Training those required to perform on-call duties in local health protection rotas in NHSScotland
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Background

Discussions on the issue of health protection on-call rotas have been taking place for some time at both Faculty of Public Health (FPH) and within the Scottish NHS. At a joint Directors of Public Health (DPH)/Chief Medical Officer (CMO) meeting in June 2003, criteria were agreed for entry to and staying on health protection rotas. Later the Scottish Executive Health Department made clear to NHS Boards and Health Protection Scotland (HPS) that arrangements should be established so that specialist health protection expertise can be made rapidly available at all times. Various options were reviewed and a preferred option was presented and agreed at the joint meeting of the DPHs with the CMO in June 2004. This involved HPS taking a more active co-ordinating role with regard to local rotas.

In March 2005, a sub-group of the Scottish Committee for Specialist Education and Training for Public Health drew up a report “Training in Health Protection for those wishing to work as Consultants or Specialists in Public Health in Scotland” which included a section on on-call rotas. The report drew up guidance on the training and the criteria to be met for working in:

- local supervised on-call i.e. usually first on-call receiving calls with Consultant supervision and national back-up;
- local unsupervised on-call i.e. operating either independently (taking calls directly or indirectly when supervising first on-call) with national back-up;
- national rota – operated by Health Protection Scotland (HPS) and the quality assurance processes for on-call rotas.

The criteria were based on these areas of preceding work and on 2003 criteria and those detailed in previous FPH reports. It proceeded on the basis that with regard to training for carrying out on-call duties in health protection, there should be equivalence between those from a medical background and those who are not.

Further to this a FPH Working Group with input from Scotland drew up revised criteria in a report “Health Protection Training for generalists in public health including Educational requirements for on-call” (see Appendix 1). In response to this the Sub-group, which drew up the 2005 report, was reconvened to review the sections of the original report covering local supervised and unsupervised on-call. It amended the report and incorporated as appropriate, the contents of the FPH report. This report was sent out for national consultation in December 2007.

This document presents the revised report in light of that national consultation and it applies to all those working on an on-call rota whether in a training post or otherwise.

The report concentrated on local arrangements for supervised/unsupervised on-call rotas. Further work is planned on a national rota.
General comments
The following were issues that were highlighted by colleagues through this consultation process:

• lack of uniformity by NHS boards as to the criteria used in determining when staff are deemed competent to undertake on-call duties;
• concern regarding non medical staff carrying out on-call duties particularly the newly appointed Specialist Trainees;
• the implementation of UK standards versus Scotland specific standards for on-call educational and training requirements;
• changing roles and responsibilities within the public health workforce;
• geographical differences in Scotland that impact on the provision of the health protection service.
### Proposed Training Programme

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<th>Operating Authority</th>
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<tbody>
<tr>
<td>Operated by an NHS Board</td>
<td>3 month attachment to Local Health Protection Team (including 5 day orientation period)</td>
<td>By end of 3-month attachment, trainee gains sufficient knowledge of health protection so that he/she can deal with routine out of hours calls while being supervised by second on-call - meets Scottish NHS criteria</td>
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<td>Operated by an NHS Board</td>
<td>3 month attachment to Local Health Protection Team</td>
<td>By end of 6-month total attachment period, trainee gains sufficient experience of practice in health protection so that he/she can assume leadership of a local health protection service out of hours - meets Scottish NHS criteria.</td>
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<td>Unsupervised on-call</td>
<td>By end of 6-month period, or end of training the trainee demonstrates/meets criteria in FPH Unsupervised Public Health on-call duties</td>
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<td>Supervised on-call</td>
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</table>

By completion of attachment able to participate as supervised member of on-call rota.

By completion of attachment able to participate as unsupervised member of on-call rota.

Not on-call

Familiarisation with the principles of health protection
Local supervised on-call

i.e. usually first on-call receiving calls with Consultant supervision and national back-up - criteria to be met before participating in rota

First criterion
Either medically qualified and registered with three years of post-qualification general professional training, or a good first degree (or equivalent) in a health-related discipline, as well as evidence of substantial relevant postgraduate professional experience of at least three years.

Those entering specialist public health training can come from a variety of backgrounds namely: medical, other clinical disciplines, from a biological sciences background or none of these. If not medically qualified, the trainee should have substantial relevant postgraduate professional experience which should include completion of an MPH or equivalent and/or work as a public health practitioner or specialist for at least three years.

Unlike most other areas of public health, health protection work can involve direct contact with patients and/or their carers. For those who have not undertaken clinical work, it is recommended that before beginning their initial attachment, they orientate themselves to clinical practice by undertaking in a health care setting an exercise to gain insight into:

- the patient journey through the NHS system;
- basic clinical processes e.g. taking a history;
- direct communication of health-related information to a patient.

Note: Length of time will be based on an individualised assessment.
Second criterion
At least three months in-service training in health protection

The training should be composed of:

- firstly, education on the principles of health protection (within a year prior to the commencement of attachment);
- secondly, a three month (whole time equivalent) attachment starting with an induction programme and featuring visits/brief attachments (see below).

The local NHS Board should ensure that prior to commencing the attachment, the trainee has a grounding (through previous experience or an Master of Public Health/or equivalent MSc) in the principles underlying health protection practice. The detail of this is given in the following criterion.

The NHS Board should organise an induction programme for the SpR/SpT. This is particularly important for those who have not undertaken clinical on-call duties in the past. It should include an explanation of key responsibilities and a presentation of the main forms and other documents used by the NHS board, an introduction and briefing on the membership of the health protection team; its priorities; its relationship to other key services and its procedures, especially those related to on-call.

Unless there are exceptional circumstances, the 3-month attachment should be completed as a block. Its purpose is to gain an understanding of health protection practice (i.e. surveillance, investigation, risk assessment, risk management and communication) and how it is carried out locally.

The trainee should then be involved in the day-to-day working of the HP team, team meetings and relevant committees. The latter should include those responsible for infection control, immunisation, med/vet liaison, food safety, and emergency planning/incident management. He/she should carry out supervised on-call in daytime e.g. responding to calls. The SpR/SpT should also attend or have already attended prior to the attachment basic training on the key principles of health protection.
Third criterion
Demonstration of basic knowledge and competencies in health protection

a. Education on the principles of health protection

After the relevant education, the trainee should be assessed by his/her trainer as having obtained an adequate basic level of knowledge of the key principles of health protection presented in Box 1.

Box 1 - Knowledge of key principles of Health Protection

- the nature, causes and occurrence of major communicable and non-communicable diseases due to infectious and non-infectious environmental hazards;
- the principles of the modes of transmission, latency, incubation periods, exposure, herd and individual immunity;
- the principles of primary, secondary and tertiary prevention programmes (including vaccination and immunisation) as they relate to major communicable and non-communicable diseases due to infectious and non-infectious environmental hazards;
- the principles, methods, application and effectiveness of screening for the early detection and prevention and control of major communicable and non-communicable diseases due to infectious and non-infectious environmental hazards;
- the nature of outbreaks and incidents and how they are managed;
- the methods employed in assessing, investigating and communicating risks to health and well-being including long-term exposure to non-infectious environmental hazards;
- the public health aspects of emergency planning and managing environmental/chemical and radiological incidents including the roles and legal responsibilities of people and organisations involved in protecting the population’s health and well-being;
- the law relating to public health protection including the Public Health etc. (Scotland) Act 2008.
Third criterion - continued

b. Understanding of health protection practice

At the end of the attachment, the NHSBoard should satisfy itself and record that the trainee can demonstrate an understanding of the issues detailed in Box 2.

Box 2- Learning from first 3-month attachment to NHS Health Protection Team
* Refer to Appendix 1 Annex A

- how surveillance, investigation, risk assessment, management and communication operate in practice in local health protection services especially as they relate to priority problems;
- how local immunisation, occupational health, travel and relevant screening programmes operate;
- roles and responsibilities of the different members of the health protection teams and how they interrelate with NHS and other key agencies;
- local health protection procedures (especially how they relate to on-call) and how these are audited and monitored;
- standard forms for information collection and recording of advice;
- local roles, responsibilities, arrangements and plans for outbreak and incident management;
- how local and national health protection policy, guidance and legislation are developed;
- local procedures for emergency planning and preparedness.
Fourth criterion
Orientation about NHS and local partners involved in health protection

The attachment should include visits to and if appropriate brief attachments to those services detailed below:

- Health Protection Scotland;
- at least one of the local microbiological laboratories;
- at least one of the local environmental health departments;
- at least one of the local hospital infection control teams;
- at least one of the following clinical services - specialist infectious diseases, Genito Urinary Medical service, specialist respiratory;
- as appropriate, at least two of the following: the school health service, State Veterinary Service, Scottish Water, Scottish Government CMO directorate/team, Scottish Environmental Protection Agency, port health, fire or other “blue light” service.

Fifth criterion
Access to and conversant with an on-call pack containing guidance on public health incidents

Each NHS Board should ensure that the trainee has in his/her possession a comprehensive on-call pack (wherever possible including the Scottish Health Protection Information Resource) which encloses information about local and national guidance on health protection practice.

Sixth criterion
Access to and be able to use on-call communication aids and any relevant electronic databases, etc.

Specific IM&T and communications training should be given tailored to local needs.
Assessment of achievement criteria

The previous criteria are derived from and dovetail with the Faculty of Public Health recommendations. As such they can be applied for both ensuring that the Faculty of Public Health specialist training requirements are fulfilled and that NHS bodies in Scotland employing public health practitioners or specialists for the purposes of supervised Health Protection on-call meet the national criteria. With regard to the assessment of the achievement of these criteria, the Faculty sets out minimum standards to be demonstrated:

- prior to entry onto the supervised (first) on-call tier;
- prior to entry to the unsupervised on-call tier.

With regard to the former, the Faculty of Public Health indicates that a person in their training scheme should have passed Part A of the Faculty of Public Health Examinations. In Scotland, the view is that the assessment of whether or not an individual in specialist training meets these criteria should be made by the trainer against the appropriate RITA/ARCP competencies. The Health Protection attachment supervisor should assess and record these competencies as described in the relevant Faculty curriculum documents.

From the nursing perspective, it is important that identified mentors meet the recognised NMC mentoring standards (NMC Standards to support learning and assessment in practice: Standards for mentors, practice teachers and teachers. August, 2006).

With regard to those who are not in specialist training but are employed by NHS boards for supervised on-call, NHS boards should ensure that prior to taking up these duties an appropriate assessment of these criteria is undertaken and recorded by the professional and his/her employer.
Local unsupervised on-call

*i.e. operating either independently (taking calls directly or indirectly supervising first on-call) with national back-up - criteria to be met before participating in rota*

First criterion
Inclusion in the GMC Specialist Register or UK Public Health Register or equivalent registration in other consultant level health discipline

To operate on an on-call rota either independently or supervising first on-call with national back-up, the person should be either be on the UK Public Health Register (specialist) or have acquired a FPH certificate of completed training and be on a specialist register or equivalent.

Second criterion
Minimum 6 months training in health protection including dealing with environmental hazards

In addition to acquiring the Certificate of Completion of Training and being on the specialist register or UK Public Health Register (specialist) by the end of training those working in health protection rotas in the Scottish NHS have had at least 6 months health protection whole time equivalent experience before participating on the unsupervised on-call rota. Preferably this should be composed of two attachments:

- the first, lasting three months, should enable the trainee to meet the criteria for participating in local supervised on-call rota;
- the second, also of 3 months, should ensure that sufficient experience of practice in health protection is obtained so that the trainee (if necessary with national back-up) can assume leadership of a local health protection response out of hours, supervised if still a trainee or unsupervised if a consultant or locum consultant.
By the end of the second 3 months attachment, the trainee, usually an SpR/SpT must demonstrate that during his/her six months training in health protection he/she has completed training and updating within the last 5 years on the subjects listed in Box 3.

Box 3 - Learning to be demonstrated by end of second 3-month attachment to NHS Health Protection Team
* Refer to Appendix 1 Annex B

- the epidemiology, clinical presentation, diagnosis, basic principles of control and sources of advice and support related to common public health problems that may present out of hours including those listed in requirements 2.5 and 2.7 of the FPH report;
- the management of hospital outbreaks/incidents, radiological incidents, major emergencies, deliberate release incidents (this could include supervised involvement in an actual incident);
- media handling;
- the legal principles underpinning health protection and related issues.

The Sub-group were of the view that this would enable an SpR/SpT to fulfil the criteria listed in the FPH requirements and the demonstration of minimum standard.
By the end of the second 3 months attachment, the trainee, usually an SpR/SpT should also demonstrate that during his/her six months training in health protection, he/she has gained experience and is competent in the areas of practice listed in Box 4. These may be obtained during the whole training period.

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**Box 4 - Areas of Practice: experience and competencies to be obtained before participating in unsupervised on-call rota (need not necessarily be obtained during second three month whole time equivalent attachment)**

* Refer to Appendix 1 Annex B

- at least 50 separate days of non-residential professional out of hours duties;
- assessment of 20 enquiries out of hours;
- joint working with HPS, microbiology and EHOs in any locality;
- chaired at least one multi-agency meeting (or training in such);
- dealt with 3 cases of meningococcal infection (including 1 out of hours) in the last 4 years; 1 case in each of the other categories listed in section 2.5 of the FPH requirements (including 2 separate categories out of hours); at least one case of E. coli O157, legionellosis and HBV (either within or out of hours);
- participated in the management of:
  - a needlestick injury
  - chemical exposure
  - chemical incident
  - actual or potential contamination of potable water supply
  - radiation exposure
  - rabies exposure
  - HAI outbreak
  - community outbreak of GI infection
  - potentially linked cases of meningococcal disease
- participated in the actual or simulated management of a rabies exposure and white powder incident;
- attending a relevant public meeting;
- working with STAC and emergency services in actual or simulated emergency.
It is expected that to obtain the learning and practical experience required, the NHS Board should offer the trainee opportunities to undertake the specific actions outlined in Box 5.

**Box 5 - Specific actions to be undertaken during second 3-month attachment to NHS Health Protection Team**

- be first on-call for day calls for the local HP Team and make themselves available to follow through the actions required from the calls;
- participate in the out of hours duty rota as first on-call (where second on-call available);
- lead a team responsible for delivering a specific health protection project or service;
- carry out and submit a report on a health protection project;
- attend at least one specialist health protection conference such as run by HPS or HPA;
- undertake a longer attachment with one of the services detailed in the previous section.

**Third criterion**

*Nomination as a ‘competent person’ or having access to a ‘competent person’*

So that the person on-call can implement necessary legislation it is advisable that at Board level unsupervised on call is undertaken by the ‘competent person’ as per the Public Health etc (Scotland) Act, 2008. If this is not the case then the Board must ensure that the person on-call has rapid access to a ‘competent person’ from within their own Board or another Board area.

**Fourth criterion**

*Access to or devolved managerial responsibility to commit resources*

Based on achievement of the above it is expected that on being appointed as a locum or substantive consultant the postholder should have sufficient expertise to commit resources especially during an outbreak. NHS Boards should have in place clear internal guidance on the roles and responsibilities and powers of defined officers to commit resources during emergencies. Those working in rotas either independently or supervising first on-call are expected to have attained sufficient experience through their general public health training or experience to fulfil any management role designated in internal guidance.

**Fifth criterion**

*Experience and competencies in managing multi-agency, multi-disciplinary teams*

Those working in rotas either as stand-alone local first on-call or supervising first on-call are expected to have attained sufficient experience in managing multi-agency and multidisciplinary teams through their general public health training or experience in this area.
Assessment of achievement criteria

The previous criteria are derived from and dovetail with the Faculty of Public Health recommendations. As such they can be applied for both ensuring that the Faculty of Public Health specialist training requirements are fulfilled and that NHS bodies in Scotland employing public health practitioners or specialists for the purposes of supervised Health Protection on-call meet the national criteria. From the nursing perspective, it is important that identified mentors meet the recognised NMC mentoring standards (NMC Standards to support learning and assessment in practice: Standards for mentors, practice teachers and teachers. August, 2006).

It is recognised that achievement of quotas in clusters will be challenging in Scotland and as such an audit will be necessary to review the practicality of achievement of the criteria. Thereafter further discussions will take place with the Faculty of Public Health and others.

These criteria apply to those in training. Further discussion should take place on the application of criteria to those in post and in particular on the on-call rota.
Faculty of Public Health
Of the Royal Colleges of Physicians of the United Kingdom

Faculty of Public Health (August 2006)

Health Protection Training for Generalists in Public Health, including Educational Requirements for On-Call

General Principles

The purposes of training in health protection (HP) for those undertaking prospective generalist training in Public Health (PH) are so that:

- all generalist public health staff have a basic understanding of this important constituent of public health (which, for those in training (referred to as ‘trainees’ in this document), will be assessed as part of MFPH and RITA or their successors);
- those who take part in NHS on-call rotas or their equivalent are competent and confident to undertake their on-call duties;
- those who will become DsPH or equivalent posts are aware of the breadth of health protection activities that they will be responsible for ensuring are adequately provided for their populations by the NHS, HPA/HPS/NPHSW and others, including what on-call arrangements are necessary;
- health protection continues to be seen as an integral part of public health by PH generalists and HP specialists alike;
- those who train in public health remain competent to apply for consultant posts with health protection responsibilities;
- all public health staff could contribute effectively to local incidents requiring surge capacity or to a national public health emergency, such as an influenza pandemic or re-emergence of smallpox.

Training for on-call

Defining the competencies required for those who undertake on-call duties is essential to ensure that Health Protection on-call services are provided to high and consistent standards and to meeting clinical governance requirements.
The background knowledge and some of the practical experience needed to undertake unsupervised public health (consultant level) on-call duties can be gained during normal working hours. However, actual out of hours on-call experience is important because:

- the risk assessment for public health problems out of hours is different to that within hours (“what are the health consequences of delaying until office hours: what actions need to be done now and what can wait?”);
- the range of support services or expert advice available, both within and outside the organisation, are different (i.e. less), the methods of contacting them are also different (i.e. usually more difficult) and access to support tools (e.g. IT and communication tools) may be less;
- effective handover pre and post on-call is a particular skill that is necessary for actual on-call practice;
- for those who will practice in general public health, most of the health protection that they will do as a consultant/specialist is likely to be on-call: therefore on-call training better replicates the situation that they are training for than within hours experience.

Training for on-call needs to be clearly focused on training needs, which would suggest:

- ensuring that those in training are properly briefed, supervised and debriefed (including feedback) to ensure that learning opportunities are fully taken;
- an appropriate time for trainees to start their out-of-hours on-call experiential training might be at the start of their 3-month health protection attachment, as proper preparation and debriefing likely to be easiest at this time;
- trainees should complete a log book (both within and out of hours), including a section for reflective learning that can be reviewed and discussed with the trainer;
- rotas should be constructed to give the maximum training experience per hour on-call. This could involve trainees covering larger areas than previously (where geographically feasible), as the amount of experience per hour on-call is likely to be proportional to the size of population covered. In addition, audit of on-call rotas is likely to reveal that some periods are consistently busier than others in terms of the number of calls or the necessary action per call: e.g. Saturday and Sunday daytime and evenings may be more useful experience than weekday nights;
- part-time or flexible trainees also undertake on-call training. In terms of training need, rather than service provision, the key periods of on-call health protection training are at pre-exam and pre-consultant stages. In total, training for this group need not amount to more than the total on-call training that is generally undertaken by full-time trainees.
There are some scenarios for which we would wish to train all PH generalists and HP specialists, but which are relatively unlikely to be experienced by all on-call trainees. Although perhaps not a complete substitute for experience of the real thing, properly designed exercises and interactive scenarios could substitute to ensure that a minimum level of competence is achieved and maintained in these areas. This will be equally relevant to existing Consultant staff as part of their CPD programme to maintain their own competence. As such scenario-based exercises are developed and their training outcomes assessed the possibility of expanding the role of validated teaching tools compared to actual experience can be re-assessed for further areas of HP training.

Annex A sets out the basic knowledge, skills and attitudes that are needed before trainees and others can undertake supervised first response public health on-call duties (equivalent to a SpR/SpT level): however, these practitioners should always be supervised by someone who has the competencies required for unsupervised public health on-call (see below).

Annex B defines the competencies that are necessary in order to undertake unsupervised public health on-call duties (equivalent to DPH/CPHM): this can be used as a series of educational objectives, the achievement of which would suggest that a trainee could be signed off as competent in Health Protection at the level expected to achieve CCT. However, if the practitioner is not trained/practising as a health protection specialist (eg CCDC), then when on-call, (s)he should always have access to advice from a health protection specialist for difficult, serious or rare problems (this is particularly important for managing outbreaks and incidents). This ‘specialist health protection’ role could be provided in a number of ways, e.g. by a third on-call CCDC rota in England or by a national centre in the other countries of the UK: health protection specialist/third on-call competencies will be the subject of a separate paper.

For those already in training, these guidelines will not be introduced in a retrospective manner: log books need not include experience from before the introduction of these guidelines and competencies measured by numbers or time could be introduced as a pro-rata target based on the length of training remaining. These requirements are primarily designed for those in training rather than existing Consultants, who may have different but equally valid experience, however, these standards can be used by existing Consultants to assess the level of experience and training they have received and use to inform their CPD/PDP plan, e.g. by attending training events that would compensate for lack of recent experience in certain areas.

In both annexes, titles of relevant individuals and organisations may be different in different countries and the equivalent title should be substituted.
Annex A: Educational Requirements for undertaking:
Supervised First Response Public Health On-Call (Equivalent to SpR/SpT)

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<tr>
<th>Requirements</th>
<th>Demonstration of minimum standard</th>
<th>Further development of competence*</th>
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<tr>
<td>1.1 Understanding of the professional responsibilities of being on-call, including:</td>
<td>• discussed in induction programme for new trainees, particularly those who have not previously taken part in clinical on-call. Could include session where trainee demonstrates understanding by explaining responsibilities to trainer.</td>
<td>• three month attachment at Local HPU in line with FYH guidance (2003); use of standard forms for information collection and recording of advice during LHPU attachment, including feedback on adequacy of completion.</td>
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<td>• professional obligations re availability, sobriety, confidentiality, ethics, etc;</td>
<td>• ensuring adequately prepared (e.g. contact numbers, access);</td>
<td>• if not on GMC/NMC/GDC register, completion of tailored learning programme**.</td>
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<tr>
<td>• ensuring adequately prepared (e.g. contact numbers, access);</td>
<td>• recognition of competence and when to seek advice;</td>
<td>• on GMC/NMC/GDC Register (or demonstration of equivalent training and assessment) or;</td>
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<tr>
<td>1.2 Understanding of the local on-call procedures, including arrangements for:</td>
<td>• administration of chemoprophylaxis;</td>
<td>• attended basic training on biological clinical basis of HP (Guidelines).</td>
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<td>• roles and responsibilities, including for action;</td>
<td>• handover and feedback.</td>
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<td>1.3 Understanding of the role of others in the control of infection and environmental hazards.</td>
<td>• initial attachment to local HPU compatible with FH guidelines*, including introductory visit to Environmental Health Dept.; part AMPH (or future Diploma in HP);</td>
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<td>1.4 Basic understanding of communicable disease process</td>
<td>• on GMC/NMC/GDC Register (or demonstration of equivalent training and assessment) or;</td>
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<tr>
<td>Requirements</td>
<td>Demonstration of minimum standard</td>
<td>Further development of competence*</td>
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<td>1.5 Awareness of the general principles of health protection response, including outbreak and incident management and the roles of others.</td>
<td>• part A MFPH (or future Diploma in HP);</td>
<td>• three month attachment at Local HPU in line with FPH guidance (2003).</td>
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<td>• induction on local outbreak plan, chemical incident plan and emergency response arrangements.</td>
<td>• supervised first on-call in daytime.</td>
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<td>1.6 Familiarity with guidelines and plans for most common problems:</td>
<td>• national meningococcal guidelines and local outbreak/incident plans discussed in induction programme for new SpTs/SpRs;</td>
<td>• three month attachment at Local HPU in line with FPH guidance (2003);</td>
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<td></td>
<td>• part A MFPH (or future Diploma in HP).</td>
<td>• Further local induction with each geographical change of location.</td>
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<td>1.7 Awareness of and access to other local and national policies, plans and guidelines or regularly updated on-call pack covering guidance on potential on-call scenarios.</td>
<td>• provision and demonstration of on-call pack or alternative resource.</td>
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<tr>
<td>1.8 Ability to use on-call communication aids and any relevant databases (or how to access them).</td>
<td>• hands on demonstration in induction.</td>
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* FPH guidance on what should be covered in the initial attachment to an HPU for all SpRs/SpTs and what should be covered in basic training on the biological and clinical basis of health protection for non-clinical SpTs will follow.

** See FPH guidance on Training in Health Protection for Specialists in Public Health, section 2 (p4-6), June 2003.

An assessment of the competencies in Annex A that are not covered by the Part A exam should be carried out by the Trainer. Guidance on this assessment will follow from the FPH.
Annex B: Educational Requirements for undertaking:

Unsupervised Public Health On-Call Duties (Equivalent to DPH/CPHM) (additional to first on-call competencies)

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Demonstration of minimum standard</th>
<th>Further development of competence***</th>
</tr>
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<tr>
<td>2.1 Familiarity with the principles and practice of being on-call, including:</td>
<td>• membership of a professional register (GMC/NMC/GDC/UKVRPH); • experience of non-residential professional out of hours duties (minimum of 50 separate days: see note below); • formal training on legal issues. (Note: e.g. a weekday evening and night session could count as 1 day and weekend days could be counted separately)</td>
<td>• experience of public health on-call, including weekday nights, weekends, bank holiday and annual/sick leave cover (minimum 25 separate days, including 12 in last 2 years); • completed training programme in public health; • experience of supervising SpRs/SpTs; • experience of using legal powers of Proper Officer or update in last 5 years.</td>
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<tr>
<td>• professional obligations;</td>
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<td>• legal issues;</td>
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<tr>
<td>• professional responsibility to ensure appropriate public health action taken in response to all incidents.</td>
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<td>2.2 Ability to perform a risk assessment of a problem, decide whether public health action is necessary and decide appropriately whether action is required out of hours.</td>
<td>• involved in assessment of 20 enquiries out of hours.</td>
<td>• involved in assessment of 40 enquiries (including 20 out of hours) in last 4 years; • able to demonstrate appropriateness of response by reflective learning, peer audit, feedback from trainer/supervisor or examination.</td>
</tr>
<tr>
<td>2.3 Ability to effectively exercise the local on-call procedures, including:</td>
<td>• induction in local arrangements; • used arrangements out of hours in this or another locality.</td>
<td>• used arrangements out of hours in this locality.</td>
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<td>• administration of chemoprophylaxis;</td>
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<td>• handover before and after on-call.</td>
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<td>2.4 Experience of practicalities of working with others out of hours, particularly:</td>
<td>• experience of working out of hours with HPA, microbiology and EHOs in any locality; • awareness of contact arrangements in this locality.</td>
<td>• experience of working out of hours with HPA, microbiology and EHOs in this locality; • experience of working with Emergency Services, Clinicians (ID/GUM), Infection Control, TB control staff, Environment Agency and HSE.</td>
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<tr>
<td>• HPA;</td>
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<tr>
<td>• microbiology;</td>
<td></td>
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<td>• environmental health.</td>
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</table>
### Requirements

2.5 Up to date knowledge of relevant aspects of natural history, epidemiology, clinical presentation, laboratory diagnosis and methods of transmission and control of common hazards that may require public health intervention out of hours, including:

- meningococcal disease and meningitis;
- gastrointestinal infections, including E.coli O157;
- Respiratory infection, including Legionella and TB;
- blood-borne viruses (HBV, HCV, HIV);
- infections requiring prophylaxis/advice, (eg pertussis, hepatitis A);
- most common chemical/environmental hazards (asbestos, CO, smoke, mercury, ammonia, chlorine);
- other hazards with increased local/regional occurrence.

### Demonstration of minimum standard

- MFPH (or future Diploma) or assessed module from MPH that covers FPH curriculum for health protection (or on GMC Specialist Register for medical microbiology or clinical infectious diseases and have suitable training/experience in non-infectious environmental hazards);
- training/updating in each of these areas during last 5 years.

### Further development of competence***

- updating in each of these areas during last 3 years (certificate in CPD file);
- training and updating to understand how clinical diagnoses relevant to health protection are made from clinical symptoms and signs and on issues in prescribing appropriate prophylactic drugs and immunisations, including awareness of contraindications.

### Requirements

2.6 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. Includes single cases of infections listed in section 2.5

- dealt with 3 cases of meningococcal infection (including 1 out of hours) in last 4 years****;
- dealt with 1 case in each of the other categories (NOT each individual organism) in section 2.5, 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 in sections 2.6 to 2.9, number of cases/incidents required as experience can include cases/incidents dealt with under the supervision of a trainer.

- dealt with 6 cases of Meningococcal infection (including 3 out of hours) in last 4 years****;
- dealt with each organism/chemical listed in section 2.5 (preferably in the last 4 years, either within or out of hours);
- dealt with E. coli O157, Legionella and HBV/needlestick out of hours in last 4 years;
- able to demonstrate appropriateness of response by reflective learning, peer audit, feedback from trainer/supervisor or examination.
<table>
<thead>
<tr>
<th>Requirements</th>
<th>Demonstration of minimum standard</th>
<th>Further development of competence***</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7 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; rubella in pregnancy); • exposure to blood-borne viruses or TB in community or health care settings (including needlestick injuries and potential lookback exercises); • potential public health emergencies (e.g. food-borne botulism); • potential deliberate release (e.g. ‘White powder’ exposures; • exposure to contaminated water; • acute exposure to chemical hazards; • urgent travel health enquiries; • major emergencies (e.g. floods, explosions); • diseases/hazards that have emerged as public health problems since these requirements were drafted and current ‘hot topics’.</td>
<td>• MFPH (or new Diploma) or assessed module in MPH that covers FPH curriculum (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 management of • needlestick injury • chemical exposure • participated in actual or simulated management of • rabies exposure • white powder</td>
<td>• updating within last 3 years on basic principles and sources of advice and support; • participated in actual management of • white powder • rabies exposure • as many of the other scenarios as possible • participated in out of hours management of: • needlestick injury • chemical exposure • as many of the other scenarios as possible • regularly updated on local incidence and prevalence of relevant infections; • able to demonstrate appropriateness of response by reflective learning, peer audit, feedback from trainer/supervisor or examination.</td>
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<tr>
<td>2.8 Understanding of the principles and practice of management of outbreaks and incidents.</td>
<td>• participated in management of both community outbreak and chemical incident.</td>
<td>• participated in management of community outbreak and chemical incident out of hours; • participated in audit/review of outbreak/ incident.</td>
</tr>
<tr>
<td>Requirements</td>
<td>Demonstration of minimum standard</td>
<td>Further development of competence***</td>
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<td>2.9 Ability to effectively co-ordinate the public health investigation (with</td>
<td>• participated in management of all 3 scenarios;</td>
<td>• participated in all 3 scenarios out</td>
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<td>appropriate expert advice) and control of (relatively) common local</td>
<td>• dealt with at least one of these scenarios out of hours;</td>
<td>of hours;</td>
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<td>outbreaks and incidents out of hours, including:</td>
<td>• experience or training in chairing multi-agency meetings.</td>
<td>• dealt with at least one of these</td>
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<td>• potentially linked cases of meningococcal disease****;</td>
<td></td>
<td>scenarios out of hours in last 4</td>
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<td>• potential community outbreaks of GI Illness;</td>
<td></td>
<td>years;</td>
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<td>• chemical incidents.</td>
<td></td>
<td>• experience of leading/chairing</td>
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<td></td>
<td></td>
<td>incident control team.</td>
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<td>2.10 Ability to contribute effectively to the</td>
<td>• familiarity with local contingency plans.</td>
<td>• participated in management of major</td>
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<tr>
<td>control of:</td>
<td>• attended training on each of the four types of incident (could include supervised involvement</td>
<td>emergency;</td>
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<tr>
<td>• hospital outbreaks/incidents;</td>
<td>in actual incident);</td>
<td>• participated in management of</td>
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<td>• radiological incidents;</td>
<td>• experience of working with JHAC/HAT and Emergency Services in actual or simulated emergency.</td>
<td>hospital outbreak/incident;</td>
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<td>• major emergencies;</td>
<td></td>
<td>• participated in actual or simulated</td>
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<td>• deliberate release incidents.</td>
<td></td>
<td>incident for all 4 scenarios in last</td>
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<td>5 years;</td>
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<td></td>
<td></td>
<td>• training in principles of infection</td>
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<td>2.11 Ability to communicate effectively on public health issues, including:</td>
<td>• awareness of out of hours arrangements;</td>
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<td>• preparing appropriate press releases out of hours;</td>
<td>• received media training;</td>
<td>• personally prepared press release;</td>
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<tr>
<td>• giving effective media interviews;</td>
<td>• involved in preparation of press release;</td>
<td>• addressed relevant public meeting;</td>
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<tr>
<td>• communicating directly with public.</td>
<td>• attended relevant public meeting (e.g. parents in a school with meningitis).</td>
<td>• given media interview, including</td>
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<td>feedback on performance.</td>
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</tbody>
</table>

*** This column is not compulsory, but is given as guidance in the pursuit of excellence for training/CPD.

**** In countries where meningococcal infection is significantly less common, can substitute ‘x cases of meningococcal infection’ with ‘x cases of severe infection with potential for person to person spread, one of which should be meningococcal infection.’

***** or, in countries where meningococcal infection significantly less common, another serious infection with potential for person to person spread.
Practical issues for on-call rotas:

This FPH guidance is concerned with defining educational standards, rather than the practicalities of providing an out of hours service, which will differ in different localities and is the responsibility of the local NHS working with the Health Protection Agency (or equivalent). However on-call providers will need to note the following:

- Current DH guidance in England is that “HAs should ensure that adequate arrangements exist to provide a 24 hour on-call service of suitably trained medical staff able to deputise for the CCDC. Although junior medical staff may participate in the rota, consultant advice must always be available” (HSG(93)56). Public health on-call rotas in England should therefore ensure that advice is always available from a suitably qualified medical Consultant.
- In Scotland, a nominated Designated Medical Officer is required to exercise certain legal powers.
- In England and Wales, Proper Officers (including deputies) for exercising Local Authority powers need to be formally appointed by each LA: however, the Public Health Act (1984) and Regulations (1988) do NOT specify that the Proper Officer has to be medically qualified.
- HPA has statutory health protection functions for England and PCT DsPH have responsibility for local population health protection. The PCT DPH needs the managerial ability to mobilise the NHS at a higher level in the event of a major emergency.

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