

3.7 There had been monitoring in March 2009 to assess how plans were being progressed and health direction was received from Oxfordshire Primary Care Trust (PCT) which took the lead for the South Central Strategic Health Authority area and liaised daily with NHS Berkshire East.

3.8 The Working Group was apprised of the spread of Swine Flu at the time of the meeting. The Acting Director of Public Health had access to airline manifests and was therefore able to track possibly infected travellers from Mexico, the source of the outbreak, although bookings through numerous flight booking services complicated the process. There was a national information cascade system which was being tested for effectiveness.

3.9 The flu emergency response was modelled on a worst case scenario pandemic which envisaged a sixteen week flu wave followed by a second sixteen week wave peaking at six weeks resulting in a mortality rate of 25-50%. One to three days was the incubation period for Swine Flu and patients were ill from seven to ten days. If no flu symptoms were present after seven days of possible transmission, it could be assumed that people were not infected with the virus. Dr Snowling expressed an opinion that incomplete information in respect of Swine Flu had been received from Mexico which had led to the WHO accelerating the response level. It was felt that Mexican port authorities should have undertaken an algorithm for the management of suspected cases of Swine Flu. Fatalities could occur where a contractee was suffering from another condition such as a respiratory problem. It was possible for the virus to mutate into a different more virulent strain hindering treatment and immunity.

3.10 At the early stage of the viral outbreak endeavours were made to contain and prevent its spread, these included tracing close contacts who were defined as a person with whom the sufferer had been within a metre's distance for an hour or

more. Some schools had been closed on the advice of the local HPU. Analysis of swabs taken from the nose and mouth of suspected suffers were undertaken to confirm contraction of the virus and 3,000 was the maximum number of cases that could be investigated. Other people could self-assess their condition with the benefit of on-line information and contact their GP by telephone. Although there was no treatment specific to Swine Flu, immediate administration of general anti-virals would reduce severity, and symptoms by one day. Stocks of anti-virals were high at the time of the meeting and doctors had been instructed against prescribing medicine on a private basis or before contraction had been confirmed. There was a model for action in the event of the failure of Tamiflu, a main anti-viral, and work to develop a flu vaccine was ongoing although this involved a certain amount of speculation as to which strains would pose the greatest threat to life each year. Two 'A' strains from Australia and one 'B' strain from the USA had been the most virulent in recent years. Although Swine Flu did not compete with these in terms of virulence and was less dangerous than seasonal flu, it transmitted rapidly, could combine with other strains, be fatal in 25-50% of cases and become the carrier of a more dangerous virus. As explained above, Swine Flu did not have the impact that was initially suspected.

3.11 Information provided to GPs was appropriate to the stage of a pandemic and there was a national communication strategy with phased responses that was launched when Alert Level 6 was reached. Information leaflets in respect of Swine Flu were delivered to all households and care had been taken to communicate sufficient warning without causing hysteria. A county radio channel and some local newspapers had assisted with communicating a positive ideology through intelligent reporting. Doctor managers and community nurses were equipped with telephone numbers to cascade information as part of a national plan involving extended flu lines manned by an Emergency Response Team and involving the out-of-hours service.

3.12 NHS Berkshire East had a budget to fight Swine Flu and anti-viral distribution centres were established when flu pandemics occurred. National guidance advised people to establish a network of 'flu friends' and symptomatic people were asked to avoid their GP surgeries, flu centres and local Accident and Emergency (A&E) centres to reduce transmission unless they were seriously ill. However, NHS Berkshire East was in daily contact with hospitals and sought an isolation area within an A&E ward to cater for the symptomatic.

3.13 The Thames Valley Influenza Planning Committee, which included an element of emergency planning, had been established three years previously. Its membership included representatives of the unitary authorities in Berkshire, human resources workers and pharmacists and its papers were circulated to the Berkshire East Community Health Service, Heatherwood and Wexham Park Hospital Trust, Broadmoor Hospital Trust and the police to keep them informed of developments. Public Health Team members were available to cover in the case of emergencies and there were replacements for provider staff. Local authority emergency plans included procedures for networking with the voluntary sector in the case of an emergency event. Changes to the Criminal Records Bureau checking system with effect from October 2009 enabled data to be linked to a national computer system resulting in the need for only one check per volunteer for all purposes.

3.14 Dr Snowling referred to daily communication with councils in East Berkshire during the Swine Flu pandemic and indicated that good relations with local

authorities had been experienced. NHS Berkshire East was obliged to report on lessons learnt in such circumstances and a report would be prepared when the Swine Flu outbreak had passed.

3.15 The Working Group received an overview of emergency preparedness which included the identification of risks, the planning and response roles of the Thames Valley HPU and NHS Berkshire East's duties and responsibilities in relation to national Core Standard 24 and the Civil Contingencies Act 2004. The Act classified NHS Berkshire East as a Category 1 responder with a statutory duty to undertake both emergency and business continuity planning in order to respond to disasters. NHS Berkshire East commissioned emergency planning and response work whilst community health services had a response rota with resources to fund and manage it. In the case of public health emergencies, the Director of Public Health 'on call' would be the lead director in any response which could include requirement to establish a Silver Tactical Team at King Edward VII Hospital or chair a STAC at Gold Command, Kidlington. In the event of an emergency, the NHS resource was energised, a police chain put in place and advice and support was received from the STAC and the HPA. The Centre for Hazards and Poisons, a national organisation formed by the Government, offered specialist advice in the event of chemical, radioactive, biological or nuclear incidents. Local emergency response plans were 'living' documents and had been updated and tested with the benefit of advice from a national team. The Council's Emergency Planning Team had a plan in place to activate in the event of mass fatalities which was in the domain of the Thames Valley Local Resilience Forum and Mass Fatalities Sub Group. Organisational charts in the NHS Berkshire East Emergency Response Plan depicted responses under the categories of Alert & Informing Cascade and Command, Control & Co-ordination in relation to health and whole system emergencies. Whilst the NHS took the lead and co-ordinated the response in the case of a health emergency such as a flu pandemic, the most appropriate agency would be identified in other situations e.g. the Environment Agency / local authority would undertake this role in a flooding disaster and SCAS would in the event of an explosion. The local authority tended to have greater involvement in health emergencies at the recovery stage.

3.16 Other public health emergencies recently experienced included Norovirus issues and damage to a cyanide gas pipe in a school playground. Although there had been no local radiological disaster, there was a response model for this owing to the moderately close location of Aldermaston. There were also models for specific sites such as Broadmoor Hospital. The Working Group was advised of NHS Berkshire East's methods of identifying public health risks. The duration and extent of exposure were factors and pathways to the cause of public health threats were checked. An example of identifying public health issues associated with flooding in Winkfied Row was given and the Working Group was advised that NHS Berkshire East's website provided advice for affected residents to follow in such situations. There was an intention that all schools should have a business continuity plan which operated at a level below NHS Berkshire East's Plan and involved communication with schools and the Council's Environmental Health Team. This Team was under a statutory obligation to involve NHS Berkshire East where there was an evidence base of acute and chronic effects of contamination in areas such as proposals to build on brown field sites. Part 2A of the Town and Country Planning Act 1990 included a significant harm to health land designation which triggered referral to the Environment Agency. There had been 380 investigations of contamination by Environmental Health during the 2008/09 financial year which involved

Health Impact Assessments. It was possible to take remediation action and acquire planning permission to redevelop contaminated sites such as landfill areas and NHS Berkshire East would assist the local authority with the intervention process in the event that such a situation arose. Under such circumstances the polluter was required to cover the cost of remediation action.

3.17 Dr Snowling felt that more engagement with care homes and training of their staff was required as they housed vulnerable people and achieving this was one of her next pieces of work. The Council endeavoured to support this by engaging with private care homes to provide them with information, and offer vaccinations etc. There was a Public Health Working Group where constructive joint working between the Council and the Acting Director of Public Health was achieved.

Meeting with the Head of Environmental Health and Safety

3.18 The Working Group met Mr David Steeds, Head of Environmental Health and Safety at Bracknell Forest. Mr Steeds described his position within the authority and outlined his role and duties.

Food Safety

3.19 Mr Steeds advised that there were over 900 registered food businesses in the Borough for which the Council enforced food safety legislation. The premises were risk rated to ensure the businesses that presented the highest risk to the public were visited at a greater frequency than those of a lower risk. Whilst on the premises officers checked for cleanliness, identified hazards and sampled food if required. Officers were empowered to control hazards through the use of notices and closure of parts or all of the business if required. Action could lead to prosecution. These powers were used infrequently and compliance was usually achieved through informal means by way of on site coaching, training and the provision of advice. Closure represented an emergency and was the last resort. Where closure had been confirmed by the court, the Council could appeal for the food proprietor to be prohibited from running a food business. The officer must prove that there was a risk to public health. Cases such as these were rare but usually involved a range of issues from a pest infestation to an immediate risk of a food poisoning outbreak for example. In general terms, officers checked food that came into the Borough and that which left the Borough when required. In rare cases the Food Standards Agency (FSA) were empowered to intervene or provide direction to the Council where a situation had regional or national implications. Officers monitored daily food alerts that were issued by the FSA warning of potential food safety hazards from food from within or outside the UK. In such circumstances officers responded by checking relevant food businesses to ensure the Borough's food businesses were not implicated in the alert. The Working Group received copies of the TVHPU's Joint Outbreak / Incident Control Plan for information and noted that the local Director of Public Health became involved where significant problems were encountered. In addition, the FSA had the power to maintain a local presence if it was perceived to be necessary and assist the Council in the event of need.

Health and Safety

3.20 There were over 1,350 premises where the Council had statutory responsibility for health and safety at work matters. Premises were visited according to a national risk rating system. The Council had a duty to inspect the premises

under Health and Safety legislation. Once on the premises, officers had powers to serve prohibition and improvement notices where contraventions were found but in general most contraventions were resolved informally through co-operation with the business.

3.21 Officers were responsible for identifying key public health issues during visits. Two examples where there was a potential for the hazard to be a threat to public health were Legionnaire's Disease and asbestos. Legionella, which was a potentially fatal bacteria, was found widely in the environment. It thrived in warm enclosed water systems and spread via water droplets. A potential source of Legionella in the Borough were cooling towers of which there were currently 25 in Bracknell Forest. Businesses were required to notify the Council of their location. To prevent an outbreak of Legionnaire's Disease, officers were required to ensure that the correct routine maintenance procedures were followed. Officers were empowered to prohibit the operation of cooling towers or any other source of Legionella if necessary. A key partner agency with whom the Council worked in such cases was the HPA which provided ongoing surveillance to identify cases of infectious disease and provide medical advice. Businesses were required to survey their premises for the presence of asbestos. Removal was not always the first option as there was a need to minimise the risk of disturbance by any work carried out by contractors, for example, and to ensure generally that any identified asbestos was maintained in a sound condition as any broken or friable asbestos if disturbed could release fibres into the atmosphere. As was the case with Legionella, officers were responsible for focussing on this area during visits as, although the disease associated with asbestos was slow to develop, the potential public health risk was high.

Infectious Disease Control

3.22 The responsibility for the surveillance of infectious disease was split between the HPA, which provided the consultation, and the Environmental Health Section, which carried out active surveillance through investigations. The Council had only the remit to undertake food poisoning and gastrointestinal investigations whilst other key diseases such as measles, mumps and diphtheria were the responsibility of the HPA. Although Environmental Health often became aware of food poisoning at first hand, the main notification was via GPs who had a duty to report any case of suspected or confirmed food poisoning to the HPA, which in turn informed the Council. Officers then made an investigation as to the source and cause. Although most instances were individual cases or family outbreaks caused in the home, periodically the source was identified as a food business either in or from outside the Borough. In either case, investigation involved consultation with the HPA and if the outbreak was wide spread, an outbreak control team could be set up with the HPA to control the investigation. An example of joint working with the HPA was outbreaks associated with institutions such as schools, colleges and residential care homes, which carried a high risk rating owing to their vulnerable occupants. Winter vomiting disease was caused by a virus. Where an individual posed a threat to health by virtue of working with food or vulnerable people, the Council had powers to prohibit the person from working until they were free from infection.

3.23 The Council had signed a statement of intent with the Health and Safety Executive (HSE) committing to working in closer partnership. Part of this was the introduction of flexible warranting during 2009. The agreement enabled

officers who were based locally to enter business premises previously outside their remit as enforcement was the responsibility of HSE which was regionally based. This arrangement enabled the Council to cope with serious situations that posed an immediate risk to the employees and public more rapidly than otherwise would be the case without acting out side their legal powers. An example being the initial investigation of an accident on a building site, such as the collapse of scaffolding, could now be dealt with by the Council's officers.

Water Quality

3.24 It was the responsibility of water companies to liaise with the Council, provide water samples for testing and advise of any issues. The Drinking Water Inspectorate had a relationship with the Council and various other bodies and there were national standards in respect of water quality utilising red, amber and green alerts. Bracknell Forest also undertook pollution tests in inland waterways. A micro organism had established itself in water and caused some problems in the 1990's. Thousands of water samples were taken and reports indicated that water quality was now very good and much improved on past standards.

Air Quality

3.25 The Council continuously monitored the Borough's air quality. Nitrogen Dioxide (caused by incomplete combustion of petrol) had been identified as the cause of air pollution. Consequently, Environmental Health staff monitored the air quality at main roads to ensure that national air quality standards were achieved. The Council undertook this by the use of air quality stations and diffusion tubes. The data was collected and sent to the Department of Environment, Food and Rural Affairs (DEFRA) for scrutiny. The Council could be directed by DEFRA to take additional measures to reduce pollution levels if national standards were exceeded. The Council was awaiting DEFRA to decide on the next stage of the Council duty to monitor air quality and may require measures to reduce nitrogen dioxide concentrations at specified locations in the Borough. Air quality was unlikely to pose an emergency situation as it was ongoing and evolved over a number of years. Notwithstanding that, the Council was dependent on other agencies to undertake some analysis and maintenance of equipment. Such dependencies had been identified in the Business Continuity Plan.

Environmental Health and Emergency Planning

3.26 As Environmental Health staff had investigation and risk assessment skills and were routinely briefed on emergency planning and roles in incidences, they could be deployed to assist the Council during a major incident.

Business Continuity Plan

3.27 Environmental Health contributed to the divisional Business Continuity Plan and dependencies had been identified to enable the section to cope with an emergency situation outside its control.

Meeting with the Emergency Planning Manager

3.28 The Working Group met Louise Osborn, the Council's Emergency Planning Manager, who described her position within the authority and outlined her role and responsibilities.

3.29 The Emergency Planning Manager's role was to ensure that the Council was equipped to respond to emergencies, disasters and major incidents and support the work of the emergency services. Ms Osborn was Bracknell Forest's main emergency contact who was informed of, and central to, its emergency response structure and she maintained effective communication links and liaised with partners to ensure that they were aware of available assistance from the Council. Although the remit of the role was Borough-wide, the Emergency Planning Team worked jointly with neighbouring Berkshire unitary authorities and other relevant parties. Bracknell Forest was a low risk Borough in terms of potential emergencies and received fewer emergency call outs than many other Boroughs such as Reading. However, a call from the RBFRS had been received on the day of the meeting to advise that there had been a chemical spill at one of the schools in Bracknell Forest.

3.30 The Council was responsible for the care and welfare of people evacuated owing to emergencies such as fire or flooding. The standard generic response to an emergency situation would be to house displaced people in a rest centre and treat all equally. Enquiries would be made at an initial stage to ascertain whether the affected people had any medical, dietary, religious or other requirements which the Council would accommodate as far as possible. Vulnerability would be assessed and being elderly or vulnerable were factors taken into consideration when suitable rest placements were identified. Response work to emergencies was generally of a short term nature. The public did not normally have high expectations of services to assist them when evacuated owing to an emergency as they recognised the associated difficulties and were grateful to be accommodated in a rest centre, however, dissatisfaction could arise when such a situation continued for any length of time.

3.31 In terms of capacity to respond to emergencies, the Council had a robust structure in place which included 24 hour 7 day emergency rotas of contact people, including chief officers, to authorise expenditure and liaise with the media, and education officers to deal with incidents affecting schools. The Emergency Planning Team had links with social care staff to advise on setting up rest centres. There was also wide awareness within the authority of actions to be pursued in response to emergencies.

3.32 Although the response to Swine Flu was health service led, the Council sought to respond jointly to such emergencies and work consistently with its health partners supporting them as required. This resulted in involvement on a daily basis to formulate responses including the identification and provision of anti-viral drug distribution centres to distribute drugs from key points in the Borough to well people to pass to the symptomatic. Transport issues were also being considered as the Council may be able to assist in that area. Subsequently during the Swine Flu event, the Council also supported NHS Berkshire East and took responsibility for managing and delivering the vaccination programme to front line health and social care staff. This included social care staff within independent providers who were not affiliated with the Council in any way.

3.33 Unhelpful media coverage had prompted disproportionate fear and panic by exaggerating the severity of Swine Flu and the press had reported incidents of ineffectiveness of the Tamiflu anti-viral drug against Swine Flu. Although the spread of the virus was at an early stage at the time of the meeting and anticipated by the medical profession to increase in the autumn when seasonal flu occurred, this was not the case. Whilst public health messages and information in respect of Swine Flu had been very clear and comprehensive at the outset, the initial level of communication had not been reinforced and had reduced to underlying media coverage other than when a newsworthy event occurred. These factors were possibly the reasons for the numerous GP contacts from people falsely suspecting that they had contracted the virus and enquiries from schools. Although there had been fewer cases of Swine Flu in Bracknell Forest schools than in those of the neighbouring authorities in East Berkshire, the majority of cases in the Borough were associated with schools. Two deaths had resulted from Swine Flu at the time of the meeting and both victims had suffered from other underlying health issues. As a key partner, the Council assisted NHS Berkshire East to convey health messages such as including relevant information on its website to complement the key NHS sites e.g. NHS Direct.

3.34 Although all Berkshire GPs received Swine Flu information from NHS Berkshire East, dissemination of the information was at their discretion and the Council did not have a structure in place to intervene. GPs did not change their regular practices in order to treat the virus and had business continuity strategies in place to plan service delivery in the event that significant numbers of doctors and other staff were affected by Swine Flu. Staff resourcing was a key issue and NHS Berkshire East determined the necessity for some GP surgeries to temporarily close if they could not all be adequately staffed.

3.35 East Berkshire was declared a Swine Flu 'hot spot' in Summer 2009 when it was no longer possible to contain the virus. As a result, NHS Berkshire East developed a 'flu line' advising patients to send their 'flu friend' to one of the three anti-viral distribution centres in East Berkshire, namely, Heatherwood, Wexham Park and St Mark's Hospitals, to ease the burden on GPs and discourage further spread. Due to the spread, Swine Flu was diagnosed on a clinical basis in place of swabbing and, in the event that GPs were overwhelmed, they could direct potential sufferers to the 'flu line' where an algorithm would be performed by telephone to establish whether the caller's symptoms matched and they had contracted the illness. Unlike Avian Flu, there had been no lead-in preparation time with Swine Flu owing to its sudden appearance and therefore planning and responding had taken place simultaneously. Other PCTs requested copies of East Berkshire's model as it had been actioned sooner than some owing to the early 'hot spot' declaration.

3.36 The Council circulated regular e-mail updates in respect of Swine Flu to its staff and schools.

3.37 Whilst the Council had a Flu Response Plan in place, flexibility and constant review were required to meet changing situations and differing types of flu, the particular characteristics of which may not be ascertained until first contact was made. Following a Berkshire-wide event considering what had been learnt over the few months following the outbreak of Swine Flu, Bracknell Forest's plans were reviewed.

3.38 In an emergency scenario, contact with the Council could be made through the Forest Care out-of-hours emergency service and all partners were aware of this and knew that all emergency plan calls were to be routed through this service which would then contact the appropriate duty rota officer(s) to take the matter forward. This initial communication structure was vital to effective response to an emergency. A meeting room at Time Square was designated as an emergency operations centre and one hour was required to set up the room for this purpose. In furtherance of the duty to warn and inform people, the Emergency Planning Manager had instigated an emergency preparedness campaign during the previous year which had consisted of distributing the leaflet 'How Prepared are You?' to every household in the Borough. The campaign, known as ICE (in case of emergency), sought to promote self-help and resilience in an emergency and, for example, advised on the equipment that motorists should have available in the event of being stranded in their cars. Unfortunately, the campaign was less successful than hoped as many residents had not attached sufficient importance to it. The Council was seeking to take emergency planning to a local level and an event in Sandhurst was proposed. Such events would inform mapping of local circumstances, such as the extent of vulnerable people in an area, with a view to assisting towns and parishes to tackle local community related incidents. Relevant information was stored on a Geographical Information System which facilitated mapping of public buildings that could be utilised as rest centres, including the majority of community centres that were owned by and could be utilised by the Council in an emergency scenario. Some local hotels had indicated that they were amenable to providing accommodation in case of emergency subject to payment. Bracknell Forest had a basic supply of sleeping bags, toiletries and baby equipment and could call on additional supplies from its neighbouring East Berkshire unitary authorities if necessary as they maintained similar stocks. Alternatively, necessary purchases could be made from retailers which had 24 hour per day opening practices. Evacuation and rest centre procedures were practiced on a regular basis.

3.39 Colleagues across Berkshire were available to assist in an emergency when needed through the Berkshire Memorandum of Understanding which involved approximately two members of staff in each unitary authority, one of whom would take the lead for a particular work stream. Monthly meetings were held with Berkshire colleagues and meetings with the police and RBFRS also took place.

Meeting with John Pullin, the Deputy Director of Commissioning (Strategy & Planning), NHS Berkshire East

3.40 Mr Pullin described his emergency preparedness brief which included the preparation and updating of NHS Berkshire East's public facing five year Emergency Response Plan that had been agreed by the organisation's Board and mapped all activities to be pursed over that timeframe. As it was not possible to legislate for all eventualities, the plan was a framework tool to aid co-ordinating staff. A second internal operational document supported co-ordination of a response to any emergency situation for use by on-call staff.

3.41 The commissioning element of NHS Berkshire East had a role under the 2005 Emergency Preparedness Guide which involved maintaining an overview of the local health community. Health leadership in an emergency situation, such as an outbreak of flu or Legionnaire's Disease, required a specific response from the local PCT and HPA. The latter organisation would provide the appropriate

clinical expertise and undertake a surveillance role offering guidance. As a strategic manager, the Deputy Director of Commissioning tended to remain remote from emergency events and had an arm's length role of notifying, co-ordinating and responding where needed by offering support, for example, the lead PCT would contact the DoH to obtain emergency equipment and staff resources where necessary. Emergencies were directly responded to by workers on the ground who were trained to do so and refer casualties to A&E hospital departments. Heatherwood and Wexham Park Hospital Trust responded well to emergency situations and undertook regular drills in preparedness.

3.42 The Police Authority would normally lead in the case of a sudden impact event such as a bomb explosion requiring immediate action when the Strategic Co-ordination Group at Gold Command, Kidlington, would co-ordinate a multi-agency response.

3.43 In the case of a 'rising tide' event, the Deputy Director would monitor the situation having regard to the 'at risk' register and put mechanisms and responses in place to support local agencies dealing with the event. Where necessary a response would be escalated and may include use of the Control Room at King Edward VII Hospital or the reserve facility at Upton Hospital. Duty managers, Directors and Assistant Directors on-call would be summonsed and there was administrative support to co-ordinate responses.

3.44 A local call centre would be established in the event that results of national health screening or vaccination programmes were called into question and patients needed to be re-called. Reputation management and press inquiry issues arose in such situations and the Deputy Director became involved at this stage. Although NHS Berkshire East was not an operational responding organisation in a major incident, its Level 1 responder status required staff to be given a level of training to meet this.

3.45 Volunteers and the goodwill of the public played a significant and valuable role in assisting in sudden impact emergencies and were addressed in the Emergency Response Plan. The availability of 1,200 acute beds in three hours during the London bombing, reduced use of A&E facilities by those unaffected by the emergency and blood donorship, although artificial substitutes were utilised in mass emergencies, were examples of such goodwill. However, during a 'slow rising tide' event such as a flu outbreak the public were anticipated to act only as far as they were obliged to. Although NHS Berkshire East had the support of GPs in such circumstances, this was not greater than usual. Bracknell Forest had fewer flu centres than other areas in East Berkshire as more cases had been identified in Slough and Windsor in the early stages of the pandemic and NHS Berkshire East had responded rapidly and called in GPs to respond with payment being made subsequently. The logistics of responding to the Swine Flu outbreak, including setting up equipment and securing qualified nursing support, had significant resource implications for NHS Berkshire East which had benefited from much support and goodwill. The Deputy Director advised that having diagnosed Swine Flu the national flu line had operated a unique reference patient numbering system to ensure that the correct dose and type of anti-viral was prescribed according to patient age, weight and risk factor. The local flu line involving NHS Berkshire East and the LEA had been successful. The mechanism to deliver anti-virals to flu sufferers without 'flu friends' had been considered and was identified as a further area where volunteers could assist. In cases where patients had waited 48 hours for

anti-virals, medication had been delivered by the 'flu car'. Although NHS Berkshire East had a distant relationship with the public this was not the case at Wexham Park Hospital where volunteers offered non-specialist support and provided added value and pastoral support and care.

3.46 The algorithm used for telephone diagnosis of Swine Flu was bespoke to flu pandemics and had been approved by all medical colleagues to ensure that it was flu specific and that other serious illnesses such as Meningitis could not be mistaken for flu and overlooked. The initial containment of Swine Flu had allowed response resources and preparations to be put in place and following the containment stage, the Swine Flu pandemic had developed into a gradual 'rising tide' event requiring rapid and daily response planning with the benefit of effective co-ordination and a multi-agency approach.

3.47 NHS Berkshire East featured a public health unit that assessed local healthcare needs and worked with local authorities to undertake an annual Joint Strategic Needs Assessment (JSNA). When local and global healthcare needs had been established, services would be commissioned to meet those needs. Planning the response to the Swine Flu pandemic had resembled the JSNA process to determine need and commission the response. Although the power of the public health unit was limited, people and organisations tended to accept and respond to its recommendations.

3.48 As flu pandemics did not follow a particular pattern, it was difficult to predict the spread or severity of Swine Flu during winter 2009/10. The emerging of Australia from its winter season informed Swine Flu developments. The flu pandemic which had followed the first world war and claimed more casualties did not inform the current situation as immunity and vaccination scenarios differed. Although Swine Flu appeared to remain mild and be more of a threat to younger people as they had not had the opportunity to develop immunity to flu, there was no guarantee that the elderly would have more evolved immunity. At the time of the meeting, Swine flu was entering its second wave and although it was not as widespread as predicted, response planning assumptions were based on it mutating with seasonal flu, which had led to more deaths last year than Swine Flu to date.

3.49 The chain of response progressed from NHS Berkshire East to the lead PCT in Oxfordshire to the Strategic Health Authority to the DoH at Richmond House in Whitehall where a national response to flu outbreaks or a fuel crisis would be co-ordinated involving business continuity matters.

Meeting with James Amos, Emergency Preparedness Manager, South Central Ambulance Service (SCAS) NHS Trust

3.50 James Amos, who was one of five SCAS Emergency Preparedness Managers, gave a presentation to the Working Group in respect of the role of SCAS in public health emergencies, a copy of which is attached at Appendix 2. The following points arose from the resulting questions and discussion:

3.51 The responsibilities of the service during a public health emergency were:

- To save lives.
- To provide medical assessment of the incident to include clinical indicators of chemical, biological or radioactive substances.

- Provision and co-ordination of all NHS resources i.e. Health Command and Control Structure (as detailed in the presentation slides).

- Triage, decontamination, treatment and transportation of casualties.

- To maintain normal operational service delivery.

3.52 The process of decontamination involved contaminated people passing through decontamination equipment housed in a large tent into the clear casualties area. Powered respirator protective suits were worn by staff assisting with contamination emergencies, which involved the use of hoses to remove contaminants from victims as soon as possible. There was, however, a risk of run off water entering drains and contaminating water supplies. A risk agreement existed between SCAS and the Environment Agency to cover such situations and required SCAS to alert the Agency to emergency decontaminations and use dyes to identify contaminated water.

3.53 Triage, the process of identifying by clinical condition the priority and order in which casualties needed to be treated or decontaminated, was a responsibility of SCAS. All walking casualties were classed as 'delayed' - priority 3.

3.54 In terms of mass casualty vehicles, SCAS had:

- National Reserves of Nerve Agent antidote combo pens.

- 2 specialised vehicles paid for by central government and equipped with sufficient kit for 100 priority 1 & 2 victims and 250 priority 3 victims.

3.55 There were three control centres across SCAS and upon receiving information in respect of an incident, SCAS alerted the following in the health system:

- The receiving hospital.

- Neighbouring ambulance trusts.

- Other emergency services.

3.56 In the event of a public health emergency, the lead PCT for the Thames Valley area, Oxfordshire, would be contacted and then communication would pass from there to NHS Berkshire East from where news could filter through its system and information be circulated rapidly. Victims were able to attend any NHS service for assistance and therefore it was important that SCAS worked with NHS partners. Hospitals were able to 'lock down' areas to prevent contamination spreading. SCAS was well supported by its neighbouring ambulance services, and provided good support in return.

3.57 Issues faced by the service after an incident had occurred included:

- Identification of contaminated equipment which would need to be decontaminated, which was the responsibility of the local authority and the Environment Agency.

- The nature of the incident in question would dictate when a return to normality could be achieved and what that normality would consist of. For example, a nuclear disaster could destroy an area and leave it uninhabitable for many decades or longer.

3.58 In Bracknell Forest there were sufficient emergency dressing packs for 500 people. This preparation was in response to a previous disaster from which lessons had been learnt and subsequent changes implemented.

3.59 SCAS used voluntary community responders and had a strong link with voluntary organisations such as St Johns Ambulance.

3.60 The relief staff scheme, present as part of a strong business continuity plan, could be used in the event of a disaster / incident. SCAS utilised all staff who were on leave and undergoing training.

3.61 The ambulance service vehicles had good off-road capability and the service felt that it could also rely on help from the militaries.

3.62 The Emergency Preparedness Manager provided an overview of progress achieved by SCAS at the time of the meeting. The following had been in response to terrorism and had been rolled out nationally since 2002:

- The National Memorandum of Understanding was in place.
- HART (hazardous area response teams) would be rolled out in 2010.
- A mass casualty vehicle was provided in December 2009 and there were 10 incident support vehicles.
- Continued collaborative working with partner organisations.

3.63 Suggested improvements to SCAS were:

- Increased resources.
- More recruitment – although active campaigns were ongoing it was difficult to recruit staff due to relatively low pay and the high cost of living within the area.
- Increased funding - whilst the SCAS annual budget was in excess of £100m, NHS Berkshire East was unable to meet this which produced funding gaps.
- More paramedics and technicians - there were currently 12,000 paramedics and technicians but ideally there would be 15,000.
- A system whereby the emergency services were funded through a central pot, for instance the system in place in Australia where it was funded through insurance, would be ideal.

Meeting with Alyson Smith, Consultant in Health Protection, Thames Valley Health Protection Unit

3.64 Alyson Smith gave a presentation to the Working Group in respect of the Thames Valley Health Emergency Preparedness System from the HPA's perspective, a copy of which is attached at Appendix 3. The presentation explained the status, functions, role, purpose, staffing teams and structure of the HPA. It also listed health organisations in the Thames Valley; identified national to local resilience links; and outlined the types of incident responded to, the legislative framework for civil protection from emergencies in the UK, legal and government requirements, the Control of Major Accident Hazards Regulations and how the HPU added value to emergency response. Emergency command, control and briefing, the sequence of response events to major incidents including radioactivity, incident and emergency response plans, issuing health advice, lessons learned from the Buncefield Oil Depot fire, and new legislative powers and duties to prevent and control risks to human health from infectious diseases and contamination by chemicals and radiation were also addressed. The following information emerged from resulting questions and discussion:

3.65 A carbon monoxide poisoning incident some weeks prior to the meeting had involved the HPU's chemical response team and there was on going work around chemical and radiation incidents, such as the Pullonium contamination in London.

3.66 Health protection policies and plans were reviewed following incidents to take account of lessons learned and ensure that they remained robust and effective.

3.67 The Health and Social Care Act 2008, to be implemented in April 2010, would introduce an all hazards approach to responding to human health threats and operational guidance was being developed. The new powers would enable the HPA to apply to have a contaminated person quarantined. At present, tuberculosis was the only threat where detention in the interests of public health was possible.

3.68 Responses to emergencies would depend on the nature of the event and could include the TVHPU contacting hospital A&E departments via the PCT, alerting walk-in centres and advising on the type of contamination experienced together with associated decontamination needs. Information mechanisms, which featured local stakeholder networks, were in place and would advise on who should be contacted under certain circumstances, for example the local authority could identify vulnerable people. However, data protection regulations were an issue under these circumstances. Communication with the public to reassure the 'worried well' was also necessary to overcome fear and relieve unnecessary pressure on emergency services, particularly where the media sensationalised events.

3.69 In terms of the HPA becoming informed of and involved in emergencies, the RBFRS was often the organisation to make first contact. Although the HPA was contacted in the majority of instances where its support and advice were required, there were examples of situations when it had been unaware of emergencies and therefore the Agency promoted the importance of it being informed of such events. The HPA was accessible to the public who would contact it under circumstances such as a meningitis outbreak in a school.

3.70 With regard to school closures under circumstances such as seeking to contain Swine Flu, the Working Group was advised that, although the HPA would offer advice on the safest course of action, the final decision to close a school was that of the headteacher. Where a headteacher decided against advice from the HPA to close a school on public health grounds, the HPA could approach a Justice of the Peace to seek closure under the new strengthened legal powers to respond to human health threats. However, schools generally followed HPA advice concerning closure. It was acknowledged that a balance needed to be struck in relation to school closures as issues such as child care arose which impacted on the workforce.

3.71 The HPA worked with the Meteorological Office to model likely characteristics of emergencies such as the behaviour of a plume of contaminated smoke under different weather conditions.

3.72 Business continuity was a significant issue for the TVHPU and some remote working had taken place during the heavy winter snow falls which had prevented staff access to the Unit's building.

3.73 Although protect, prevent and prepare were elements of the HPA's work, on occasions it could act as a reactive service only such as during the Buncefield Oil Depot fire. Hoax emergency calls were experienced occasionally. Although there was a national plan to respond to Swine Flu, this had not been implemented as a different sequence of events took place. There were other plans in place which featured provision of advice relating to coping with heat waves, cold winter temperatures and flooding. As other organisations also had plans with similar themes and there was a danger of conflicting advice being circulated, a more central strategic response with dovetailing of plans had been adopted which took account of local perspectives. The last response exercise undertaken had related to Swine Flu and further exercises would be beneficial.

3.74 The response to Swine Flu had been positive and a good test of the HPA's resilience. As the NHS had not been prepared to respond as rapidly as required and had not been involved in the containment stage, the HPA had stepped in with contingency plans. Subsequent de-briefings in the Thames Valley had addressed resulting criticisms, mainly directed at the NHS and HPA, and acknowledged that media sensationalism had exacerbated the situation and created management difficulties.

3.75 There had been fewer incidents of seasonal flu during the past winter than was the norm and Swine Flu, which had occurred out of the normal flu season during the summer, had less impact than anticipated. Results of the outbreak of Swine Flu were awaited and data sources included mortality rates, hospital admissions, rest centre registers and the SCAS. The figures would be incomplete as many sufferers had Swine Flu without knowing or self-treated at home without accessing health services. The Strategic Co-ordination Group was a central information repository and had provided daily updates in respect of school closures and answered media enquiries during the outbreak.

3.76 There had been numerous outbreaks of Norovirus with which the TVHPU had been closely involved. The NHS had been tackling outbreaks by hospital ward closures whilst the TVHPU's work had concentrated on residential care homes and schools. Discussions had been held with the 18 care homes in the Thames Valley which had been advised to minimise movements between the sites and notify the NHS of outbreaks. Although the outbreaks had been mild, they

spread suddenly and posed a threat for vulnerable people. There had been no need to close any schools.

3.77 South East Berkshire Emergency Volunteers were involved in direct action rather than emergency response planning during events.

Civil Emergencies - Trauma Support Service

3.78 The Council provides a Trauma Support Service to assist the Borough's residents and visitors in the aftermath of a major incident which can leave many people, such as survivors and their families and friends, bereaved families and friends, responders and the local community, deeply affected by their experiences of it which can lead to strong emotional and physical reactions. This service involves the Council working closely with voluntary and statutory agencies with teams of trained, skilled, organised and supported workers and volunteers who can assist in meeting the practical and emotional needs of individuals in centres that have been set up, or in their homes. The support includes:

- Assistance with communication.
- Care of children and pets.
- Clothing and bedding.
- Documentation.
- Emotional support, befriending and listening.
- First aid and health care.
- Liaison with other organisations.
- Medical and mobility aid equipment e.g. wheelchairs.
- Refreshments.
- Sign-posting to other organisations.
- Transport.

WHO Update

3.79 As of 21 May 2010, worldwide more than 214 countries and overseas territories or communities have reported laboratory confirmed cases of Swine Flu, including over 18,097 deaths amongst confirmed cases. At least 4,874 of these deaths were reported by the WHO's Regional Office for Europe. The WHO is actively monitoring the progress of the pandemic through frequent consultations with its Regional Offices and member states and through monitoring of multiple sources of information.

4. Conclusions

The Working Group is generally satisfied that there are sufficient emergency preparedness and response plans in place for the Council and its partners to respond effectively to public health emergencies. The Swine Flu pandemic, which occurred at the outset of this review, provides a good example of how the emergency preparedness and response system operates.

From its investigations, the Working Group concludes that:

Swine Flu

4.1 The 2009 outbreak of a new strain of flu, Swine Flu, demonstrates that continuing vigilance, planning, and strong public health research capability are essential defences against emerging health threats. A significant amount of work is undertaken locally, regionally, nationally and globally to anticipate and respond effectively to flu pandemics and other threats to human health.

4.2 A co-ordinated multi-agency response is necessary to tackle such threats and the preparation for and coping with the Swine Flu pandemic locally confirms that Bracknell Forest's extended partnership worked well together. We particularly commend the creation of the Thames Valley Influenza Planning Committee (paragraph 3.13). Communicating that successful outcome would assist public confidence.

4.3 It is difficult to plan finite responses to flu pandemics until the characteristics of a particular outbreak, such as the incubation period, rate of transmission, virulence and mutation of viral strains, are known.

4.4 There was a sufficient amount of anti-virals available at the time of the Swine Flu outbreak.

4.5 The Swine Flu pandemic did not reach anticipated levels or have the expected impact in terms of severity and mortality rates.

General Public Health Emergencies

4.6 Residential care homes carry a high food poisoning risk rating, are a possible source of Legionnaire's Disease and are at threat of the Winter Vomiting virus. Further engagement with care homes to tackle these risks to their vulnerable residents would assist.

4.7 Regular drills in preparedness are undertaken by the Council and its emergency preparedness and response partners.

4.8 The new comprehensive Thames Valley emergency preparedness advice booklet, 'Are You Ready?', is welcomed and will complement the emergency preparedness booklet produced by the Government.

4.9 The capacity of the voluntary sector to assist in dealing with public health emergencies is very valuable.

4.10 Whilst the Army is not an integral part of the emergency planning response mechanism, it is possible that it may be available to provide assistance at the

time of need via the appropriate route, for example through military aid to the civil community.

4.11 Although responsibility within the Council for co-ordinating the response to public health emergencies lies in the Environment, Culture and Communities Department, the response to the Swine Flu pandemic, which was led by the Director of Adult Social Care and Health, is an example of a different line management chain and there are a number of information routes into the Council whereby information is received and passed.

4.12 Whilst we acknowledge that incidents of chemical or nerve agent cases requiring decontamination are rare, we are please to note that the South Central Ambulance Service has acquired two specialised decontamination vehicles to respond to varying potential future emergencies.

4.13 Notwithstanding the shortfall of paramedics and technicians reported by the South Central Ambulance Service, it appears to be ably staffed to meet current demands.

4.14 There are concerns that the Health Protection Agency claim not to have been made aware of all emergencies which implies that links between partners are not sufficiently strong in some instances.

4.15 Although the Council stores relevant information on a Geographical Information System which facilitates mapping of public buildings that can be utilised as rest centres in an emergency scenario, including the majority of community centres that are owned by the Council, there is no evidence of associated plans being shared with community centre lessees or keyholders.

Fire Emergency

5. Recommendations

Although existing emergency preparedness arrangements are robust, the Working Group has identified some recommendations that seek to maintain good practice or secure improvements. It is therefore recommended to the Executive Member for Culture, Corporate Services and Public Protection, the Executive Member for Adult Services, Health and Housing, and the relevant partners of the Council that:

5.1 Good hygiene campaigns and practices be encouraged at all times;

5.2 More engagement with residential care homes be undertaken to mitigate the risks to their vulnerable clients posed by high food poisoning risk rating, possible source of Legionnaire's Disease and threat of the Winter Vomiting virus;

5.3 The Thames Valley emergency preparedness advice booklet, 'Are You Ready?', be continued and updated as appropriate and distributed as widely as costs allow.

5.4 As the Voluntary Sector's resources fluctuate, its capacity to provide support during public health emergencies be monitored by the Council and its partners at the time of need depending on the situation.

5.5 As the Army is not integral to any emergency response mechanism, the Council and its partners seek to identify the parameters within which military aid may be available.

5.6 The South Central Ambulance Service ensures that it has adequate contingency arrangements with other strategic health authorities to ensure that sufficient resources are available on demand when required to respond to public health emergencies;

5.7 Communication systems between the Council and its partners be reinforced to ensure that all agencies are made aware promptly of all public health threats and emergencies to prevent incidents such as the Health Protection Agency being uninformed of situations from re-occurring.

5.8 The Council communicates its plans for the potential use of its community centres as rest centres in an emergency scenario to the lessees and keyholders of the community centres.

6. Glossary

A&E	Accident and Emergency
BECHS	Berkshire East Community Health Services
DoH	Department of Health
EA	Environment Agency
EP	Emergency Preparedness
FSA	Food Standards Agency
Flu	Influenza
GP	General Practitioner
HPA	Health Protection Agency
HSE	Health and Safety Executive
JSNA	Joint Strategic Needs Assessment
MIO	Medical Incident Officer
NHS	National Health Service
PCT	Primary Care Trust
RBFRS	Royal Berkshire Fire and Rescue Service
SCAS	South Central Ambulance Service NHS Trust
STAC	Scientific and Technical Advice Cell
TVHPU	Thames Valley Health Protection Unit
UK	United Kingdom
WHO	World Health Organisation

UK Resilience Logo

APPENDIX 1

EMERGENCY PREPAREDNESS AND RESPONSE ROLES AND RESPONSIBILITIES OF LOCAL AGENCIES

The emergency services, i.e. the ambulance, fire and police services, maintain a state of readiness to enable them to provide a rapid initial response and alert local and health authorities and other services to public health emergencies as soon as possible. All organisations that are required to respond rapidly to a disaster need to have response arrangements that can be activated at short notice. These arrangements should be clearly established and promulgated to all who may be involved with the response, and all those who could be involved have a responsibility to ensure that they are confident to do so.

Each service or agency working at the scene of an incident in the region has its own role and functions. These are outlined below:

1. **Police Services**

   The police co-ordinate all the activities of those responding at and around the scene, which must, unless a disaster has been caused by severe weather or other natural phenomena, be preserved to provide evidence for subsequent enquiries and possible criminal proceedings. Where practicable, the police establish cordons to facilitate the work of the other emergency services in the saving of life, the protection of the public and the care of survivors. They oversee any criminal investigation and facilitate enquiries carried out by the responsible accident investigation body, such as the Health and Safety Executive, Railway Inspectorate or the Air or Marine Accident Investigation Branch. The police process casualty information and have responsibility for identifying and arranging for the removal of the dead. In the latter task they act on behalf of HM Coroner who has the legal responsibility for investigating the cause and circumstances of deaths arising from a disaster.

2. **Fire and Rescue Services**

   The first concern of the fire service is to rescue people trapped in a fire, wreckage or debris. They will prevent further escalation of the disaster by extinguishing fires or undertake protective measures to prevent them. They will deal with released chemicals or other contaminants in order to render the incident site safe. They assist the ambulance service with casualty handling and the police with recovery of bodies. The fire service is responsible for the health and safety of personnel of all agencies working within the inner cordon and will liaise with the police in respect of who should be allowed access to ensure that they are properly equipped, adequately trained and briefed. However, in the event of any situation which is, or is suspected to be, the result of a terrorist incident, all activities within the cordon are under the direct control of the police.

3. **Strategic Health Authorities and Primary Care Trusts (PCTs)**

   The overall responsibility for the health of the population lies with the PCTs. First line emergency response for health services will continue to be through the ambulance service, receiving Accident and Emergency hospitals and Directors of Public Health.

   Elements of national and regional NHS emergency planning form part of the remit of the Health Protection Agency in collaboration with the Strategic Health Authority.

4. **Acute and Foundation Trusts**

Casualty receiving hospitals are able to respond to requests from the ambulance service to accept casualties for medical treatment and to provide appropriately trained staff to act as Medical Incident Officers (MIOs) and contribute to Mobile Medical Teams at the scene of an incident.

5. **Ambulance Service**

The ambulance service has responsibility for co-ordinating the on-site NHS response and determining the hospital(s) to which injured persons should be taken. If necessary, the ambulance service will seek the attention of a MIO. The ambulance service, in conjunction with the MIO and medical teams, seeks to save life and limb through effective emergency treatment at the scene, to determine the priority for release of trapped casualties in conjunction with the fire service, and to transport the injured in order of priority to receiving hospitals.

6. **Local Authorities**

In the immediate aftermath of a disaster, the principal concerns of local authorities are to provide support for the emergency services, continue normal support and care for the local and wider community, use resources to mitigate the effects of the emergency and co-ordinate the response by organisations other than the emergency services. The local authority can provide support, for example by sourcing equipment, services or specialist knowledge. As time progresses, and the emphasis switches to recovery, the local authority will take a leading role to facilitate the rehabilitation of the community and restoration of the environment processes, which can take years.

7. The Environment Agency (EA)

The EA has primary responsibilities for the environmental protection of water, land and air in England and Wales. The EA has key responsibilities for maintaining and operating flood defences on rivers. These responsibilities cover direct, remedial action to prevent and mitigate the effects of the incident, to provide specialist advice, to give warnings to those likely to be affected, to monitor the effects of an incident and to investigate its cause. The EA also collects evidence for future enforcement or cost recovery.

8. **HM Coroners**

The role of the coroner is defined by statute. The coroner must determine who has died and how, when and where the death came about in relation to those bodies lying in his district who have met a violent or unnatural death or a sudden death of unknown cause. This function is regardless of whether or not the cause of death arose within the coroner's district and is normally undertaken at a formal inquest. The powers and duties of coroners do not vary with the number of people who are killed or the circumstances in which the deaths occur. Only the coroner may authorise the moving of a body at the scene of an incident and only the coroner may authorise a post-mortem and the release of a body to relatives. The police act as the coroner's officers when dealing with fatalities arising from an incident.

9. **(Local) Chamber of Commerce**

The chamber of commerce provides an invaluable two-way pipeline into the private sector (industrial or commercial organisations) who may play a direct part in the response to disaster if their personnel, operations or services have been, or may become, involved.

10. **Scientific and Technical Advice Cell**

A Scientific and Technical Advice Cell (STAC) is an important part of the health and environmental protection responses to serious or major incidences at the strategic level. It provides a collective route for the generation of authoritative advice to multi-agency Command and Control structures on the health and environmental consequences of an incident and guides tactical and strategic policy making in addition to providing tactical advice to the operational response. A STAC comprises senior health protection professionals trained to provide an incident commander with information to support policy making at a strategic level. Advice is provided through a STAC directly to the incident commander, or Strategic Co-ordinating Group, by a nominated STAC Adviser. The STAC Adviser sits in addition to other representatives of the health sector, for example the ambulance service. Health Protection Units, in collaboration with PCT public health staff, will often be expected to organise and establish a STAC for a major incident in their area. Potentially there can be several locations for a STAC to work from, dependent on the type and scale of the incident.