Health Education East of England

Training in Health Protection in the East of England

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Version	Date	Author	Contributors
1.0 Draft	03/11/2015	Bernadette Nazareth Deputy TPD Health Protection	Anne Swift and David Edwards Specialty Registrars
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1. Introduction

This document aims to provide up-to-date and clear information on the opportunities for training in health protection available to public health registrars in the East of England (EoE) training scheme. Health protection training encompasses both a mandatory part of general public health training and a separate higher subspecialty training for the subset of registrars who wish to pursue a career in health protection, for example as a Consultant in Communicable Disease Control (CCDC) or a Consultant in Health Protection.

It will be of interest to:

- Current registrars in the EoE who are interested in specialising in health protection (HP)
- Registrars on the scheme who do not intend to specialise in HP but need to understand what the generalist HP training entails
- Educational and clinical supervisors so they understand HP training requirements
- CsCDC, HPTs and specialist placements so that a shared understanding of the principles and aims of HP training can be achieved
- Programme management staff, for reference
- Potential applicants to public health training.

2. Overview of Public Health training in the East of England

Public Health StR training in the East of England (EoE) is provided by Health Education East of England (HEEE) School of Public Health, which divides training locations into a North zone (Bedfordshire, Luton, Cambridgeshire, Peterborough, Norfolk and Suffolk) and South zone (Essex and Hertfordshire). The first training location is usually a local authority (LA) placement for two or more years, with each LA providing a public health offer to one or more NHS Clinical Commissioning Groups (CCGs).

The Public Health Training Pathway (FPH PH Specialty Training Curriculum 2015) consists of two phases of learning across five years of specialty training (ST1 to ST5).

Public Health Training Pathway

<table>
<tr><th colspan="3">PHASE 1</th><th colspan="3">PHASE 2</th></tr>
<tr><th>ST1</th><th colspan="2">ST2</th><th>ST3</th><th>ST4</th><th>ST5</th></tr>
<tr><td>KNOWS</td><td colspan="2">KNOWS HOW/SHOWS</td><td colspan="2">SHOWS HOW/ DOES</td><td>DOES</td></tr>
<tr><td></td><td colspan="2">ARCP</td><td>ARCP</td><td>ARCP</td><td>ARCP</td></tr>
<tr><td></td><td>PART A**</td><td>PART B***</td><td colspan="3"></td></tr>
<tr><td colspan="3">2 years (normally up to 30 months maximum). Part A and Part B MFPH obtained in this phase and public health knowledge and core skills gained. Registrars are also expected to begin to demonstrate development of ability to integrate their use of those skills as progress towards independent practice. In phase 1 this will be assessed by examination, at each annual appraisal and ARCP.</td><td colspan="3">This phase allows the registrar to take increasing levels of responsibility leading to the final year when registrars are expected to work at consultant level but under supervision. In the final year, supervision will become increasingly 'light touch' as the Educational Supervisor judges that the registrar can be entrusted with work reflecting a high level of responsibility. 'Acting up' into a consultant post is encouraged in the final year of training. In phase 2 workplace based assessment, annual appraisals and ARCP will continue to assess this progress.</td></tr>
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The two phases of learning are distinguished by successful acquisition of the learning outcomes defined for each phase. Passage from phase 1 to phase 2 requires a pass at the examinations for Part A MFPH and Part B MFPH **and** a satisfactory assessment in phase 1 learning outcomes in the workplace **including** a formal placement in a health protection attachment **and** assessment for competence for out-of-hours on call.

2.1 Phase 1

The first phase of training usually involves completion of formal academic study in preparation for Part A of the Faculty of Public Health membership (MFPH) exam. For example, registrars may attend the MPhil in Public Health at the University of Cambridge.

Completion of Part A of the MFPH exam, an induction programme in HP (Appendix 1) and a separate on-call assessment (Appendix 2) are required before a registrar can join the local HP out-of-hours rota.

During phase 1 the registrar will undertake a minimum three-month whole time equivalent (WTE) attachment to a Health Protection Team (HPT), where they are expected to acquire many of the public health skills to deal with health protection issues. It is recommended that this is undertaken prior to starting on the out-of-hours rota.

The Part B MFPH, a scenario based Objective Structured Public Health Examination (OSPHE) of public health skills, is undertaken during the latter stages of phase 1.

2.2 Phase 2

During phase 2, special interest options for training can be undertaken in addition to core training. This may include specialist health protection training to meet the requirements for becoming a consultant in communicable disease control (CCDC).

2.3 Delivery of the Health Protection function

The health protection roles and responsibilities of some relevant organisations are outlined in Appendix 3.

Public Health England (PHE) was established on 1 April 2013, bringing together some 70 separate public health organisations including the Health Protection Agency, Public Health Observatories, Cancer Registries, Screening Quality Assurance Reference Centres, and the screening and immunisation functions embedded within NHS. PHE is an Executive Agency of the Department of Health and the national public health agency for England.

PHE East of England (EoE) is one of nine PHE Centres across England. Each Centre brings together the range of public health functions at a local level and acts as the interface between PHE and the local delivery of public health within local authorities and elsewhere. The EoE Centre was formed in 2015 from the two former PHE Centres of Anglia & Essex and South Midlands & Hertfordshire as part of PHE's internal change process.

The area covered by the Centre includes the following local authorities:

- **County Councils:** Hertfordshire, Essex, Norfolk, Suffolk, Cambridgeshire;
- **Unitary Authorities:** Bedford Borough, Central Bedfordshire, Luton, Milton Keynes, Peterborough, Southend, Thurrock.

This includes the whole of the East of England Speciality Training Programme and placements are open to all registrars in the programme.

Health Protection in the EoE Centre includes the HPT, currently based in two locations in Thetford (Norfolk) and Harlow (Essex), as well as the Field Epidemiology Service (FES) based in Cambridge.

3. Principles and aims of Health Protection training

The FPH PH Specialty Training Curriculum 2015 defines and describes the processes of training including: the phases of training, learning methods and outcomes. Health protection training will primarily cover Key Area 6 of the curriculum (Appendix 4).

This area of practice focuses on the protection of the public's health from communicable and environmental hazards by the application of a range of methods including hazard identification, risk assessment and the promotion and implementation of appropriate interventions to reduce risk and promote health. It aims *to identify, assess and communicate risks associated with hazards relevant to health protection, and to lead and co-ordinate the appropriate public health response*.

Key elements include:

- Disease surveillance
- The investigation and control of communicable diseases
- The public health aspects of environmental hazards (including chemical, radiological and nuclear hazards),
- Managing 'deliberate release' incidents
- Health emergency planning

Health protection requires some key skills and knowledge which are usually acquired through clinically based training. Trainees coming to health protection without such a background or range of skills and knowledge will need to discuss their learning needs with their educational supervisor.

Training in public health needs to ensure all trainees understand professional principles, including confidentiality and ethics. Professional principles include recognition of competence and knowing when to appropriately seek help and advice from more expert colleagues. To practise health protection, trainees must learn the skills necessary to take a clinical history, undertake risk assessments, and manage and communicate risk.

During training, StRs should gain an understanding of the aetiology and pathogenesis of infectious and environmentally caused diseases, and their management on an individual and population basis. This may require understanding of principles of:

- Epidemiology and statistics;
- Information management and surveillance;
- Microbiology, virology and immunology;
- Therapeutics;
- Non-Infectious Environmental Hazards;
- Principles of communicable disease control including modification of health behaviour, screening and vaccination;
- Principles of infection control.

These basic sciences will be taught as part of the University of Cambridge M.Phil course. The practical application of the basic health protection sciences will be during the HPT attachment, on call and as need arises to meet learning outcomes (for example follow up of an outbreak or incident on call).

4. Health Protection training for generalist Public Health registrars

The mandatory 3 month health protection attachment is usually undertaken after sitting the Part A exam (usually in January although there is also a sitting in June). Each HPT office can take a maximum of 2-3 trainees at a time, so there may be a time lag for some registrars between sitting the exam and starting the attachment. In most cases the registrar must have at least started their attachment before taking the on-call assessment. Registrars are advised to contact the local HPT office at an early stage to ensure availability. If a long wait is likely and registrars would like a short attachment to observe practice before the on-call assessment this can usually be arranged.

To ensure coordination of the HP attachments across the deanery, all attachments will need to be agreed with the deputy TPD health protection. Where a registrar wishes to take advantage of the option to train in another zone/patch, priority will be given in terms of timing to those registrars whose home zone/patch they belong with.

4.1 Pre-placement meeting

In keeping with the requirements of the training programme, every registrar is allocated a clinical supervisor (CS) for the duration of their placement. It is the joint responsibility of the two to ensure learning needs are identified and met. Trainees should organise a meeting with their nominated CS in the month before starting the placement. This will ensure that an assessment of foundation knowledge and skills is undertaken and a programme of learning agreed, based on their needs.

4.2 Key elements of the training

4.2.1 Induction

As part of an introduction to the practice of health protection, the trainee will get acquainted with the training location, organisation structures, roles of PHE and roles of partner organisations.

Induction to the office environment and acute response service will cover:

- Security of information
- Record keeping and retention
- Health and safety in the office environment
- Work station audit
- Familiarisation with the acute response service (a phased process covering observation and familiarisation, supervised practice, and independent practice with regular case review)

Induction to health protection practice is an essential component of the on-call training to obtain an understanding of the control of communicable and non-communicable diseases. Appendix 1 outlines the key elements of a basic induction programme to provide an overview of the scope and practice of health protection. The programme can be tailored to the needs of the trainee based on their previous training and experience. The induction can be undertaken pre Part A (may be beneficial) or at the start of the HP attachment, recognising that the individual components are likely to be spread out over a period of time.

4.2.2 Day-to-day work at the HPT

You will be an integral part of the team and participate in the “acute response service” – answering calls and handling queries from the public, GPs, hospital staff and others – once you have completed your induction phase. This “acute service” experience is the most important part of the attachment as it allows the trainee to develop an understanding of the principles and processes that underpin health protection work.

It will also develop competencies and skills for undertaking supervised first on-call duties, as well as provide preparation for the on-call assessment.

In addition to duty work, there will also be opportunities to be involved in outbreak investigations, incident management, emergency planning work, strategic health protection work and academic health protection. It is up to the individual registrar to take advantage of opportunities as they arise and to discuss with their CS the types of work that they are particularly interested in.

4.2.3 Project work

Trainees will be supported in undertaking projects appropriate to their stage in training and learning needs. For example, local and regional audits, developing leaflets for health professionals and the public on common infectious diseases, updating on call packs, needs assessment. The trainee will be supervised by the Consultant and/or Health Protection Nurse leading on that area of work.

4.2.4 Teaching and training

- Participation in relevant clinical meetings and in regular case/incident review meetings.
- Access to ongoing educational sessions organised by the HPT. These may be 1:1 or as part of the team.
- Opportunities for shared learning through regional on-call teleconferences and study days.
- Attendance at emergency planning exercises
- PHE also run national courses, e.g. Introductory Course on the Epidemiology and Surveillance of Communicable Diseases (NB: course fees will not be met by PHE).

4.2.5 Expected outcomes of generalist HP training

Following the three month attachment, registrars would be expected to have developed an understanding of the principles of health protection work both in and out of hours. In addition the following topic areas should be covered (many of these are reflected in KA6 learning outcomes – see appendix 4):

Topic area	Examples (not exhaustive)
Communicable disease surveillance	Routine surveillance; COVER data; disease notification; laboratory reporting; enhanced disease surveillance (e.g. TB); non-routine surveillance (e.g. the use of syndromic surveillance)
Managing common public health problems	Meningitis; gastroenteritis (especially E. coli O157 / VTEC, norovirus), single cases and as outbreaks; tuberculosis; blood borne viruses; invasive group A streptococcus infection; PVL-Staphylococcus aureus; rash illness (e.g. measles), including in pregnancy; environmental issues (e.g. fire)
Managing less common but important problems	Legionella; rabies; diphtheria; botulism
Public Health Law	Application of Part 2A orders
Principles of infection control	Both in hospital / healthcare settings and in the community
Environmental hazards	Including chemical hazards, routes of exposure and basic toxicology
Outbreak management	Including the role of PHE in relation to other agencies, the role and nature of the IMT and principles of outbreak control
Emergency Planning	Knowledge of relevant planning and operational arrangements, and the principles of managing a major incident
Commissioning, delivery and organisation of health protection services	Sexual health; immunisations; tuberculosis
Partner agencies and their relationship with PHE	Including Directors of Public Health and other local authority PH staff, other sections of PHE, local authority EHDs, water companies, Food Standards Agency, Environment Agency

4.3 Maintenance of HP skills

While on the on-call rota, it is a requirement that registrars undertake the equivalent of one day a month HPT duty service. This will enable ongoing CPD and competence to be maintained.

Maintenance of HP skills in Phase 2 training is also necessary prior to taking up a consultant-level appointment in Public Health. All trainees are encouraged to maintain their basic health protection knowledge/skills by further top-up experience in the acute response service of the HPT.

Calls taken during these additional HPT attachments will be recognised as contributing to the educational requirements for undertaking unsupervised public health on-call duties (Appendix 5).

Additionally, ad-hoc attachments later in training are usually possible and are encouraged for those trainees close to CCT who have had little recent health protection experience, in preparation for consultant roles.

5. Training for registrars wishing to specialise in HP

Specialist training in health protection is possible during public health training and this route leads to the same CCT as would any other training path in public health. There are some national placements available for those with an interest in health protection; these provide Phase 2 training for the remainder of the individual's training programme and are advertised nationally.

Specialist experience in health protection would provide a suitable background for applying to roles such as Consultant in Communicable Disease Control, Consultant in Public Health with a health protection portfolio (for example in a Local Authority), or roles in infection control, emergency planning and specialist health protection roles such as in chemical or radiological hazards services.

5.1 Higher Specialist Training in HP in EoE

Health Protection specialist training in the East of England is usually available for two registrars per year. An invitation to apply is sent out by the training programme, usually in October/November, and places are allocated through a competitive interview process in which candidates are expected to demonstrate a commitment to and understanding of health protection. *Registrars must have at least two years (WTE) training time remaining and will hold full MFPH.*

There is no predetermined "rotation" for this training. Appendix 6 provides details of some of the available HP placements in the East of England and at national level. The programme will be tailored to the needs of the trainee and coordinated by the Deputy TPD Health Protection or the PHE Field Epidemiology Service (FES) Consultant Epidemiologist who can provide advice on career routes and training experience.

It is essential that all aspiring health protection specialists should spend time (usually six months WTE) in a senior placement within a health protection team. Placements in a microbiology laboratory (Addenbrooke's or the Norfolk and Norwich hospital) and with the FES are also advisable; each of these placements would usually last for 4-6 months WTE. The remaining time may be spent in regional or national placements gaining experience in infection control, national infections surveillance and control or other areas of interest. There may also be opportunities to undertake national project work while based within the region.

Outline Induction Program for Health Protection

Introduction

An induction in health protection is an essential component of the on-call training to obtain an understanding of the control of communicable and non-communicable diseases. The programme can be tailored to the needs of the trainee based on their previous training and experience. The induction can be undertaken pre Part A (may be beneficial) or at the start of the HP attachment, recognising that the individual components are likely to be spread out over a period of time.

Aims of the induction program

- To provide an overview of the scope and practice of health protection

Suggested areas to be covered (based on the learning needs of the StR)

1. Managing communicable and non-communicable disease cases and incidents

Learning aim: To acquire background knowledge on the control of infectious diseases and non-infectious environmental incidents.

Objectives

- Understanding of the basic principles of infectious disease control and the public health response to non-infectious environmental incidents
- Familiarise with common on-call infections/ hazards

How met

- Recommended reading
  (Good introductory book is: Hawker J, Begg N, Blair I et al. Communicable Disease Control and Health Protection Handbook)

2. Structure and functions of Public Health England (PHE)

Learning aim: To understand the organisation and functions of PHE and the Centre, the role of the Health Protection Team (HPT) and the Field Epidemiology Service (FES).

Objectives

- Understand how PHE functions
- Understand the relation with different local stakeholders, e.g. DPH, local authorities
- Understand the statutory notifiable diseases and surveillance systems
- Understand role of the HPT in:
  - undertaking surveillance and monitoring communicable diseases
  - developing guidelines to ensure effective management of communicable diseases
  - public health management of communicable diseases and non-infectious hazards
  - outbreak investigation
- Understand the role of the FES in:
  - co-ordinating surveillance of disease
  - providing expert advice and support to the HPT

How met

- Meet with individual HPT staff to understand their role and lead areas
- Shadow individual team members in their day to day practice
- Participation in the HPT duty service
- Meet with FES staff to gain an understanding of their work
- Use PHE website

3. Role of microbiology in control of infection and communicable disease

Learning aim: Understand how the microbiology service works

Objectives

- Understand the role (including public health role) of the microbiologist
- Understand role of microbiology in:
  - analysing routine samples
  - microbiological investigation of communicable diseases outbreak, food and drink products
- Gain basic understanding of microbiological tests used in investigation of communicable diseases and recognise time scales to yield results
- Familiarise with modern diagnostic microbiological techniques and follow new developments in medical microbiology, including molecular typing
- Know interpretation of microbiological results and appreciate test limitations
- Understand the flow of data to HPT/FES

How met

- Short attachment to microbiology lab to understand how the lab operates: from specimen reception, processing, reading, and reporting of results
- Handbook of basic microbiological tests (indication, incubation time, reliability, and validity)

4. Infection Prevention and Control

Learning aim: To understand the role of Provider Infection Prevention and Control (IPC) Committees and Infection Control Nurses in control of infection.

Objectives

- Understand the organisation of local IPC Committees
- Understand the role of these committees in Health Care Associated Infection (HCAI)
- Understand the role and responsibilities of hospital and community IPC Nurses
- Understand the role of the TB Nurse in prevention, control, and treatment of TB

How met

- Short attachment to hospital/ community IPC team and TB Nurse to follow their day-to-day work
- Attendance at IPC meetings

5. Immunisation

Learning aims: To understand the principles of immunisation and implementation and management of immunisation programs

Objectives

- Familiarise with the national immunisation schedule
- Know where to find relevant references
- Understand the role of the NHS England Screening and Immunisation Team (SIT)
- Familiarise with systems for monitoring vaccine uptake and adverse events
- Familiarise with different approaches to running immunisations campaigns such as childhood immunisation program and influenza immunisation campaign

How met

- 'Green book' https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
- Meet with the SIT

6. Emergency planning and response to major incidents

Learning aim: To understand the principles of emergency planning and the networks involved in the emergency planning process

Objectives

- Understand local emergency planning structures
- Learn about the operation of the emergency services (fire, police, and ambulance)
- Understand the functions of expert organisations such as Environment Agency, Animal and Plant Health Agency (APHA), etc
- Understand the roles and responsibilities of NHS organisations and the Department of Health and local authorities in planning for and responding to major incidents

How met

- Discussion with the EP lead
- Attend relevant emergency planning meetings

7. Local Authority Environmental Health

Learning aim: To understand the duties of environmental health services of local authority relevant to communicable disease control

Objectives

- Understand the structure and organisation of LA
- Understand the roles of district and county council
- Understand the role of LA in control of notifiable diseases and working relations with the proper officer
- Be aware of Public Health Law
- Understand the divisions and responsibilities of Environmental Health Services
  - Food team
  - Pollution team
  - Safety team

How met

- Short attachment to the different teams of Environmental Health Services
- Discussions with the team leaders
- See day to day operation of EH department in responding to enquiries from the public, registration, inspection, monitoring and dealing with other environmental hazards, etc
- Participation in inspection of food premises

8. Suggested time scales (pre Part A MFPH would be beneficial)

Areas to be covered	**Minimum time periods**
Introduction to CDC and non-CDC	Own time reading
PHE structure and functions	3 days
Microbiology services	2 days
Infection prevention and control	2 days
Immunisation	1 day
Emergency planning	1 day
EH department	1 day
Total	**10 days**

On-call Policy

1. Context

Health protection is one of the key areas of public health practice. Response to health protection incidents is a part of this. First on call duties out-of-hours will give experience of response to health protection emergencies in line with the requirements in the new curriculum. Before a specialty registrar (StR) begins out-of-hours duty they are required to have the appropriate knowledge platform and to be certified safe to start on-call.

Registrars will continue to participate in an out-of-hours on-call rota until they have, at a minimum, achieved the competence for participation in an unsupervised out-of-hours rota (LO 6.9). This Learning Outcome (LO) would normally be assessed towards the end of training.

2. Mandatory requirements for joining the on-call rota

Preparation for supervised on-call requires several steps. Each of these steps must be satisfactorily achieved before on-call can start. These requirements are:

- An induction in health protection and on-call training to include demonstration of basic health protection skills, understanding of the control of communicable and non-communicable diseases and simple skills in assessment of risk and clinical history taking
- A full pass at the Part A examination to fulfil the knowledge requirements for health protection
- Satisfactory assessment of on-call procedures
- Agreement to maintain a reflective log book (Appendix 7) of in and out-of-hours calls.

3. Knowledge platform

Registrars will be assessed as competent to begin participation in a supervised out-of-hours rota, once they have demonstrated Learning Outcomes 1.2, 4.2, 6.1 - 6.6, 9.2, and satisfactory knowledge of on-call procedures in a formal assessment. Out-of-hours experience will require passing Part A MFPH as the examination is an indicative assessment method for LO 6.1, 6.2, 6.3, 6.6. The Part A MFPH examination is generally taken in the January of ST2.

4. On-call training

Following the period of academic study the StR should arrange a three month (WTE) attachment with a HPT. This attachment should include familiarisation with on-call procedure and local on-call guidelines and ensure that StRs are familiar with operational and administrative aspects of the on-call system. A workshop ‘Introduction to On-call’, held in May/June each year, introduces StRs to the principles of starting on-call duties and helps to prepare them for their on-call assessment.

There are also regular health protection on-call teleconferences which provide a forum for the discussion of on-call scenarios and support the on-going learning and development of StRs.

5. On-call assessment

Formal assessment must take place before supervised on call starts. This assessment will take about half an hour and is intended to provide assurance that the StR is safe and confident to start on-call and has reached the minimum standard of practice.

The StR will be asked to provide written evidence of their level of achievement for LO 1.2, 4.2, 6.1 - 6.6, and 9.2. This will be reviewed by the assessment panel and will be followed by a test of the StR’s understanding of basic on-call principles and how and when to seek further information and expertise. StRs will be given up to four scenario-based questions which they will need to answer in terms of immediate response to out-of-hours and short-term follow-through as a part of handover on the next working day. The assessment criteria cover the following areas: information gathering; risk assessment; public health action required; systems/roles and responsibilities. The panel is likely to consist of a specialist consultant in health protection, a generalist consultant and one other usually from the programme team.

Assessment will normally take place in July, with an option to defer in certain circumstances, or resit, in the early autumn. Registrars failing one or both papers of part A may sit the on-call assessment, the validity of which will last 6 months, i.e. until after one exam resit. A further part A fail will require a further resit of on-call assessment.

6. Logbook (Appendix 7)

StRs should complete a log (both within and out of hours), including a section for reflective learning that can be reviewed and discussed with the trainer. This will include action taken and learning from the episode. The log should be uploaded to the e-portfolio.

7. Health Protection Team attachment

Under normal circumstances all registrars will have completed most or the majority of their 3 month health protection attachment before their on-call assessment. While this is not mandatory in the curriculum it will ensure that all registrars are equally advantaged in the timing of the assessment and will be able to start on-call duties together in the late summer.

Registrars training outside their own on-call patch will be required to spend a familiarisation period of a minimum of 3 days with their local HPT before starting on call duties.

8. On-call rota

StRs are required to have an honorary contract with PHE for on call work. An additional supplement is payable for out-of-hours duties. The supplements are governed by relevant terms and conditions of service. Banding is only payable once the StR has been certified as competent to start on-call and been included in the on-call rota. The StR is responsible for notifying HR once they have been included on the rota.

In line with requirements under the European Working Time Regulation (EWTR), StRs will not be required to undertake more than 1:9 out-of-hours duties. StRs working less than full time will undertake out-of-hours duties *pro rata*. For a full-time StR, this will equate to up to 10 on-call sessions in a quarter. To maximise the learning while on-call, a typical rota might consist of up to 4 bank holiday or weekend days (Saturday or Sunday, 9am - 9am following day) and up to 6 week days (Monday – Friday, 5pm - 9am following day). StRs are expected to provide sufficient availability to enable rotas to be constructed equitably.

9. Placements and being on call

Being on call

Registrars will need to participate in the out-of-hours on-call rota until they have, at a minimum, achieved the competence (6.11) for participation in an unsupervised out-of-hours rota.

During training, placement moves are planned in discussion with their Educational Supervisor (ES) and locality TPD to agree the placements that best meet with identified educational needs and career aspirations. This should also include the on-call requirement and the table below details the criteria for remaining on call during the various training placements that the StR may move through.

	Placement	Criteria for being on call
	Health Protection (HP) Placements	
1	In area	None
2	Out of area (in programme or OOPT) e.g. PHE Colindale or CRCE	Equivalent of one day/month HPT duty service*
	Non HP Placements	
3	In area/ in programme	Equivalent of one day/month HPT duty service*
4	Out of area	Cannot remain on call

* In discussion with their ES and agreement with the dTPD health protection, a reduction may be considered for part-time StRs, taking into account their training needs.

When a registrar comes off the on-call rota, the on-call supplement will cease and restart on re-entry to a local on-call rota. Registrars should arrange to refresh their skills appropriately before starting out-of-hours duties again and will be supported in arranging for experience in an HPT and/or 1:1 tutorials. Registrars are also advised to maintain some skills by dialling in to the regional on-call teleconferences.

On-call rota

Since May 2016, the EoE HPT is located in two offices – Harlow and Thetford. Currently there are three first on-call HP rotas in the EoE, Anglia, Bedfordshire/Hertfordshire/MK (BH) and Essex. The existing on-call arrangements may be reviewed towards the end of 2016 and may change.

StRs start their training in either the North or South zone. The initial training location may be used as the basis for deciding on the particular on-call rota. As a general principle, the primary 1st on call rota for North zone registrars will be the Anglia or BH rota and, for South zone registrars, the BH or Essex rota, however, there is flexibility around this. The rota that the StR joins will be agreed between the HPT acute service lead, the HPT training lead and the registrar taking into account factors such as training location and staffing of the rota.

10. Indemnity

StRs are covered by NHS Hospital and Community Health Services indemnity against claims of medical negligence. StRs are strongly advised to secure personal indemnity through a medical defence union or other appropriate insurance package.

11. Governance

Details of expectations for availability and procedures while on call are provided below.

On-Call Governance/Handover arrangements

BEING ON THE ROTA

- Training and competence – meet FPH requirements.
- Attend health protection team (HPT)/ other available on-call training session (e.g. monthly teleconferences) on a regular basis to keep up-to-date.
- Be familiar with any relevant guidelines/on-call guidance.
- If new to the rota (and until you are confident) – make contact with the CCDC at the start of your on-call sessions so that they are aware that you might require additional support.
- When you receive the rota, log your on-call days/weeks in your diaries/planners.

Check availability during the scheduled on-call day/period to ensure you will be able to respond appropriately to calls at all times and in a professional way.
Plan and prepare to receive calls at times when you may be asleep or undertaking another activity.

- You are also responsible for pre-arranging suitable cover in good time if you are unable to cover an on-call shift and informing the rota administrator of the change.
- In the case of illness or unexpected circumstances where you cannot fulfil on-call responsibilities please ensure you let the rota administrator know as soon as possible. If you are unable to do this, then please ask your manager or equivalent to inform the rota administrator/HPT.
- In case of illness whilst you are on call, please alert the CCDC on-call, so that they can consider whether alternative arrangements are needed
- For information, Medicom are instructed not to leave a message on any phone (as they cannot guarantee receipt of the message) so if they get no answer from the first they will try the next (mobile/landline, etc.).

BEING ON-CALL

- Before starting your on-call shift, please ensure that you have:
  - ✓ your mobile switched on and charged;
  - ✓ an alternative phone line, e.g. landline, in case of failure;
  - ✓ internet and e-mail access;
  - ✓ a secure nhs.net account;
  - ✓ the most up-to-date version of any relevant guidelines/on-call guidance and relevant contact details
- Ensure you are available during your on-call period.

You have a responsibility to be able to answer any call within 30 minutes so consider where you will be and how you can stop what you are doing to answer a call, undertake the relevant risk assessments and make notes.

- Be contactable at all times by phone.
- Maintain contemporaneous records of incidents and the actions taken.
- Ensure escalation upwards. Discuss incidents as required with CCDC on-call.

HANDOVER ARRANGEMENTS

- For any new relevant incidents with potential out-of-hours implications, the HPT should give verbal updates to 1st on call before 5pm.

First on-call on the rota:

- ***Before starting your on-call***, if you haven't heard from the HPT, phone them by 5pm in the afternoon to get details of any ongoing health protection issues that you need to know about.
- ***At the end of your on-call period***, i.e. 9 am on weekday morning and by 10 am at the latest, provide an update to the HPT in accordance with agreed arrangements (e.g. verbal update or email/fax of case notes using secure email or confidential fax).
- Even if you have no cases, contact HPT with a nil return.
- ***During weekends***, the outgoing first on-call will contact the incoming first on-call at 9am on Saturday, Sunday or Bank Holiday Monday.
- Outgoing 1st on-call to communicate to incoming 1st on-call a nil return or a summary of any cases/situation and further potential actions or follow up required.

HPZone

This section applies to those on the on-call rota who have access to HPZone while on-call

- Prior to going on the rota you have a responsibility to make sure that you are familiar with HPZone, arranging suitable training with the HPT as necessary
- Before starting on-call, log on to HPZone and check if there are any actions that need to be undertaken out of hours
- Management of your calls will need to be documented in the relevant sections in HPZone (see below for key information required)
- Schedule actions that need to be followed up the next working day to the duty desk.

Records, paper or electronic: include the information below

- For cases: demographic details and contact details of patient and their GP
- Caller details and other key contacts e.g. school, care home
- Risk assessment of the situation/incident/case
- All decisions/interventions and communications made, including rationale
- Any outstanding actions required.

Confidentiality and security

- Comply with local HPT records management protocol
- Consider security of clinical information (patient identifiable data). This includes hand written notes.

FOLLOW-UP/LEARNING AFTER ON-CALL

- Situations/ incidents should be followed up for own learning
- Take part in any incident debrief
- Discuss incidents at the regional on-call teleconference if relevant
- Keep a log of the calls you have dealt with for your training portfolio.

Appendix 3

Roles and Responsibilities in Health Protection
(including in the management of incidents and outbreaks)

Public Health England

PHE is an executive agency of the Department of Health. Under the Health and Social Care Act 2012 the Secretary of State has a duty to protect the health of the population and carry out activities as described in the Health Protection Agency Act 2004. In practice these functions are carried out by PHE.

PHE delivers a specialist health protection service, including the response to incidents and outbreaks, through Health Protection Teams (HPTs), which sit within PHE Centres (PHECs). Local HPTs investigate and manage outbreaks of communicable disease, provide surveillance of communicable diseases and infections and support local authorities (including port health authorities) in their responsibilities under the Public Health (Control of Disease) Act 1984 and associated regulations. Local HPTs are staffed by Consultants in Communicable Disease Control (CsCDC)/ Consultants in Health Protection (CHP), nurses, health protection practitioners and other staff with specialist health protection skills and access to expert advice.

The Screening and Immunisation Team includes public health specialists employed by PHE and embedded in NHS England Area Teams. It is led by a Consultant in Screening and Immunisation, supported by Screening and Immunisation Managers and Coordinators. Depending on the nature of the outbreak, input from Screening and Immunisation Leads (SILs) may be required.

PHE National Infection Service

The Centre for Infectious Disease Surveillance and Control (CIDSC) Colindale is responsible for the collection and collation of data on outbreaks of communicable disease and is involved in prevention and control at a national level in England. Where appropriate, CIDSC Colindale can provide experts to assist in local outbreak investigations or, in the case of outbreaks with a national distribution, its experts may themselves design and carry out outbreak investigations.

The PHE Microbiology Services comprise the reference laboratories at Colindale (which assist in the identification and investigation of outbreaks by subtyping isolates), Porton Down and the eight Lead Public Health Laboratories, which together with the Food, Water and Environment (FW&E) laboratories form the Specialist Microbiology Services. Lead Public Health Microbiologists within each public health laboratory manage or commission regional public health microbiology services (including food, water and environmental microbiology). PHE's regional public health laboratories undertake specialist tests and provide support for NHS microbiology laboratories. In addition, the reference laboratory at Porton deals with special pathogens.

The Field Epidemiology Service (FES) was created to improve the consistency of high quality epidemiological investigations including those in response to outbreaks and incidents. FES is a nationally co-ordinated but geographically dispersed service with Consultant Epidemiologists, specialising in the epidemiology of communicable disease and in the application of epidemiological methods, supported by scientists and analysts. FES supports the investigation of outbreaks/incidents, including providing on-site support where needed and would be contacted in all significant incidents.

Director of Public Health

Following the implementation of the Health and Social Care Act 2012 which resulted in the reorganisation of health services on 1 April 2013, the responsibility for health protection is shared between a number of organisations. As part of the reorganisation DsPH moved to LAs, and the overarching responsibility for the health of the population served by each LA rests with that authority and is carried by the DPH. A key feature of this responsibility is that for the majority of services the DPH has this accountability with no managerial responsibility. The DPH must therefore be assured on behalf of the LA they serve that all health sector organisations in their local area have adequate plans in place to meet the health protection needs of the population in any circumstance.

The DPH is responsible for the LA's contribution to health protection matters, including the LA's roles in planning for and responding to incidents that present a threat to the public's health.

DPH and PHEC roles are complementary; both are needed to provide an effective response and they should act together as a single public health system. This means that there must be early and ongoing communication between the PHEC and DPH about emerging health protection issues and to agree the nature of response required.

Local Resilience Forums (LRF) and Local Health Resilience Partnerships (LHRP)

Local Resilience Forums (LRF) are existing multi-agency partnerships which bring together senior representatives of emergency services, LA partners, NHS bodies and other responders. The purpose of the LRF is to prepare for the response to emergencies as part of national coordination arrangements and enable and build local resilience capability through planning and testing. There are currently 39 LRFs that map directly on to police areas. The LRF facilitates preparedness at a local level but does not have an operational role.

The Local Health Resilience partnership (LHRP) is a strategic forum for organisations in the local health sector which facilitates health sector preparedness and planning for emergencies at LRF geographic level. It supports the health representatives on the LRF in their role to represent health sector Emergency Preparedness, Resilience and Response (EPRR) matters.

NHS England

NHS England is the overarching organisation that has responsibility for ensuring that health care is commissioned for the population of England. It is a single organisation with representation at national, regional and local level. The national team is based in Leeds and London, the regional team for this area covers the Midlands and East of England.

NHS England's responsibilities include:

- Allocation of resources to CCGs
- Supporting, developing and assuring the commissioning system
- Planning for civil emergencies and making sure the NHS is resilient
- Directly commissioning some health services including primary care, some public health services and specialised health services
- Developing commissioning support

The principal areas of health protection responsibility are:

- Commissioning Immunisation and Screening services led by a PHE team embedded with the NHS England Area Team
- Providing NHS leadership for Health Emergency Preparedness, Resilience and Response (EPRR) at local, regional and national level
- Overseeing the commissioning role of CCGs and supporting commissioner development.

Clinical Commissioning Groups

CCGs have been formally established under the Health and Social Care Act 2012 as clinically led groups that include all GP practices in their geographical area and are responsible for commissioning health services for the population they serve. The services they commission include:

- Elective hospital care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

The principal areas in which CCGs impact health protection are:

- Commissioning health services for the population they serve including services to prevent and manage communicable diseases
- Responsibility for ensuring the quality of the care they commission including issues such as prevention of healthcare associated infection
- Responsibility for ensuring the resilience of the health services they commission, with 24/7 responsibility to deal with resilience issues and ensuring robust business continuity plans are in place.

Providers of NHS Funded Health Services

These include NHS trusts and organisations that deliver acute health services, mental health services, pre-hospital services such as ambulance trusts and community health services. In addition to NHS trusts and organisations, NHS commissioners may commission services from providers in the third sector such as voluntary organisations and social enterprises as well as providers in the private sector. All NHS funded health care must meet the standards set down by the commissioning organisations and by NHS England which includes standards for patient safety and health protection.

Following implementation of the Health and Social Care Act 2012, NHS England issued core standards for EPRR for all NHS organisation and providers of NHS funded care. All organisations are required to meet the requirements of the Civil Contingencies Act 2004. This includes having a 24/7 response capability for emergencies.

Local Authorities (Environmental Health Departments)

Key health protection responsibilities include:

- Environmental health – including dealing with contaminated land.
- Community safety
- Air quality - statutory duty under the Environment Act 1995 to manage Local Air Quality which involves monitoring and identifying areas where nationally prescribed objectives are at risk.
- Occupational Health and safety – LA Environmental Health Practitioners (EHPs) inspect workplaces and respond to notifications of injury, disease and dangerous occurrences.
- Legionella – investigation of cases/outbreaks and potential sources.
- Food safety - EHPs inspect food businesses and investigate food incidents and outbreaks of food-borne illness.

LAs and port health authorities play a key role in managing outbreaks of foodborne illness. The Food Safety Act (1990) and the Food Hygiene Regulations (2006), or their equivalent in devolved administrations, place responsibilities and powers of control with LAs. LAs have powers to assist both investigation and control of outbreaks, including powers of entry, sampling powers and powers to exclude food handlers, seize and detain food and close premises.

The specific statutory responsibilities, duties and powers significant in the handling of an outbreak of communicable disease are set out in the following legislation:

- Public Health (Control of Disease) Act 1984
- Health Protection (Notification) Regulations 2010
- Health Protection (Local Authority Powers) Regulations 2010

- Health Protection (Part 2A Orders) Regulations 2010
- Health and Safety at work (Etc) Act 1974
- Food Safety Act 1990
- Food Safety and Hygiene Regulations 2013 (in place December 2013)
- Food Law Code Of Practice (England)
- International Health Regulations 2005
- Public Health (Ships) Regulations 1979
- Public Health (Aircraft) Regulations 1979

Food Standards Agency

The Food Standards Agency (FSA) is a UK-wide non-ministerial Government department, established under the Food Standards Act 1999 with responsibility for the protection of public health in relation to food. This is issued under section 20 of the Act, which confers powers to issue guidance upon the FSA.

LA EHDs have a responsibility under Codes of Practice (Food Law Code of Practice 2006 section 1.7.6) to inform FSA of all national or serious localised outbreaks. The FSA Incidents Branch is the point of contact for LAs in relation to outbreaks and incidents. Where relevant, the FSA will assist in the investigation of foodborne outbreaks and lead on any food chain analysis and action that may be required for implicated foods.

Where investigations implicate a food distributed in the UK the FSA will carry out a risk assessment and work with LAs to advise the food business operator (FBO) on steps that ought to be taken in relation to the affected product(s). These steps may include the withdrawal or recall of food pursuant to EC General Food Law Regulation 178/2002, which prohibits food being placed on the market if it is unsafe (i.e. it is either injurious to health or unfit for human consumption). Under this EC regulation FBOs are also required to notify the competent authorities (i.e. both the FSA and relevant LA) where they consider or have reason to believe that food is not in compliance with food safety requirements.

Animal and Plant Health Agency

The Animal and Plant Health Agency (APHA) was launched on 1 October 2014. It merged the former Animal Health and Veterinary Laboratories Agency (AHVLA) with parts of the Food and Environment Research Agency (FERA) responsible for plant and bee health to create a single agency responsible for animal, plant and bee health. APHA is funded by Defra to give assistance to outbreak control teams as appropriate where a direct or indirect animal source is implicated in outbreaks of enteric (or other zoonotic) illness and where veterinary investigation (including collection of appropriate animal samples) or intervention could help reduce risks to the public. Veterinary involvement may be initiated centrally by Defra or locally following contact between the CCDC or the LA and the local APHA regional laboratory.

FPH Curriculum Key Area 6: Learning outcomes and assessment

(FPH PH Specialty Training Curriculum 2015)

Key area 6 focuses on health protection. Other learning outcomes can also be achieved during health protection training, e.g. 8.7 Make a significant contribution to the design and implementation of a study in collaboration with appropriate team and relevant partner (e.g. academic partner); and 8.8 Write and submit an article of sufficient quality for publication in a peer review journal

Key Competence 6: Health Protection *To identify, assess and communicate risks associated with hazards relevant to health protection, and to lead and co-ordinate the appropriate public health response.*				**Suitable assessment methods (indicative)**					
				MFPH exam		**WPBA**			
Learning Outcome		**Target phase**	**Related Learning Outcome**	**Part A**	**Part B**	**DOP**	**WR**	**CBD**	**MSF**
6.1	Demonstrate knowledge and awareness of hazards relevant to health protection.	1		X		X	X	X	
6.2	Gather and analyse information, within an appropriate timescale, to identify and assess the risks of health protection hazards.	1	KA 1.3, 1.6	X	X	X	X	X	
6.3	Identify, advise on and implement public health actions with reference to local, national and international policies and guidance to prevent, control and manage identified health protection hazards.	1	KA 2.3, 2.4, KA 3 &KA 4	X	X	X	X	X	
6.4	Understand and demonstrate the responsibility to act within one's own level of competence and understanding and know when and how to seek expert advice and support.	1	KA 9		X	X	X	X	
6.5	Document information and actions with accuracy and clarity in an appropriate timeframe.	1	KA 1.2			X	X		
6.6	Demonstrate knowledge and awareness of the main stakeholders and agencies at a local, national and international level involved in health protection and their roles and responsibilities.	1	KA 3	X	X	X	X	X	
6.7	Demonstrate an understanding of the steps involved in outbreak/incident investigation and management and be able to make a significant contribution to the health protection response.	Any	KA 1.6	X	X	X	X	X	
6.8	Apply the principles of prevention in health protection work.	2	KA 1.9, 2.3, 2.5 & 5.9	X	X	X	X	X	
6.9	Demonstrate competence to participate in an unsupervised out of hours (OOH) on call rota.	2				X		X	

Important Note: Registrars may commence out-of-hours supervised on-call once they have demonstrated learning outcomes 1.2, 4.2, 6.1 - 6.6, and 9.2 (the latter must be assessed in the health protection setting even if it has already been signed off in another placement). This would be done through workplace based assessment and would normally also require passing part A of the MFPH examination.

Guidance for assessment of competency

	Learning outcome	*Level of Achievement*	
6.1	**Demonstrate knowledge and awareness of hazards relevant to health protection.** *Examples: Effective application of knowledge and awareness in acute response.* *Deliver teaching/ tutorial to peers/medical students on health protection topic.*	*Minimal*	Has minimal knowledge and awareness of hazards relevant to health protection.
		Partial	Understands key concepts and can demonstrate important factual knowledge of hazards relevant to health protection.
		Full	Demonstrates effective application of knowledge and awareness of relevant HP hazards and is able to apply in appropriate situations in a supported environment.
6.2	**Gather and analyse information, within an appropriate timescale, to identify and assess the risks of health protection hazards.** *Example: Ascertain appropriate clinical, demographic and risk factor information when handling health protection enquiries and use that information to make a risk assessment.*	Minimal	Does not gather relevant information within appropriate timescales.
		Partial	Understands information gathering and analysis within appropriate timescales in line with relevant guidance and policies.
		Full	Is able to gather and analyse information in the appropriate timeframe and demonstrate ability to make a risk assessment based on the information with reference to relevant guidance and policies.
6.3	**Identify, advise on and implement public health actions with reference to local, national and international policies and guidance to prevent, control and manage identified health protection hazards.** *Example: Identify and manage close contacts associated with a case of bacterial meningitis, within an appropriate timeframe.* *Respond to an immunisation query from a practice nurse for a child who has recently arrived in the UK with reference to the WHO country specific information on immunisation.*	Minimal	Is not able to identify, advise on or implement public health actions relating to health protection hazards.
		Partial	Understands the importance of identifying, advising on, and implementing public health actions in relation to health protection hazards.
		Full	Demonstrates effective identification, advice and implementation of public health actions to prevent, control and manage identified health protection hazards.
6.4	**Understand and demonstrate the responsibility to act within one's own level of competence and understanding and know when and how to seek expert advice and support.** *Example: Appropriate management of health protection enquiries and cases, with reference to local Consultant or National expert as necessary.*	Minimal	Does not understand the responsibility to act within one's own level of competence nor when to seek expert advice and support.
		Partial	Understands the importance of acting within one's own level of competence and appreciates the importance of seeking expert advice and support.
		Full	Demonstrates responsible practice within own level of competence and actively seeks expert advice and support.

	Learning outcome	*Level of Achievement*	
6.5	**Document information and actions with accuracy and clarity in an appropriate timeframe.** *Examples: Documentation of case notes on electronic or written case management systems (real time updating of case notes).* *Outbreak or incident control team minutes and actions produced and disseminated in an appropriate time frame as per outbreak plan.*	Minimal	No awareness of need to document information and actions.
		Partial	Keeps accurate and clear documents, following appropriate supervision.
		Full	Independently maintains accurate and contemporaneous records in relation to a range of health protection situations.
6.6	**Demonstrate knowledge and awareness of the main stakeholders and agencies at a local, national and international level involved in health protection and their roles and responsibilities.** *Example: Demonstrated by effective participation in multiagency meetings e.g. Working across agencies on strategic plans and involving the correct agencies in acute response work.* *Respond to a travel associated case of legionnaires disease demonstrating an understanding of the role of international surveillance systems*	Minimal	Limited or no ability to identify main stakeholders and agencies and limited or no knowledge of roles and responsibilities.
		Partial	Has knowledge and awareness of main stakeholders and agencies with developing knowledge of roles and responsibilities.
		Full	Able to effectively apply knowledge and understanding of stakeholders and agencies and their roles and responsibilities in acute and strategic health protection work.
6.7	**Demonstrate an understanding of the steps involved in outbreak/incident investigation and management and be able to make a significant contribution to the health protection response.** *Example: Active membership of an incident/outbreak control team including investigation, implementation of control measures,* *Write up of outbreak report and identification and response to lessons learnt.*	Minimal	Has no, or limited understanding of outbreaks/ incident investigation and management.
		Partial	Understands the principles and steps involved in outbreak/incident management, but is able to only make limited contribution to the health protection response, and requires significant support and guidance.
		Full	Good understanding of incident and outbreak management. Has contributed to the HP response on one or more occasions, and has the ability to run an HP incident with minimal support and guidance.
6.8	**Apply the principles of prevention in health protection work.** *Examples: Providing opportunistic advice on vaccination during routine health protection work.* *Ensuring schools and care homes have up to date guidance on infection prevention and control.*	Minimal	Has limited or no understanding of the concepts of prevention as applied to health protection.
		Partial	Understands the principles of prevention in HP work.
		Full	Is able to actively demonstrate implementation of prevention as part of regular health protection response and strategic health protection planning.

Appendix 5

Demonstration of competence to participate in an unsupervised OOH rota (LO 6.9)

	Learning outcome	*Level of Achievement*	
6.9	Demonstrate competence to participate in an unsupervised out of hours (OOH) on call rota. *Examples: Continuing regular participation in acute health protection work in and out of hours to attain a wide range of experience, skills and knowledge.*	Minimal	Has started participation in the supervised tier of an OOH rota and discusses all calls with Consultant / Supervisor.
		Partial	Has gained some experience out of hours; demonstrates ability to act on own initiative but refers and discusses most calls.
		Full	Has gained a wide range of experience in out of hours work. Demonstrates ability to work on own initiative; has competence in risk assessment and management; has developed an understanding of what would still need to be referred for expert support and advice.

The criteria below have been adapted from the FPH document *Health Protection Training for generalists in public health, including Educational Requirements for on-call*. This document is no longer valid, but the elements below are provided as a guide for Educational Supervisors.

Criteria	Demonstration of competence
Ability to perform risk assessment of a problem, decide whether public health action is necessary and decide appropriately whether action is required out-of-hours.	• Involved in assessment of 20 enquiries out of hours
Ability to interpret national guidelines and local policies for the most common scenarios that present on-call and to effectively co-ordinate public health action. Examples provided below. • Meningococcal disease and meningitis. • Gastrointestinal infections, including E coli O157. • Respiratory infection, including Legionella and TB • Blood-borne viruses (e.g. HBV) • Infections requiring prophylaxis/advice, (e.g. pertussis, hepatitis A) • Most common chemical/environmental hazards (e.g. CO, smoke, contaminated water)	• Dealt with 3 cases of meningococcal infection (including 1 out of hours) in previous 4 years. • Dealt with 1 case in each of the other categories (NOT each individual organism), including 2 separate categories out of hours • Dealt with case of E. coli O157, Legionella and HBV (either within or out of hours) Note: in all cases, number of cases/incidents required as experience can include cases/incidents dealt with under the supervision of a trainer.
Awareness of the basic principles of control and sources of advice and support (particularly out of hours) for serious, less common public health problems that may present out-of-hours, including: • Imported infections (eg VHF, diphtheria, rabies exposure, possible SARS/avian flu) • Exposure of particularly vulnerable groups (e.g. chickenpox in immunosuppressed/neonates) • Exposure to blood-borne viruses or TB in community or health care settings (including potential lookback exercises) • Potential public health emergencies (eg food-borne botulism) • Major emergencies (e.g. floods, fire)	• MFPH or on GMC Specialist Register for medical microbiology or clinical infectious diseases and have suitable training/experience in non-infectious environmental hazards. • Training/updating within last 5 years on basic principles and sources of advice and support. • Participated in actual or simulated incident of one of the listed

Ability to contribute effectively to the public health management (with appropriate expert advice) of local outbreaks and incidents out-of-hours, including: • Potential community outbreaks of a communicable disease • CBRN incidents • Hospital outbreaks/incidents	• Familiarity with local contingency plans • Participated in management of both community outbreak and chemical incident • Experience or training in chairing multi-agency meetings • Experience of working in Major Incident Command and Control structures in actual or simulated emergency
Ability to communicate effectively on public health issues, including: • Preparing appropriate press releases out-of-hours • Giving effective media interviews • Communicating directly with public.	• Received media training • Involved in preparation of press release • Attended relevant public meeting (e.g. parents in a school with meningitis)

Appendix 6

Specialist Health Protection Placements

East of England Placement Options

Placement	Duration
PHE Health Protection Team (Essential) Currently based in three locations in Thetford (Norfolk), Letchworth (Hertfordshire) and Witham (Essex)	Placements are usually for six months (WTE)

PHE Eastern Field Epidemiology Service Institute of Public Health University Forvie Site Robinson Way Cambridge CB2 0SR	Placements are usually four to six months (WTE)

Screening and Immunisation Team NHS England Midlands and East (East) / PHE EoE Currently three locations: Fulbourn, Essex and Welwyn Garden City	Three to six month (WTE) placements are available

Microbiology **Addenbrooke's Hospital** PHE Public Health Laboratory Cambridge University Hospitals NHS Foundation Trust Cambridge Biomedical Campus Hills Road Cambridge CB2 0QW **Norfolk and Norwich University Hospital** Colney Lane, Norwich, NR4 7UY	Three to six month (WTE) placements are available

National Placement Options

The following are also available as National Treasure placements. 'National Treasures' are training placements which offer trainees opportunities to acquire specific additional or contextual experience which may not be available in all programmes.

Placement	Duration	N.T. details
PHE Centre for Infectious Disease Surveillance and Control (PHE CIDSC) 61 Colindale Avenue London NW9 5EQ	Placements are usually four to six months (WTE), but longer placements of up to 12 months can be arranged	For full details about this placement, please click here

PHE Centre for Radiation, Chemicals and Environmental Hazards and Emergencies 151 Buckingham Palace Road, London, SW1W 9SZ	Placements are usually four to six months (WTE), but longer placements of up to 12 months can be arranged	For full details about this placement, please click here

PHE Emergency Response Department Porton Down Salisbury SP4 0JG	6 months to one year (WTE)	For full details about this placement, click here

PHE Public Health Strategy Division 4th Floor, Wellington House, 133-155 Waterloo Road, London SE1 8UG	Open to negotiation – expected to between 6 months to 18 months unless there are exceptional circumstances.	For full details about this placement, click here

Appendix 7

Health Protection On-call Log

Date	**Health Protection query** (HPZone number)	**Your initial action (brief details)** Include whether observed (O), acted under supervision (S) or acted independently (I)	**Your further action** Include whether observed (O), acted under supervision (S) or acted independently (I) Did this experience include new (N) or consolidated (C) learning	**Registrar**