Memorandum of Understanding (MoU)

Between

The Department of Health

and

Public Health England

Delivering a UK Public Health Rapid Support Team (UK PHRST) (the Project)

1. The Department of Health (DH) will make available to Public Health England (PHE) a sum not exceeding £8.75 million over the Spending Review period 2016/17 to 2020/21 to deliver the above Project in equal partnership with the London School of Hygiene and Tropical Medicine (LSHTM). This sum does not include any costs associated with the future appointment of the Director of the Project. In the event that the Director and/or his/her team are employed by PHE, this sum may be increased and this MoU will be revised accordingly.

2. The Project has the primary purpose of ensuring the United Kingdom has a standing capacity of multidisciplinary public health professionals and researchers that can be ready to deploy within 48 hours to a possible or known disease outbreak in a country that is eligible for Official Development Assistance (ODA), as defined by the Organisation for Economic Co-operation and Development (OECD).

3. Arrangements for the Project and the purpose for which the funds will be used are set out in this MoU and its Annexes, including the attached Project proposal attached at **ANNEX A**. This MoU will be subject to review and possible revision on an annual basis.

4. Ongoing funding for the Project will be subject to agreement by DH of a five year strategy (covering period 2016/17-2020/21) and annual business plans developed jointly by PHE and LSHTM.

5. The Project will commence on 1 October 2016 and will end on 31 March 2021.

FIVE YEAR STRATEGY

6. PHE, with LSHTM, will submit a joint five year strategy (Five Year Strategy) for approval to DH within 3 months of the appointment of the Director of the Project or 31 December 2017(whichever is earlier), or such later date as DH may agree. The strategy shall cover the period 2016/17-2020/21 and shall include the points set out in **ANNEX B**. DH will seek to confirm agreement of the 5 year Strategy with PHE and LSHTM within 30 days of receipt, or such later date as DH may agree.

7. If the Five Year Strategy is not agreed within the specified timeframe DH may terminate this MoU with immediate effect by notice in writing to PHE.

INTERIM ARRANGEMENTS

8. In advance of agreement of the 5 Year Strategy and annual plans, the Project will operate under the arrangements of the Interim Plan that has been agreed by DH and is attached at **ANNEX C.**

9. Interim arrangements will cover the period 1 October 2016 to 31 March 2017. Interim arrangements may be extended subject to the written agreement of DH.

PARTNERSHIP AGREEMENT

10. PHE and LSHTM (the Participants) shall submit to DH a near final draft partnership agreement which complies with condition 16 of the contract between DH and LSHTM and enter into a formal collaboration by no later than 6 months from the commencement date.

11. The partnership agreement will be finalised to the reasonable satisfaction of DH not later than 30 days after its submission to DH.

FINANCE AND PAYMENT SCHEDULE

12. Overall funding for the Project will be split 50:50 between PHE and the LSHTM, excluding the funding for the post of Director of the UK PHRST and his/ her team (a sum not to exceed £2.5m). The funding for the Director and his/ her team will be allocated to the organisation(s) that employ(s) them.

13. DH will make a Grant in Aid transfer to PHE for a sum not exceeding £8.75 million of Resource Departmental Expenditure Limit (RDEL) over the Spending Review period 2016/17 to 2020/21 (up to £1.75m per annum) for delivery of PHE activity agreed under the Interim Plan and to be agreed under the 5 Year Strategy and annual plans. This sum will be increased by an amount not exceeding £2.5m if the future Director of the UK PHRST and/ or his/her team is employed by PHE.

14. The Project budget and payment schedule (at **ANNEX D**) will be reviewed, confirmed and set on an annual basis by DH (each financial year), following agreement of the Five Year Strategy and annual plans.

15. DH will issue funds to PHE for expenditure incurred on the Project through a quarterly Grant in Aid payment. PHE will administer the funding on behalf of DH in accordance with PHE's financial regulations, procedures and practices.

REPORTING REQUIREMENTS

16. In addition to the Five Year Strategy, PHE, with LSHTM, will submit a joint annual plan to DH by 31 December of each year of the Project, covering the period of the subsequent financial year (i.e. by 31 December 2017 for the period April 2018 to March 2019), that

complies with **ANNEX B.** The annual plan will also include a joint report of delivery against the objectives and milestones set out in the action plan of the previous year.

17. PHE, with LSHTM, will provide DH with joint quarterly progress and financial reports that include progress against the milestones defined in the agreed 5 Year Strategy and annual plans. Financial reports must set out clearly actual expenditure against the approved Project budget lines (broken down by PHE and LSHTM expenditure) and forecast expenditure for the rest of the Project.

18. DH is required to spend 90% of the DH Official Development Assistance (ODA) budget by the end of each calendar year in order to meet the government's target to spend 0.7% of Gross National Income (GNI) on ODA each calendar year. PHE will endeavour to provide DH with accurate forecasts of ODA spend and to deliver the activity agreed under the Interim Plan, 5 Year Strategy and annual plans in line with the payment schedule at ANNEX D. PHE will provide DH with sufficient information to populate provisional and final Organisation for Economic Co-operation and Development (OECD) ODA returns.

ACCOUNTABILITY AND INDEMNITY

19. The Medical Director of PHE will be accountable to the SRO of the DH Global Health Security Programme (the Director of Emergency Preparedness and Health Protection Policy), through the DH Global Health Security Programme Board, for all Project spend and activity. For the avoidance of doubt, HM Treasury has confirmed that the DH Permanent Secretary is the accountable officer for the ODA funding of this Project.

20. Notwithstanding his Project accountability to the DH Global Health Security Board, the Medical Director of PHE remains accountable at all times to PHE's Chief Executive. As such RST activity (particularly activation of the response capability and expenditure incurred) must be reported to and reviewed by the PHE Management Committee routinely, and the Chief Executive kept promptly informed of any short notice instructions from the SRO of Global Health Security Programme.

21. DH will not be responsible for the activities of any person, organisation or company engaged by PHE or its agencies as a result of this MoU.

ODA

22. PHE acknowledges that it is DH's intention that all monies paid to PHE will be properly categorised as ODA by the OECD.

23. PHE shall use reasonable endeavours to ensure that all monies paid to PHE can be properly categorised as ODA by the OECD.

24. PHE shall notify DH as soon as reasonably practicable of any concern it has that monies paid to PHE cannot or may not be properly categorised as ODA by the OECD.

25. If, as a consequence of PHE's breach or negligent performance or non-performance of this MoU, monies provided to PHE are not classified as ODA by the OECD, PHE shall repay to DH a sum equal to the amount which the OECD determines is not ODA.

ODA TRANSPARENCY

26. PHE acknowledges that HMG supports the requirements of the International Aid Transparency Initiative (IATI) Standard and, at DH's reasonable request, will provide all necessary assistance to enable DH to meet the IATI standard, which shall include the provision of all information and data necessary for the transparent, accurate, timely and comprehensive publication of all data on all activities related to the delivery of development co-operation and humanitarian aid. To this end, PHE will familiarise itself with the requirements of the IATI standard.

EVALUATION

27. PHE shall provide all reasonable co-operation and assistance necessary to allow DH to meet the Secretary of State for Health's obligations under the International Development (Official Development Assistance Target) Act 2015 and the International Development (Reporting and Transparency) Act 2006. Such reasonable co-operation and assistance shall include but not be limited to:

    a. the provision of all information requested by DH within the scope of the Project;
    b. reasonable access to any of PHE's premises, records, data and to any equipment used (whether exclusively or non-exclusively) in the performance of the Project; and
    c. access to PHE's personnel involved in the Project.

28. In accordance with paragraph 16, the joint annual plans submitted by PHE and LSHTM will include a joint evaluation of delivery against the objectives and milestones set out in the action plan of the previous year.

29. At the end of the Project, PHE will work with LSHTM to provide a draft final report on activity undertaken as part of the 5 Year Strategy within sixty (60) calendar days of the completion of the Project. The draft final report shall be in a form to be agreed with DH and shall include the data, methods, results and final conclusions together with a post-project evaluation focussing on the results achieved, efficiency, and effectiveness of implementation, management information and quality of administration.

DEPLOYMENT

30. In the event that DH or PHE proposes a deployment, PHE and DH will discuss the merits of the proposed deployment, including the public health benefits of the proposed deployment, the capacity and capability of the UK PHRST to undertake the proposed deployment and the potential risks to the safety and security of the UK PHRST in the proposed deployment. After such discussions, DH may authorise or refuse the proposed

deployment. Exceptionally, DH may direct that a deployment be carried out where DH is reasonably satisfied as to the capacity and capability of the UK PHRST to undertake the proposed deployment and as to the mitigation of any potential risks to the safety and security of the UK PHRST in the proposed deployment. PHE shall conduct all deployment activity throughout the Project period only upon DH's authorisation and/or direction, acting in accordance with any relevant procedures notified to PHE from time to time.

31. In the event of any conflict between the conduct of a deployment and the conduct of any other activity agreed under the Interim Plan, 5 Year Strategy or annual plans, PHE, with LSHTM shall ensure that deployment activities take precedence.

GENERAL TERMINATION

32. If DH becomes concerned that the provisions of this MoU have not been fulfilled by PHE, or if any activities occur which in DH's opinion will significantly impair the development value of the Project; DH will discuss with PHE and form an assessment. DH may then take any of the following actions:

    a. Signal a possible future response;
    b. Delay or reduce the applicable funding;
    c. Stop aid under the termination provisions set out within this arrangement.

33. Both Participants will at first negotiate in an attempt to resolve any issues that might arise throughout the Project. However, this MoU can be terminated, at any time, by three months' written notice by either Participant. All remaining funds other than those irrevocably committed in good faith before the date of termination, in line with Project objectives and approved between the two Participants as being required to finalise activities, will be returned to DH.

34. Additionally any unspent funds remaining at the scheduled end of a Project, must be returned to DH unless specifically decided between both Participants, in writing.

INTELLECTUAL PROPERTY RIGHTS

35. All intellectual property rights in any materials including but not limited to techniques, information, know-how, and software used or supplied under this MoU (Background IP) shall remain the exclusive property of the party owning it (or, where applicable, the third party from whom its right to use the Background IP has derived).

35. The details of ownership, management and exploitation of any intellectual property rights created in the course of the Project (Foreground IP) shall be set out in clauses 16 and 17 of the Research Contract between the Secretary of State for Health and London School of Hygiene and Tropical Medicine (the "Agreement") and in particular those clauses set out in the Contractor IP Policy and the Partnership Agreement (both defined within the Agreement).

PUBLICATIONS, COMMUNICATIONS AND BRANDING

36. PHE may, subject to paragraphs 41, 42 and 43 on confidentiality below, discuss the work undertaken as part of the Project in external seminars, tutorials and lectures.

37. PHE will promptly notify and secure agreement from DH in relation to any plans to publish material relating to the Project, including project data, results or matters arising from such data or results.

38. PHE must submit in writing to DH for review at least thirty (30) days before submission for publication or before presentation, as the case may be. DH shall within thirty (30) days of receipt provide in writing any reasonable objections it has to the proposed publication and PHE shall give due regard to any amendments required by DH and shall refrain from publication of any information in respect of the Project which in DH's reasonable opinion is damaging to its interests.

39. PHE will collaborate with DH to build support for development and raise awareness of the UK government's funding for development activity. Both will proactively look for ways to raise awareness of UK government funding for development. PHE will explicitly acknowledge UK government support (as advised by DH) in all communications with the public or third parties about this Project, unless otherwise agreed in advance.

40. PHE shall comply with guidance and advice from DH on DH branding and publicity which may be issued from time to time including, but not limited to, permitted use of the Department of Health brands, names and logos and ensuring all branding references to the UK PHRST are prefixed with the term "UK Public Health Rapid Support Team, funded by the UK Government" unless otherwise agreed with DH.

CONFIDENTIALITY

41. The parties each undertake to use reasonable endeavours to keep confidential and not to disclose unless as set out in the paragraphs below to any third party or to use themselves other than for the purposes of the Project any confidential or secret information in any form directly or indirectly belonging or relating to the other, its or their business or affairs, disclosed by one and received by another pursuant to or in the course of the Project.

42. DH may disclose PHE's Confidential Information:

    (i) to any department, agency or office of the UK government for any proper purpose of DH or of the relevant department, agency or office;

    (ii) to the UK Parliament and any committees of the UK Parliament or if required by any Parliamentary reporting requirement;

    (iii) to the extent that DH (acting reasonably) deems disclosure necessary or appropriate in the course of carrying out its public functions;

(iv) on a confidential basis to a professional adviser, consultant, supplier or other person (including any benchmarking organisation) for any purpose relating to or connected with this MoU;

(v) on a confidential basis for the purpose of the exercise of its rights under this MoU; or

(vi) on a confidential basis to a proposed successor to DH in connection with any assignment, novation or disposal of any of its rights, obligations or liabilities under this MOU.

43. PHE shall use reasonable endeavours to disclose Confidential Information of DH only to those of its officers, employees, students, agents and contractors, to whom and to the extent to which, such disclosure is necessary for the purposes contemplated under this MoU.

44. The obligations contained in these paragraphs shall survive the expiry or termination of this MoU but shall not apply to any Confidential Information which:

a. is publicly known at the time of disclosure to the receiving party;
b. after disclosure becomes publicly known otherwise than through a breach of this MoU by the receiving party, its officers, employees, agents or contractors;
c. can be shown by reasonable proof by the receiving party to have reached its hands otherwise than by being communicated by the other party including being known to it prior to disclosure, or having been developed by or for it wholly independently of the other party or having been obtained from a third party without any restriction on disclosure on such third party of which the recipient is aware, having made due enquiry;
d. is required by law, regulation or order of a competent authority (including any regulatory or governmental body or securities exchange) to be disclosed by the receiving party, provided that, where practicable, the disclosing party is given reasonable advance notice of the intended disclosure and provided that the relaxation of the obligations of confidentiality shall only last for as long as necessary to comply with the relevant law, regulation or order and shall apply solely for the purposes of such compliance; or
e. is approved for release, in writing, by an authorised representative of the disclosing party.

45. If either party receives a request under the Freedom of Information Act 2000 to disclose any information that, under this MoU, is the other party's Confidential Information, it will notify that other party and will consult with that other party promptly before making any disclosure under that Act. The owner of the Confidential Information will respond to the party that has received the request within 10 days after having been notified of such a request. Notwithstanding this paragraph, where disclosure relates to information that is not Confidential Information, each party shall at its discretion determine if the disclosure of such information is necessary to comply with the Freedom of Information Act 2000.

FRAUD AND CORRUPTION

46. PHE will immediately notify DH of any event which interferes or threatens materially to interfere with the successful implementation of the project, whether financed in full or in part by DH, including credible suspicion of or actual fraud, corruption or any other financial irregularity or impropriety.

47. DH and PHE have a zero tolerance approach towards fraud and fraudulent behaviour that may lead to the misuse of funds and agree in principle to recover such funds. PHE will, at first, take timely and appropriate action to investigate credible allegations of fraud, however both participants will fully co-operate with investigations into such events, whether led by PHE or DH.

GENERAL

48. The parties are aware that Public Health England is an executive agency of the Department of Health. It is therefore the intention that this MoU shall operate as an instruction from the Secretary of State to Public Health England rather than as a legally enforceable contract.

49. This MOU may be modified by written agreement between the parties.

Signed on behalf of DH: [redacted]

Name: [redacted]

Position: DIRECTOR, EMERGENCY PREPAREDNESS & HEALTH PROTECTION POLICY

Address/Contact Details: RICHMOND HOUSE, 79 WHITEHALL, LONDON SW1A 2NS

Date: 26/1/2017

Signed on behalf of PHE: [redacted]

Name: [redacted]

Position: CHIEF EXECUTIVE

Address/Contact Details: PUBLIC HEALTH ENGLAND
WELLINGTON HOUSE
133-155 WATERLOO ROAD
LONDON SE1 8UG

Date:
26/1/2017

ANNEX A

Joint proposal for a UK Public Health Rapid Support Team

1. Introduction

In the wake of the Ebola crisis in West Africa and other recent disease outbreaks around the world, the Prime Minister announced at the G7 Summit in June 2015 that the UK would establish a public health rapid support team. This commitment was underscored as a key global health security deliverable in the UK Government's National Security Strategy and Strategic Defence and Security Review, which was published in November last year.

The team's primary purpose will be a standing capacity of multidisciplinary public health professionals and researchers that can be ready to deploy to a possible or known disease outbreak within 48 hours in an ODA-eligible country. When not responding to a disease outbreak, the team will focus on operational research to better inform outbreak response. The team will also work towards building capacity for effective outbreak response in ODA eligible countries and strengthening local capabilities to meet the International Health Regulations (IHR). Following an NIHR-led application process, Public Health England (PHE) and the London School of Hygiene and Tropical Medicine (LSHTM) have been commissioned to establish this new UK capacity.

In broad terms PHE will lead on the operational aspects, the practical training and operational capacity building, while LSHTM will lead an academic consortium, involving University of Oxford and Kings College London, which will lead on operational research, academic teaching and overseas capacity building. However, we envisage the RST as a single cohesive group with unity of purpose. It will respond to surveillance data, identifying situations where the deployment of specialist expertise can mitigate the threat of infectious diseases globally. It will rapidly deploy on behalf of UK Government, with the *World Health Organization* (WHO), through the Global Outbreak and Response Network (GOARN), or bilaterally, a standing team of multidisciplinary public health professionals and researchers[1] as required in ODA eligible countries. The RST has the following main objectives:

- Within ODA eligible countries to support the rapid investigation and response to disease outbreaks at source, with the aim of stopping a public health threat becoming a health emergency
- Conduct rigorous research to aid epidemic preparedness and response and improve future response
- Generate an evidence base for best practice in disease outbreak interventions within ODA eligible countries.
- Train a cadre of public health reservists for the RST who could be rapidly deployed to respond to disease outbreaks
- Build capacity in-country for an improved and rapid national response to disease outbreaks and contribute to supporting implementation of the International Health Regulations (IHR).

[1] When deployed, researchers will not operate in a purely research capacity but as integral members of the operational response.

This proposal lays out the joint vision of how the RST will be governed and operates.

The UK's leadership and concerted efforts to strengthen global health security are not happening in isolation. The WHO is engaged in a series of reforms to strengthen not only its institutional response but also the global community's capacity to respond to disease outbreak and larger scale health emergencies. As part of those reforms, the WHO is developing the concept of a Global Health Emergency Workforce (GHEW). National public health response teams will form part of the GHEW and we will work closely with WHO and other partners (e.g. CDC and Institut Pasteur) to ensure alignment with these global mechanisms and network.

2. Operating Model

The RST will be a collaboration between PHE and an academic consortium led by LSHTM with partners at University of Oxford and Kings College London. The RST will be a stand-alone entity that is funded by and operates on behalf of HM Government. For details of how the RST operates and links with HM Government please see annex 3, which sets out the governance structure.

RST Functions

The operations of the RST will be based on the following functions:

1. Monitoring and risk assessment of developing infectious diseases and other health threats including providing risk assessment advice and expertise for HMG
2. Response in affected countries to reduce the impact of the outbreak, including scoping the need for further support and research.
3. Building of regional and in-country capacity and capability through training and coaching, in line with International Health Regulations (IHR) and Global Health Security Agenda requirements
4. Conducting operational research programmes to develop new knowledge for surveillance, detection and response
5. Developing a pool of future international responders

The RST will be led by a Director, based at either PHE or LSHTM, responsible for:

- Leadership, management, coordination, delivery and evaluation of the RST objectives.
- Team development and performance management, and fostering a single cohesive group with unity of purpose.
- Developing a 5-year strategy followed by annual action plans with measurable targets covering all key objectives of the RST. The strategy and annual plans (covering all key areas of the RST's work) will be developed with team members and key stakeholders and will be agreed with DH each year.
- Acting as a single focal point for requests for and decisions on deployment for outbreak investigation and control.
- Coordination, organisation and support for deployment of the RST, including pre-deployment training and assessments, command of the RST when deployed and post-deployment debriefing, follow up and psychological support.

- Ensuring delivery of a research programme that is closely aligned with the RST's mandate and builds the evidence base for international disease outbreak response and interventions.
- Ensuring delivery of an effective capacity building programme in ODA eligible countries, which supports IHR implementation and is aligned with HMG's global health security objectives.
- Representing the RST in cross-Whitehall discussions and co-ordination and with other external partners, including the media, as appropriate.
- Liaison with PHE, LSHTM and across the public health and 'one health' community to ensure support for the RST's work to respond to infectious diseases internationally.
- Liaison with WHO and other international partners (e.g. Centre for Disease Control (CDC) and EU), in partnership with HMG, on all aspects of RST work, including: disease surveillance, operational planning, training and capacity building.
- Leadership of a management team, which supports the RST's operations. See details below.
- Compliance of the RST programme with ODA eligibility guidelines
- Please see annex 4 for the full job description and person specification for the Director.

The Director will represent the RST, on behalf of HMG, in international fora (e.g. on Global Health Emergency Workforce issues at WHO), ensuring coherence with HMG policies.

The Rapid Support Team

A full-time core deployable RST will be established consisting of a multidisciplinary group of 8 individuals who can be ready to deploy within 48 hours. The RST will draw on the institutional strengths of PHE, LSHTM and their wider networks, both domestically and overseas, to support its work – spending a considerable amount of time (approximately 50%) in ODA-eligible countries. The team will comprise:

- senior epidemiologist
- clinical researcher
- field epidemiologist
- social scientist
- microbiologist
- data manager/analyst/systems expert
- infection prevention and control expert
- logistician

It is envisaged that the team will be equally divided, and have primary contracts split evenly between PHE and the academic institutions. In addition, all RST members will also hold a HMG contract to cover deployments. We will provide training for senior members of the RST to enable them to take on the role of Field Coordinator when needed, rather than their technical role. We anticipate that in most scenarios a deployable RST of 8 members will be sufficient to cope with supporting local outbreak investigation and control, though there is access to additional support when required and the UK RST team would also often be deployed alongside other international teams or through current mechanisms such as GOARN. On occasion, additional specialist skills may be required and these will be drawn

from the UK's International Emergency Public Health Register or personnel from PHE or the supporting faculty at academic institutions.

All RST members will be employed full time in that capacity and will not retain other professional commitments that might impede their RST duties, other than commitments essential to retain professional skills and registration.

One of the key requirements for the RST to be successful is that they operate as a cohesive team and so undertake training and development together, share knowledge and experience and could be collocated. When RST members are not required for outbreaks, they will, among other things, conduct operational research in ODA eligible countries and be based at some of the overseas centres in the well-established networks of collaborators of LSHTM, University of Oxford, Kings College London and PHE. They will also spend some time in the UK teaching, training and conducting operational research.

To ensure the rapid response capability globally, a quorum of the RST will be based in the UK when not on deployment. While in the UK, these RST members will undertake a range of activity and pre and post-deployment tasks. This includes: intelligence gathering and risk assessment; development and review of deployment standards and guidelines; operational research; development and delivery of training; undertaking their own training and professional development programme; liaison and co-ordination with WHO (e.g. on GHEW development) and other national rapid response teams, providing advice and support for ongoing outbreak response operations; and carrying out other mandatory post-deployment processes e.g. report writing, occupational health assessment and other administrative tasks.

RST reserve cadre

To ensure we are able to maintain the capability to rapidly scale up our response to any disease outbreak or health emergency, we will develop a cadre of RST reservists. They will be trained to RST standards and protocols but will have routine "day jobs" in their employing organisation. They will be available to support RST deployments where necessary. Reserve cadre personnel being deployed in support of an RST operation in an ODA eligible country will be funded through the RST. To avoid duplicating existing mechanisms in the UK, the cadre of RST reservists will be registered with a new UK International Emergency Public Health Register, which is hosted by UK-Med and funded by DFID.

We will aim to deploy RST reservists at least once every two years to maintain their skills and to build their experiences, as well as to ensure their continued interest and engagement. We will also consider instituting an 'on-call' period of several weeks each year, when a reservist might be called upon to deploy. This will provide more certainty for the reservist and the employer during their 'off-call' periods.

RST Director's Office

In order to support the RST and the wider operational delivery of the RST programme, the Director will be supported by a small support unit, which will comprise the following roles:

- Programme Manager
- Operations/Deployments Manager
- Logistics Manager

All positions for the RST and Director's Office will be appointed by open competition, with the Director to be appointed first.

Strategic Planning and Reporting

As a HMG asset and ODA-funded programme, the Director will be required to agree the strategic direction and activity of the RST programme with the Department of Health, as the Government Department responsible for RST work. As part of this, the Director will provide the following to the Senior Responsible Officer (SRO) of DH's Global Health Security (GHS) Programme (Director for Health Protection and Emergency Response) for approval, through the PHE Medical Director:

- A five-year strategy (2016-2021)
- An annual action plan
- An annual operational research programme
- An annual programme of work for overseas capacity building

The strategy and plans will be costed and include measurable targets covering all RST objectives.

Training and teaching are a critical component of the RST programme and will form part of the five year strategy and the annual action plans.

The RST Director will be accountable to the PHE Medical Director for delivery against the strategy and annual plans

Regular governance meetings chaired by the SRO and attended by the PHE Medical Director, RST Director and NIHR will review delivery, financial spend and forecasts against the annual plans, with reports provided to the GHS Programme Board as required.

Further details on the governance and accountability arrangements for the RST can be found on page 12.

Deployment criteria

Any decision to deploy or not deploy the RST will be agreed in discussion with HMG, with DH as the lead responsible Department. Standard Operating Procedures will be developed to clarify the format and purpose of this consultation between RST Director and HMG. In essence, the RST Director provides the professional public health assessment of the need for, and potential benefits from, deployment while other partners across Government will add an additional dimension from not only a safety and security perspective but also on HMG's broader policies.

The Director's office will alert HMG partners (i.e. DH, FCO and DFID) and the Senior Management Team when deployment requests are received. This alert system will enable any decision to deploy to be rapidly agreed. This will require HMG partners to ensure robust arrangements are in place to manage these requests and take any action required 24/7 to ensure timely and effective decision-making. Annex 6 sets out the provisional deployment and step-down process, which will guide decisions on when to deploy and withdraw the RST from an outbreak. To assist the Director, the FCO will provide a security risk assessment for each new deployment. Deployment of the RST will always be at the invitation of the host government, or the UN system, where appropriate. We will employ a 'no regrets' policy, with the expectation that some deployments will be a 'false alarm'. When a deployment is activated, the Director will alert and mobilise the core deployable team, agreeing on the size, scale and relevant expertise needed. The terms of reference, remit and limits of delegated authority of the deployed team will be agreed prior to embarkation. We anticipate that the RST will support the local leadership of the outbreak response in the field during the acute and recovery stages.

We anticipate requests for assistance may arise from:

- A request from HMG in response to emerging outbreaks
- Invitation by international bodies such as the Global Outbreak and Response Network (GOARN), WHO or EU
- A bilateral request from an affected country to HMG
- DFID for support for disease outbreaks in humanitarian responses in conjunction with UK-Med

During deployment to an outbreak, line management of deployed RST members will be through a designated RST Field Team Leader to ensure coordination and security in the field. Communications to the RST UK team and other stakeholders will be through the designated Field Team Leader, who will report directly to the Director. For logistic and operational support, the Field Team Leader may liaise directly with the Deployments Manager with the approval of the Director. During deployments an Outbreak Operations Committee may be established and chaired by the Director.

The outline deployment arrangements described in this proposal are provisional and will be further developed during the interim arrangements, including how DH and wider HMG partners' engagement will work in different scenarios.

Consideration of deployment rotations

The length of deployment of the RST will depend on the circumstances of any particular outbreak but may last from one or two weeks to, on occasion, several months. It is anticipated that the team will, where appropriate, scope and make recommendations on how the affected country can be supported in strengthening its public health systems including meeting its commitments under the International Health Regulations. We anticipate that an average deployment will involve up to three members of the RST for up to 4 weeks. In the event of a longer-term deployment, members of the RST will be rotated with 6-week duty stints in the field with at least a two-week break. Generating an understanding of the needs of the psychological wellbeing of the team will be a core role of the research programme. The deployed team will be supplemented from the cadre of RST reservists (see page 4) on occasion when their skills are required or for them to gain experience.

Deployment Platforms and Logistics

The establishment of a UK public health rapid response capacity requires a co-ordinated and functioning operational platform from which the RST can be deployed safely and effectively. The UK Government's global footprint through its overseas network (principally through FCO and DFID), provides a ready-made platform which the RST can draw on to support its work, including representation in many low and middle income countries. This means the UK is well placed to provide support and response to these countries when needed. In those cases where the UK receives a bilateral request for assistance from another country or where the Director and HMG partners decide (see Governance section below for further details) it is appropriate, the RST will deploy through a UK platform model, which is set out below. In the unusual situation when neither a UK or UN platform is available, the Director will take a risk based decision in discussion with HMG and with DH as the lead department

As currently occurs, it is anticipated that many of these deployments will be through the well-established Global Outbreak and Alert Response Network (GOARN) co-ordinated by WHO. This has been one of the main routes for the deployment overseas of UK public health expertise, since the network was established in 2000. Also set out below are the modalities for how an RST deployment through GOARN would operate.

General Arrangements

UK Platform

The RST will always operate in country with the express knowledge and agreement of the host government. In practical terms, the Director's office would have full responsibility for organising the RST's administrative and logistical arrangements (e.g. travel, accommodation, visas). They would notify HMG partners of the deployment in advance. In country, the team will work within the One HMG platform (which brings together all partners on the ground e.g. FCO, DFID and MOD). This will be facilitated through PHE's existing membership of the One HMG Network. The FCO are in the process of revising the current "MOU on the use of the One HMG Platform". Once that is complete, PHE will then become a signatory to the revised MOU. Amongst other things, this will give the team access to the FCO's network of overseas security managers, who can assist on a broad range of safety and security issues. This would include the pre-deployment risk assessment (as described above). Arrangements for medical evacuation of the team will be provided by the team's health insurance policy. We would look to the MOD, as a provider of last resort, for medevac support (e.g. where air transportable isolators may be required). Evacuation on other grounds (e.g. civil unrest) will be in line with FCO guidance and form part of HMG's evacuation of its personnel from the country or region. Any determination on whether the team should remain in country when other HMG personnel are being evacuated will be taken with advice from across government. An event of this magnitude overseas would likely require activation of COBR, which would ultimately decide HMG's footprint in any given country.

RST Deployment through GOARN

The Global Outbreak Alert and Response Network (GOARN) is a global collaboration of existing institutions and networks, which is able to drawn on a pool of health experts that can deploy quickly to a disease outbreak or health event. The network is well-established and

recognised globally as the primary vehicle through which countries respond to disease outbreaks and other health emergencies.

GOARN deployments are co-ordinated through a WHO-based Secretariat. When staffs are deployed through GOARN, they are placed on temporary WHO contracts and operate in theatre under the UN's auspices. The GOARN Secretariat arranges their travel, admin and other logistical support and their security is subject to UN in-country arrangements. In addition to the standard medical and health insurance in place for the RST, the team would also have recourse to WHO's health insurance scheme. WHO co-ordinates GOARN deployments through their Country Offices in partnership with the host country Government. This ensures that any UK deployment through the RST has the support of the host country as well as WHO.

Although the RST would be embedded and form part of the WHO team on the ground, they would represent HMG's official contribution to the response. In cases where the RST is deployed through GOARN, HMG partners will be notified. And, as a UK asset, HMG would retain ultimate duty of care and consular responsibility for the team while in country.

Disease outbreaks in Humanitarian Emergencies

In the event of a major disease outbreak during a humanitarian emergency which requires an escalation of the UK response, the RST will consider deploying alongside UK Emergency Medical Teams (or DFID's humanitarian response teams), whenever possible. This will enable a comprehensive public health component to any humanitarian response. This will be agreed through existing governance structures (see the section below on governance arrangements) and in close consultation with DH, DFID and UK-Med.

As part of HMG's efforts to strengthen its humanitarian response capabilities, DFID has funded UK-Med to establish a UK International Emergency Public Health Register (IEPHR) for large scale public health responses such as Ebola. The Register will bring together the breadth of public health expertise across the UK, including the cadre of RST reservists.

RST personnel or personnel from the IEPHR being deployed through UK-Med on humanitarian operations will be funded by UK-Med. If deployed by UK-Med, UK-Med will cover costs and backfill, as they currently do.

Strengthening the relationship with UK-Med will enable to us to harmonise UK deployment processes, protocols and training. This will ensure that we have a single list of health reservists across government to act as the escalation route should we need to launch a larger humanitarian response, which will facilitate a more effective and joined up UK response to health emergencies and humanitarian crises in the future.

Specific provisions

Duty of Care

In line with standard recruitment process, we will ensure that all members of the RST receive full medical clearance prior to appointment. This clearance will be periodically refreshed and specific additional clearance may be required for specific types of deployments in certain countries.

The RST will undergo dedicated preparatory mental health assessment and all team training will aim to foster high levels of camaraderie and leadership which have been shown to be supportive in terms of mental health. Post deployment/recovery processes to support psychological wellbeing will also be implemented. The occupational health team, at PHE or the academic institution, will ensure the team's vaccinations are in place and that other medical provisions are available (e.g. anti-malarials and bed nets).

The team will also receive briefing prior to any operational deployment to ensure (a) they receive dedicated briefing on the event they are responding to (e.g. a disease outbreak or natural disaster) and (b) political and security briefing to ensure they understand the broader context within which they'll be operating.

Health and Medical Insurance

We will ensure that all members of the RST have adequate health and travel insurance in place. Healix International provides a range of medical services to HMG staff posted overseas (e, g. through the FCO and DFID) and we are exploring with them whether cover through Healix would be appropriate for the RST. As we do not envisage members of the RST undertaking clinical work overseas (as this would be delivered by an Emergency Medical Team in the event of large scale UK deployment), we will not be seeking cover for medical indemnity or arranging medical registration with host governments.

Hostile environments

We will ensure all core RST members undergo dedicated deployment training (see training section for further details) in the field to prepare them for operational deployment. In line with other Government Departments (e.g. FCO and DFID), the team will undergo hostile environment awareness training (HEAT) training, to ensure they are able to operate as safely as possible in a variety of settings. This comprehensive package of pre-deployment training will ensure that the RST will be able to sustain themselves in the field, where necessary. They will be issued with bespoke kits which will enable them do this.

Interim arrangements

As the posts for the RST, RST Director and Director's Office will not be filled until later in the year 2016 (subject to recruitment processes); PHE and LSHTM will agree a 6-month interim plan with DH. This plan will set out business critical work, which will need to take place to enable the UK to have a standing capacity to deploy and conduct research.

3. Research

Members of the core deployable RST will conduct operational research relevant to the prevention, detection and response to infectious disease outbreaks in ODA eligible countries when not involved in outbreak response. Research activities will largely be undertaken while working at established centres within the well-established networks of collaborators of LSHTM, Oxford University, Kings College London and PHE. The initial overseas research and teaching sites will be chosen ensuring that they are in ODA eligible countries where LSHTM, PHE, the academic partners or other key agencies have established presence and/or activity. Suitable centres will have existing academic and research activities, which can provide support, academic interaction and an appropriate environment for the work of

the RST. The presence of the RST members will build in a new element of rapid response and outbreak control into the activities at the host centre. We will work from a small number of sites in the first year, which will allow for RST members to spend time together to help to build a cohesive team. It will also allow flexibility to conduct key relevant research projects in appropriate sites as opportunities arise. We aim to expand the range of sites in later years of the programme, learning from our experiences. LSHTM, PHE and the academic partners, in consultation with DH, will decide the choice of host centres.

This overseas research model enables the RST to have credible field presence and to gain an understanding of the issues faced when working in an ODA eligible country. The overseas sites will provide a platform for capacity building and establishing a legacy, and enable the development of regional hubs for teaching and research. This recognizes that inter-epidemic research and capacity building needs an established presence. In our experience this cannot be effectively achieved by short-term placements across multiple countries. Experience in multiple countries will be mainly gained by the RST members through outbreak deployments. Community engagement events, including open days and media events will be held regularly at each site. Named academic investigators and support faculty will act as academic coaches for the RST members to provide support and guidance.

Outbreak Response will necessarily take precedence over the operational research programme, so written research continuity plans will be required. These plans will define responsibilities of the wider faculty at the host academic institutions for maintaining research programmes whilst RST members are deployed to respond to outbreaks or to conduct urgent research at another site.

All of the operational research programme will have the primary purpose of benefitting ODA eligible countries by informing and improving the response to outbreaks. Key research themes will cover a range of scientific perspectives, for example:

- Developing improved methods for the collection, analysis and presentation of information for surveillance and control
- Analysis of information from outbreaks and evaluation of the policy response to improve future public health responses
- Developing mathematical modelling capabilities to provide real-time situational awareness and future projections
- Patient-orientated research to refine the case definition and characterise the clinical features of outbreaks, in order to inform the clinical and public health response, and improve models for future scenarios
- Ensuring that appropriate and ethical clinical trials can be established rapidly to help develop and test new therapeutic and preventative measures.
- Developing rapid microbiological and genetic sequencing capabilities adapted for the field to enable diagnosis of causative agents and analysis of outbreaks, taking into account antimicrobial resistance
- Social science research including developing methods for rapid assessment of community perspectives, and ensuring community engagement and involvement to inform contextually-adapted interventions
- Developing appropriate approaches for mental health and wellbeing support for affected communities, responders and their families.

Data arising from both the public health and research activities of the RST should improve the evidence base for decision-making. Rapid availability of this data to decision makers will be critical to maximise the benefits of the data during outbreaks. Therefore data capture, management, and dissemination will be a key cross-cutting theme. The RST will establish procedures for management and sharing of data and biological samples that will aspire to provide global leadership in data quality, transparency, benefit sharing, and access and will be consistent with UK research principles.

We expect all research to be published in peer-reviewed journals. Any research findings of immediate relevance to outbreak control programmes will be communicated immediately. There is now agreement with major scientific journals that dissemination of important public health findings in the context of an epidemic will not preclude later formal publication. We will also ensure that data and samples relating to work conducted by the RST are shared as widely and rapidly as possible.

4. Training, Teaching and Capacity Building

One of our top priorities will be to ensure that the Rapid Support Team is operational and deployable as quickly as possible. To do that, we will bring together the expertise of PHE and LSHTM to develop a new comprehensive package – as part of the 5-year strategy and annual plans - of teaching and training for the RST and cadre of reservists with the primary aim of supporting response and research capability in ODA eligible countries. Although the RST members will already have core technical skills, so that they can be immediately deployable, all members will be offered refresher training in field epidemiology, infectious diseases, electronic data management and additional training to ensure that they are conversant with modern approaches and opportunities for outbreak control, and are familiar with epidemiological methods and the contribution that can be made from allied disciplines. This will include ensuring an understanding of core RST methods and standard operating procedures. We anticipate that each member will have skills or receive training in a complementary discipline to increase their effectiveness in response and allow cross-cover if more than one team is deployed at a time.

Short-course training, will build on PHE's existing experience, and will include appropriate academic and research components, and is harmonized with global initiatives such as the WHO Global Health Emergency Workforce (GHEW), GOARN and national response teams such as those of CDC and Institut Pasteur.

Prior to deployment all members of the RST, including reservists, will undergo mandatory training. This will include, for example, a bespoke pre-deployment course giving an overview of the global health security context, the broader health and humanitarian architecture, staying safe and healthy during deployment (including the generic principles of psychological first aid), ethics and code of conduct. It will also cover teamwork and communication skills aiming to foster a mutually supportive and well-led team. In addition, the RST will undertake a four-day operational deployment course covering many of the challenges the team may face when operating in the field, including security, culture and team dynamics, applying a human rights approach and respect for ethical standards for the collection and sharing data and specimens. They will learn how to use communication technology, emergency power and water supplies, sanitation in the field and personal kit. This will be delivered in partnership with UK-Med or WHO and will be aligned to the UK Emergency Medical Team training and operating procedures. The team will also receive

specialist training in operating in hostile environments. The team will receive briefing prior to any deployment, which will ensure they fully understand the nature of event they are responding to (e.g. technical briefing on a specific disease) and they will also receive a political and security briefing from the FCO, to ensure they understand the country and broader context within which they will be operating. If members of the RST are working overseas at the time of a deployment, briefings will be conducted by Skype or videoconference.

We will develop a technical training programme for microbiologists, including how to establish and maintain a laboratory in an outbreak response environment while retaining a high quality diagnostic service. It will give participants critical training in how to work in rapid response or mobile laboratories in hostile or low resource settings. We will also run a one day introduction course on microbiology and laboratory operations in outbreak response. This will be mandatory for all RST members and will form part of the supplementary training for the cadre of RST reservists. We will develop further courses on Emergency Outbreak and Response, Epidemiology and Infection Prevention and Control and provide access to the vast amount of training and learning resource materials available at PHE, LSHTM and the other academic institutions.

We will expand our cadre of reservists, and train future RST members, through both the PHE Field Epidemiology Training Programme (FETP) and the Masters teaching programme at LSHTM. The FETP is run in partnership with the European Centre for Disease Control and Prevention. The expansion of the programme will ensure a larger cadre of epidemiologists working at PHE in the UK is available for the RST and access for a broader range of specialists to participate. In order to develop a more multidisciplinary pool of reservists we will develop a training curriculum at LSHTM in Disease Outbreak Response. We will create an outbreak and response stream within existing MSc courses. This will be based largely on existing modules of Masters and short-course teaching, and can be run full-time, part-time, in modules, or by distance learning. We plan to develop short courses for those requiring an update (every 3-5 years) and as an introduction for humanitarian workers not from the health field.

We wish to ensure that reservists come from a multidisciplinary range of backgrounds, and so we will offer 5 bursaries annually, targeted at individuals with valuable expertise and scarce specialisms wishing to undertake a Master's degree at LSHTM to ensure a wide spread of capabilities across the reservist force and potential future members of the RST. These bursaries will cover part of the cost of the course, and will be offered to recipients on the condition that they apply to become members of the UK International Emergency Public Health Register run by UK-Med and with the expectation that their employing institution will release them if they are called upon to assist with an outbreak in ODA eligible countries. We expect they will be employed at a range of institutions including academia, health facilities, NGOs, PHE, DFID and other government departments in the UK and overseas.

Funds have been included as sub-contracted services, based on DH's current provision of 'backfill costs' to employers for National Health Service (NHS) staff deployed through UK-EMT which are extended to non-NHS staff deployed as reservists under the RST.

It will be essential to ensure that members of the RST and cadre of RST reservists are accredited as trained and ready for deployment during an outbreak. We will establish criteria in conjunction with GHEW and other national teams to ensure consistency in approach. The

criteria will include attendance at appropriate academic teaching course, recent attendance at required short training courses, and previous appropriate experience of working in outbreak or crisis situations.

Overseas Capacity Building

Building capability overseas is a vital component of strengthening global health security and research. Less than a third of WHO Member States have implemented the IHR core capacities. The vast majority of those that have not are from low and middle income countries. The UK has a strong track record in working with these countries, which provides a base on which the RST can build, in particular building the capacity for rapid response in country. We will ensure that this work is complementary to DFID's existing health system strengthening work and is similarly aligned with Department of Health's new funding for IHR work overseas.

We will develop teaching modules based on those used at LSHTM, PHE and our academic partners for delivery at the overseas research and teaching sites. Teaching modules will cover field epidemiology, clinical research, International Health Regulations assessment and compliance, research methods, infection prevention and control, and emergency preparedness and outbreak response. Teaching will be delivered by members of the RST, academic staff from the collaborating UK institutions and by public health experts from PHE. Local national research associates recruited at the research and teaching sites will receive training in research and assist the RST members in their operational programmes. We also envisage offering external training courses to key personnel in ODA eligible countries, which could be provided face-to-face at the overseas research and teaching sites, by distance-learning, and free on-line courses. We will explore using Moodle, Panopto and FutureLearn teaching systems for delivery of materials. Using FutureLearn will ensure that courses are freely available worldwide. The training modules will be trialled initially at the research and teaching sites and we will consider rolling them out to other countries in subsequent years according to need and demand.

5. Governance arrangements

The RST management structure will have academic and PHE components, each with a head who reports to the Director. One of these heads will be appointed as Deputy Director, at either PHE or LSHTM, depending where the Director RST is based, in order to maintain institutional balance. We will form a Senior Management Team, which will include (among others) the RST Director and both PHE and LSHTM leads for the RST. The Senior Management Team will meet regularly to ensure the RST becomes a single cohesive group with unity of purpose. We will establish working groups including staff from PHE and the academic institutions for teaching and training, laboratory activities, evaluation, and data and knowledge management. We will hold regular full team meetings for academic and PHE staff to agree working terms and expectations and to build a single cohesive team. We will use the specialist expertise at Kings College London to achieve this aim.

Annex 3 sets out the governance structure for the RST and how it sits in the established cross-government health security architecture. As the RST is funded through the Department of Health's global health security ODA programme, PHE's Medical Director will report all RST spend (i.e. both PHE and LSHTM) to DH's Director for Health Protection and Emergency Response, who is the Senior Responsible Officer (SRO) for DH's global health

security ODA funding. As part of this, the NIHR will manage the LSHTM contract and facilitate the necessary reporting against it. PHE's Medical Director sits on the Global Health Security Programme Board, which is chaired by the SRO. The RST Director will attend meetings of the Board, where necessary. In turn, the GHS Programme Board reports to the GHS Senior Officials Strategy Group, which is co-chaired by the DH's Director General for Public and International Health and DFID's Director General for Policy and Global Programmes. This Strategy Group reports to the Cross-Government Ministerial Group, including the Chief Medical Officer. These arrangements complement and respect the internal accountability arrangements in each institution (i.e. PHE and LSHTM).

In addition to the governance and accountability structure, it is recognised that regular formal contract/ MoU management meetings between the Director and DH will likely be required. This would be an opportunity to review progress against the annual plans and detailed finance review before submitting reports to the programme board/ SRO.

The annual RST plan, prioritised research agenda and operational research programme will be submitted to the SRO and the Programme Board each year as part of the annual agreement between DH and the RST. Governance of the research programme will be through an academic steering committee that meets quarterly, chaired by the academic lead, with representation of the academic institutions and PHE and the RST Director. The committee will develop the prioritized research agenda, in consultation with relevant partners as appropriate, and will oversee research progress. We will ensure that all partners can contribute to each research work stream, as appropriate, no matter which institution may lead it. Priorities for research will be based on quality of the science and the needs of the countries and communities at risk or affected by outbreaks, not on any predefined allocation to particular institutions or work streams.

Within LSHTM, the academic head will report through usual institutional mechanisms to the Dean of the Faculty of Epidemiology and Population Health, and the PHE lead will report to the RST Director and follow existing managerial and governance structures.

We will establish an Advisory Board that will include senior representatives of Department of Health, DFID, PHE, LSHTM, WHO and independent members. This Board will meet regularly and will provide advice to the Director of the Rapid Support Team. This Board could also be invited to undertake a review of activities after 18 months.

The RST Director will also be expected to respond in a timely manner with any requests for information regarding RST activity from DH or as part of any independent evaluation (e.g. the Independent Commission for Aid Impact).

RST Accountability and Advisory Arrangements

- We have agreed that it would be preferable if the RST director has one reporting line. This will avoid duplication of messages and any confusion.
- We propose that the RST director reports to the PHE Medical Director, who then represents the RST across government, including at the Global Health Security group meetings.
- An Advisory Board will be established, including senior representatives of DH, DFID, PHE, LSHTM, WHO and independent members to provide advice and support to the RST Director.

- This arrangement provides an appropriate accountability framework to give assurance to HMG for the delivery of the RST function as a stand-alone entity.
- Given the critical nature of the RST work and the need for flexibility and rapid deployment, additional routes of accountability could limit the effective operational delivery of the RST functions.

6. Finance

The MOU and contract for the RST will set out in more detail the programmatic and financial reporting requirements which we are obliged to meet, in line with the governance arrangements set out above. As an ODA funded programme, we recognise that there are specific compliance and spend criteria that we are bound by as part of the UK's development assistance obligations under OECD rules. When deployed under ODA, the team will operate under the International Development Assistance Act.

The costs associated with the Director and his or her office, including non-staff related costs, which amount to £2.5M, have been set aside, as these costs will be allocated to whichever institution hosts the Director. The remainder of the £20M budget has been divided equally between PHE and LSHTM. The details of the budget lines at PHE and LSHTM are included in annex 5.

We are aware that the funding will be £4M per year and that there is little or no flexibility to move funds from one year to another. Since we recognise that the very essence of the RST is to respond to outbreaks that are unpredictable in their nature, their size, location and timing, this is going to be challenging. Flexibility on this should be sought.

However, we will achieve this by balancing the needs of deployment against the operational research plan. Since the RST staff salaries will be the same during deployment or otherwise, we need to take into account the actual costs to deploy and activities while responding and factoring these into the research and capacity building plans. We have allocated about £400,000 per year to cover deployments of the RST. We estimate this will be sufficient for about 8-9 deployments per year. In order to retain flexibility, each year we will draw up operational research plans that are categorised as essential and those that are subject to contingency. So we will have a list each year of research activities that can be put on hold if there has been heavy demand to respond to outbreaks, and also of activities that can be started or scaled up towards the end of the year if funds permit. We will therefore need to assess the demands on the budget regularly throughout the year.

ANNEX B

FIVE-YEAR STRATEGY

Document	Date for submission
Five Year Strategy	
a) Five Year Strategy for the UK PHRST that complies with guidance and advice from DH on content which may be issued from time to time, and to include but not limited to the UK PHRST approach to: 1. Strategic Objectives; 2. Risk management; 3. Performance requirements together with priorities and strategic goals; 4. A mechanism for agreeing Deployments within an appropriate timeframe (so to meet the 48hr Deployment requirement set out in the Application); 5. Insurance including arrangements for Deployments and employee security; 6. Financial management and reporting including management of the costs of Deployments; 7. Governance including reporting lines and employment position (including the need for employees to have HMG contracts for deployments as required); 8. Milestones and quantifiable deliverables and metrics to ensure the research, training, capacity building and Deployment elements are properly addressed (that will then be updated in the annual action plan). PHE shall work with LSHTM and DH to prepare the Five Year Strategy.	Submitted for DH's approval within 3 months of the appointment of the Director of the UK Public Health Rapid Support Team, or December 31 2017 (whichever is earlier) or such later date as DH may agree.
Annual Plans	
a) First annual plan covering the financial year 2017/2018 from commencement of the Main Phase, that is developed jointly with LSHTM and that complies with guidance and advice	Submitted for DH's approval along with the Five Year Strategy, within 3 months of the appointment of the

from DH on content, to include, but not limited to: 1. an annual action plan with measurable targets covering all key objectives of the UK Public Health Rapid Support Team; 2. an annual research programme.	Director of the UK Public Health Rapid Support Team, or such later date as DH may agree.
b) An annual plan for each of the following financial years that is developed jointly with Public Health England and that complies with guidance and advice from DH on content, to include, but not limited to: 1. an annual action plan with measurable targets covering all key objectives of the UK Public Health Rapid Support Team; 2. an annual research programme.	Submitted for DH's approval on or before 31 December 2017, 2018 and 2019.

ANNEX C

UK Public Health Rapid Support Team – Interim Six Month Plan (1 October 2016 -31 March 2017)

Objectives	Lead	Actions	Timescales (completion dates)	Comments
1. To install interim RST with (interim) Director and Deputy by July 2016.	PHE/LSHTM	1a. Nominate and secure agreement with DH on appointment of interim Director and Deputy (NB. critical for progressing work under interim arrangements)	End July	[Includes agreed pre-interim initiation activity]
		1b. Identify and appoint interim RST deployment team.	End September	
		1c. Identify and put in place interim core management support capability.	End July	Core management team activity [Includes agreed pre-interim initiation activity]
2. Agree process and start recruitment of public health reserve cadre.	PHE/LSHTM	2a. Identify resource within PHE and LSHTM to provide additional reserve capacity.	End October	Core management team activity

Note: the interim core management team will be responsible for supporting the interim Director in taking forward the activities outline d in this business plan, including the function of operational and logistical support for any RST deployment. See page nine of the joint proposal and annex 7 for further details on interim arrangements.

	PHE/LSHTM	2b. Work with DFID and UK-Med to develop the UK IEPHR	Mid-December	
3. Agree and deliver core mandatory pre-deployment training (for interim team)	PHE	3a. develop and implement pre-deployment course for interim RST	Mid-September	[Includes agreed pre-interim initiation activity]
	PHE	3b. Secure agreement and provision of deployment training with UK-Med	Mid-September	[Includes agreed pre-interim initiation activity]
	PHE	3c. Secure agreement and delivery of hostile environment training with FCO	Mid-October	
4. Develop broader training offer as input to the Director's RST strategy.	PHE/LSHTM	4a. Develop other training materials/courses (e.g. epidemiology and microbiology)	End December	
		4b. Identify two fellows for the FETP		
	PHE	4c. Work with DFID and UK-Med to secure agreement on	End July	
	PHE	reciprocal training arrangements	End December	Core management team activity
		4d. support delivery of Masters of Public Health course in Sierra Leone		

	LSHTM	4e. develop training curriculum on conducting clinical research during epidemics (with WHO/TDR)	End March 2017	
	LSHTM	4f. Provision of training bursaries for public health practitioners in Sierra Leone.	End January 2017	
	LSHTM		End March 2017	
5. Ensure corporate services and equipment are in place to support operational deployment.	PHE/LSHTM	5a. Agree arrangements for provision of occupational health services (inc. medical clearance, vaccinations and psychological support)	End-October	Planning assumption: one bilateral deployment of full team.
	PHE/LSHTM	5b. Agree arrangements for insurance and medical cover	End-June 2016	Core management team activity
	PHE/LSHTM	5c. Source and procure kit for interim RST (e.g. personal kit and comms)	End July 2016	Core management team activity
6. To agree One HMG Platform arrangements	PHE	6a. PHE to become signatory to revised MOU on use of the One HMG Platform	End August 2016	

	for bilateral deployments		6b. PHE agree SLA with FCO on RST use of the One HMG Platform.	Mid November	Core management team activity RST will be charged based on services provided per deployment
7.	To deliver short-term research projects in the area of outbreak response, focussing on ODA eligible countries.	LSHTM	7a. call for proposals from the RST supporting faculty 7b. Academic Steering Committee to develop priority list of research activities (in discussion with DH) 7c. Conduct studies aligned with research priorities. 7d. scope potential overseas research and teaching sites	End September End October for ASC (but confirmation from DH still awaited) End March 2017 End February 2017	
8.	To ensure the RST programme complies with	PHE/LSHTM PHE/LSHTM	8a. Provide financial and activity reporting as set out in the MOU 8b. Meet with DH, as	Quarterly reporting Quarterly reporting	

agreed financial and governance arrangements (inc. ODA obligations)	PHE/LSHTM	appropriate, to provide programme updates 8c. Establish process to set up independent Advisory Board, consulting DH as appropriate	End December	
	PHE/LSHTM	8d. Develop and maintain RST Risk Register	End September	
9. To ensure effective communication and representation on RST issues with internal and external partners	PHE/LSHTM	9a. Develop interim communication plan with DH, in consultation with other HMG partners	End November	Core management team activity
	PHE/LSHTM	9b. Represent UK in developing RRT/GHEW concept with WHO and international partners	Ongoing	
10. To monitor and respond to disease outbreaks, as agreed with DH and other HMG partners	PHE/LSHTM	10a. Monitoring and reporting on disease outbreaks and other relevant health risks in ODA eligible countries (NB: as part of existing cross-Whitehall mechanisms)	Ongoing	
		10b. Deploy an RST to an ODA eligible country in a timely,	As required, in consultation with	Planning assumption: one bilateral deployment of

		safe and effective manner.	DH and other HMG partners	full team for 3 weeks. Core management team activity
11. Establish (interim) handling, alert and response system for deployment requests	PHE/LSHTM	11a. Design, agree and implement a preliminary alert/response mechanism, in consultation with DH and other HMG partners.	End October 2016	Core management team activity
12. Develop concept paper on RST capacity building work in LMICs.	PHE/LSHTM	12a. In consultation with DH, HMG partners and others (e.g. WHO), undertake preliminary scoping exercise of capacity building/training needs in ODA eligible countries (in line with IHR implementation, UK global health security objectives and RST research objectives)	End February 2017	

RST: Interim Business Plan – Budget Annex

Objective/Action	Description	Q1 (April – June) (Actual)	Q2 (July – September) (Actual)	Q3 (October – December) (Forecast)	Q4 (January – March) (Forecast)	Detail
1a	Interim RST Director	[redacted]	[redacted]	[redacted]	[redacted]	Q1: 40% Q2: 55% Q3/Q4:75% full time. Total: [redacted]
1b	Interim RST Staff costs (PHE)			[redacted]	[redacted]	1 x 100% full time (full-time Microbiologist recruited but at lower grade than previous planned) 2 x 50% full time 1 x 60% full time (increased senior epi to 0.6 from 0.5WTE job share) Total: [redacted]
1b	Interim RST Staff costs (LSHTM)		[redacted] (including overheads)	[redacted] (including overheads)	[redacted] (including overheads)	2 x 100% full time (epidemiologist, data manager) 2 x 50% full time (microbiologist, social scientist) Overheads: [redacted] Total: [redacted]
1b	Interim RST (T&S)		[redacted]	[redacted]	[redacted]	Travel and subsistence Total: 11,600 **PHE** T&S and associated costs for two FETP Fellows and training staff have been accounted for here. [redacted] **LSHTM**

						[redacted]LSHTM
1c	Interim core management support function (PHE)	[redacted]	[redacted]	[redacted]	[redacted]	**PHE** Total: [redacted] Q1: Prog. Manager (G6) – 30% Project Manager (G7) – 100% Project Manager (G7) – 30% Q2 Prog. Manager (G6) – 100% Project Manager (G7) – 100% Project Manager (G7) – 30% Deployment Man (HEO) – 30% TE (G6) – 10% Q3 – Q4 Project Manager (G7) – 100% Project Manager (G7) – 30% Deployment Man (HEO) – 30%
1c	Interim core management support function (LSHTM)		[redacted] (for oxford, including overheads)	[redacted] (LSHTM, KCL and Oxford including overheads)	[redacted] (LSHTM, KCL and Oxford including overheads)	**LSHTM** Q3&4Total: [redacted] Q3 – Q4: Programme manager – [redacted] plus £5,500 overheads = [redacted] 7 support faculty [redacted] [redacted] verheads = [redacted] Oxford Research clinician – [redacted] Research nurse – [redacted] Ops Admin – [redacted] PI – [redacted] Data Manager – [redacted] Capacity Building manager -

						[redacted] Oxford overheads = [redacted] Kings Support faculty [redacted] Kings overheads = [redacted] LSHTM Consumables Minor items [redacted] Total: [redacted]
1c	Interim core management team (T&S)	[redacted]	[redacted]	[redacted]	[redacted]	Travel and subsistence Total: [redacted] PHE [redacted] LSHTM [redacted] LSHTM
3a	Pre-deployment course			[redacted]		One day course for 15-20 people, including full interim RST.
3a	Training – staff costs			[redacted]	[redacted]	Training Lead (G7) Training Manager (HEO) Total: [redacted]
3c	Hostile environment training (SAFE)			[redacted]		SAFE and SAFE Plus course for all interim RST. Provided through FCO.
4a	Broader training offer: microbiology				[redacted]	5 day technical rapid response laboratory training - [redacted] 1 day general core training course [redacted]

4b	FETP		[redacted]	[redacted]	[redacted]	Two FETP fellows Q2 covers 3 weeks only and not full quarter. Total: [redacted]
4b	FETP Staff costs		[redacted]	[redacted]	[redacted]	FETP Training Supervisor (G7-38.5%) FETP Training Admin (EO-38.5%) Total: [redacted]
4d 4e	Support Masters of Public Health Programme in Sierra Leone Training curriculum for clinical research			[redacted] [redacted]	[redacted] [redacted]	- Provision of LSHTM lecturers - T&S for visiting lecturers - Salary support for non LSHTM lectures University of Oxford Collaboration with WHO/TDR.
4f	Provision of training bursaries for Sierra Leone public health workers			[redacted]	[redacted]	
5a	Provision of occupational health services			[redacted]	[redacted]	Includes: Medical clearance, vaccinations, medicines and self-treatment kit and access to dedicated occupational health nurse. Total [redacted]
5b	Deployment insurance cover			[redacted]		One bilateral deployment of full RST under interim arrangements: Through PHE exiting provider
5c	Provision of comms and personal kit		[redacted]	[redacted]		For interim RST: Comms kit - [redacted]

						Personal kit - [redacted]
7a-b	Operational research			[redacted] (including overheads)	[redacted] (including overheads)	Portfolio of short term operational research projects: [redacted] plu[redacted] overheads (research salary overheads shifted from 1c as more appropriately placed here)
10b	RST Operational Deployment				[redacted]	One bilateral deployment of full RST under interim arrangements: - Flights - Accommodation - Travel and subsistence
1a/1b/1c/3a/4b	Staffing overheads (PHE – 29.8%)	[redacted]	[redacted]	[redacted]	[redacted]	Total: [redacted]

Quarterly split between PHE and LSHTM (figures include overheads)

Organisation	Q1	Q2	Q3	Q4	Total
PHE	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
LSHTM		[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

ANNEX D – PAYMENT SCHEDULE

PAYMENT SCHEDULE FOR THE INTERIM PHASE

As detailed in Annex C, DH recognises that significant costs of initiation were incurred prior to the commencement of the RST Schedule (termed the "Interim Phase") which will be reimbursed from programme funds. PHE's approved costs for the Interim Phase are detailed below:

Approved Costs

Date	Amount (£)
1. 30 June 2016	£72,547
2. 30 September 2016	£123,837
3. 31 December 2016	£298,394
Calendar Year 2016 sub-total	**£494,478**
4. 15 March 2017 (Interim Phase completion)	£294,121
Financial Year 2016/17 sub-total	**£788,899**

PAYMENT SCHEDULE FOR THE MAIN PHASE

Date	Amount (£)
5. 15 June 2017	£437,500
6. 15 September 2017	£437,500
7. 15 December 2017	£437,500
8. 15 March 2018	£437,500
Financial Year 2017/18 sub-total	**£1,750,000**

9. 15 June 2018	£437,500
10. 15 September 2018	£437,500
11. 15 December 2018	£437,500
12. 15 March 2019	£437,500
Financial Year 2018/19 sub-total	**£1,750,000**
13. 15 June 2019	£437,500
14. 15 September 2019	£437,500
15. 15 December 2019	£437,500
16. 15 March 2020	£437,500
Financial Year 2019/20 sub-total	**£1,750,000**
17. 15 June 2020	£437,500
18. 15 September 2020	£437,500
19. 15 December 2020	£437,500
20. 15 March 2021	£437,500
Financial Year 2020/21 sub-total	**£1,750,000**
TOTAL	**£7,437,500**