Questions & Answers
UK Rapid Response Team

**SCOPE/REMIT**

1. **Can a single academic institution apply more than once for a RRT?**

No. It is not permissible for an academic institution to apply more than once. In order to ensure critical mass, focus, and clarity, the funding for the RRT will be awarded to a single academic institution working in partnership with PHE.

2. **Can we be listed as collaborators on multiple applications?**

The evaluation panel will be advised to make a selection based on the academic team and skills put forward by the applicant university alone. You are encouraged to detail only those academics from your university at this stage.

3. **Please comment on the inter-operability of the RRT, both medical and legal, as it will be deployed within or parallel to established healthcare environments.**

The RRT will not be a clinical group of experts but rather a public health advisory group able to support with leading on outbreak response activities. As the team will not be undertaking clinical practice in-country we will simply require a request and agreement from the affected country for the team to operate in the field. If undertaking operational research, the team will be expected to work within the host country’s parameters for ethical approval, although in general operational research will only need a short proposal which can be approved immediately. If proposals include the provision of laboratory technicians or directly handling samples, the RRT will need to explore the legal provisions needed during deployment.

4. **What criteria will be used for making a decision to deploy?**

In the final proposal submitted by PHE and the academic partner, the RRT will be expected to suggest deployment criteria for the team. Criteria will then be reviewed and approved by the Chief Medical Officer. This should consider where the request has come from (bilateral, WHO, UK EMT), the clinical conditions of the disease outbreak, a country’s risk rating as dictated by the FCO, social, environmental, and population risks. Where possible the deployment criteria should complement WHO guidance on outbreak threats and infectious diseases.

Using this criterion, the RRT Director will make the decision to accept or reject a request for assistance.

5. **How long will the deployment be for and how many people would be expected to deploy from the core team?**
The Prime Minister announced a deployable team of 6 – 10 experts. We would expect that this number represents the available staff for an outbreak deployment at any one time but each deployment would not necessarily require the full team.

Lengths of deployments may vary, however the remit of the Rapid Response Team is focussed on the onset of a disease outbreak rather than longer term treatment activities when the outbreak is under control. That said the team would be expected to re-deploy for lessons learning and capacity building activities after each deployment, and in some cases to support with a country’s recovery after an outbreak. Not all activities will be undertaken by the same staff or in the same deployment. The final proposal submitted by PHE and the academic partner should consider an operating model for deployments which includes a suggested process for deployment rotas – for example 6 weeks in country followed by 2 week respite.

6. What is an ODA eligible country?

Official Development Ssistance (ODA) is defined as government aid designed to promote the economic development and welfare of developing countries. The OECD maintains a list of developing countries and territories; only aid to these countries counts as ODA. The list is periodically updated and currently contains over 150 countries or territories with per capita incomes below USD 12 276 in 2010. Data on ODA flows are provided by the 29 OECD members of the Development Assistance Committee (DAC).

7. Do you consider the army as a public sector partner with a strong research portfolio?

Yes, the army would be considered a public sector partner, although at this stage you are encouraged to detail only the team and skills of the applying university.

8. We presume International NGOs are seen as public institutions, rather than private.

That is correct.

9. What is the “separate mechanism” for health care reservists to be deployed?

The separate mechanism for health care reservists relates to the UK Emergency Medical Teams (EMTs) which are deployed through the UK Med roster of professionals. This is a mechanism that can be deployed through the DFID Secretary of State and, although it will be linked with the Rapid Response Team, is a separate response function.

10. We are asked to suggest a model of operation. Is this for the whole RRT or for just the research component?

The suggested operating model should reflect what your staff and institution can offer as a contribution to the entire scope of the project. You are not expected to make suggestions in your operating model as to how PHE will work. Although the academic institution may not be the lead partner on some activities, we would expect the academic partner to be involved in both response and research. If your institution does not wish to be involved in specific areas of the project’s scope –for example training, there is no need to include this in the operating model. The operating model will need to be adapted with PHE in the final proposal to incorporate the work of the whole team.
11. What do you mean by “existing information management platforms” on page 8 of the Guidance Document?

Information management platforms which can help support the collection, sharing and analysis of data and information during response activities and when undertaking operational research. The RRT should have to hand a site or piece of software to enable them to share data and information across the group, particularly if members of the team are in different regions of the country at any given time. Given the size of files, this may also be important in sending analysis back to London if necessary.

12. You ask how staff capacity would be adapted in the event of a major outbreak response incident on page 10 of the Guidance. Does this refer to members of the core team, or more widely, such as the “reservists”?

This refers to the ability of the team to adapt their contribution to the outbreak response if needed. This might include sending all their deployable staff at the same time, in addition to drawing on other skills from their institution and links with other institutions to deploy the right skill sets to suit a major response. For example, this might be a link with a department that has strong skills in political economy analysis in developing countries if the core team was lacking this experience.

13. How does the RRT interface with UK Med and with CHASE (Conflict and Humanitarian and Security Department), which is a cross HMG/DFID department on all things humanitarian. Within that, there is a Humanitarian Response Group which does the cross rapid response stuff. I don’t yet know how this fits in with the UK Rapid Response Team for disease outbreaks (the so called “disease detectives”?) but can find out.

The Rapid Response Team will deploy to support disease outbreak responses whereas UK EMTs (deployed through the UK Med roster) are not limited to the type of humanitarian response they can attend. In the event of a UK EMT deployment, it is envisaged that one or two members of the Rapid Response Team will deploy with them (having all been registered on the roster) for experience and to support the response with public health expertise. It is expected that the Rapid Response Team will develop and deliver public health training for the public health pillar of the UK Med roster.

In the event of a disease outbreak response where the RRT are clear from their assessments that a larger clinical response will be required to contain the outbreak, as with Ebola, the DFID CHASE team will be alerted and the DFID Secretary of State will have the option to deploy the UK EMT.

14. You state on page 2 of the Guidance that research costs are likely to require grant applications or joining existing research. However, this works requires operational research and outbreak response research when not responding to outbreaks (pg. 3). The Guidance states research is supported by funding on page 5, although complex lab based research may not be included. Please can you clarify what research is and is not eligible.

Operational research during an outbreak response and when not responding to an outbreak will be eligible for funding under this budget. Complex lab based research is not expected to be included. When not responding to an outbreak, to augment the budget available for research if undertaking a larger scale research endeavour, bidders may want to consider how other grant applications could support this work.
15. Does an HPRU count as a public body with a substantial research portfolio?

HPRUs are not eligible to apply.

16. When you ask about track record dealing with ethics and regulatory boards and conducting work in difficult circumstances, is this at Institutional or Individual level?

The preference would be to show a track record of dealing with the ethical and regulatory boards from the key researchers and staff being proposed for the core team. However, institutional experience of this if the learning can be shared or drawn upon would be usefully noted in the absence of direct personal experience.

17. If you are selected, do you need to be based in London?

No, institutions can be based anywhere in the United Kingdom.

18. If the vision is for the RRT to be periodically dispersed worldwide, how will we be expected to plan for and be able to deploy within 48 hours? For example, we may have a plan to deploy to Country X from the UK, but how do we plan for deploying from Country Y to Country X, when we're not sure where we'll be?

This emphasises the importance of a detailed plan for when the team is not responding to an outbreak. It also highlights the importance of having mechanisms in place for keeping tabs on where the team members are and what partnerships you can draw on quickly worldwide. Once the decision to deploy has been agreed, the core team would be expected to deploy within 48 hrs. The team must have a full time member of staff tasked with managing deployments to facilitate this.

19. It seems the vision is for 5-6 people to be ready to deploy with £20 million to support them but not necessarily to support the infrastructure?

It is expected that the £20 million funding would be used to support core deployable team of up to ten members of staff with the capacity to draw upon specific skills from additional staff if required, as well as the RRT operations team (Director, Programme Manager, Deployments Manager). It is up to institutions to propose the logistics of the core deployable team, but it should be noted that they serve more as an advisory team versus being engaged in clinical care. However, we are open to seeing any alternative concepts that institutions may propose.

20. Will the RRT be expected to deploy into potentially dangerous situations or areas of ongoing conflict?

The final proposal, which includes the selected academic bidder and PHE, will detail the criteria for deployment, so ultimately this will be negotiated in the next stage. However, we do not envisage that civilians would be sent into dangerous areas and will work closely with the Foreign Office to ensure proper risk mitigation measures are taken for every deployment, including a provision of Hazardous Environment Awareness Training (HEAT).

21. Because outbreaks appear gradually, how does one define “deploying within 48 hours”?

The mandate from the Prime Minister is that response to an outbreak needs to happen as soon as possible and was specified as within 48 hours. The operating model should suggest
specific guidelines for deployment, but WHO or a certain country may issue a formal request
for aide. Once a decision has been made that the UK will respond to a request for support,
the team needs to be able to deploy in 48 hours.

22. The timeline says the team will need to be operational by April 2016
considering the decision timeline and the process of creating a final proposal
with PHE, is April realistic?

As the funding for the RRT will be available from 1 April 2016, it is intended that the RRT will
be operational from April. It is understood that processes like recruitment take time and
some of this will be dependent on the operational model proposed.

23. If a proposal includes research plans, what is the mechanism for quality
assurance of the research unit (i.e. peer review process)?

Bidders should suggest an appropriate level of quality assurance for the research proposed.

24. Who will be the employer of the support staff?

This is dependent on the operational model proposed. It could be Public Health England or
the academic institution. Patterns may want to consider releasing an open advertisement to
ensure the right skills are available.

**FUNDING**

25. When will we know the results of the ODA Spending Review outcome?

It is expected that the results of the spending review will be confirmed in late November/early
December. Given the high priority of this work, there is a strong expectation that funding will
be allocated. Should this not be the case, potential bidders will be informed as soon as
possible after the announcement (and well before the deadline for bids.)

26. How will the £4 million per annum be split between the academic institution
and PHE?

£4 million per annum will need to include all deployment costs such as travel and
accommodation, visas, insurance, subsistence, and equipment. After these costs are ring
fenced the remaining budget will be split between the academic institution and PHE,
informed by the division of staff hosted by each institution and the division of activities to be
delivered by each partner. The amount of funding will therefore be dependent on the scale,
nature, and quality of research and response activities agreed between the two parties.

27. How much of the £4 million per annum may we bid for?

It is envisaged that at least 40% of the rapid response team budget will be awarded to the
successful academic institution. This figure may be higher depending on the agreed division
of activities and responsibilities. As such, academic institutions are free to bid for the
amount deemed appropriate and justifiable in accordance with the proposed operational
plan, in the context of value for money and an understanding that proposed costings will
undergo negotiations with PHE. Bidders should also consider that all deployment costs for
both PHE and the academic partner will need to be represented in the £4 million a year
budget.
28. Do we need to flat profile the finances, predicting the same amount of spend for each year of the contract?

At the application stage, it is expected that costings should be profiled evenly over the duration of the contract. Any variations to the funding schedule will need to be discussed with the NIHR CCF once the contract has been agreed.

29. Please expand on what “limited research costs” are. Can you clarify how much research will be included in the funding - the application discusses operational research and limited research costs?

Applicants are permitted to apply for limited non-pay research costs to support the programme of work. This includes consumables, equipment costing less than £5,000, travel and subsistence. Funding will not normally be provided to support significant laboratory research.

30. Can you suggest a percentage of research costs recommended for our application?

The award will fund limited research costs including consumables, travel, software licences, equipment costing less than £5,000, and equipment maintenance contracts. The percentage of research costs is dependent on the operational model proposed and the justification behind them.

APPLICATION PROCESS

31. Are there any guidelines for how the institutions may interact with PHE (if at all) prior to application submission?

We do not expect or encourage academic bidders to interact with PHE ahead of submitting proposals, as PHE will be submitting a proposal in parallel through the same NIHR review process – although not in competition with academic bidders. Once the academic partner is selected there will be time at this point to speak directly with PHE and develop a joint and final proposal.

32. What is the selection process? Will applicants need to be available for interview?

Our expectation is that the Panel will either interview all applicants or have a formal triaging process and only the highest ranking applicants will be invited to interview. Further details will be provided once the applications have been submitted.

33. Just to clarify, the process is that academic institutions are bidding separately and without communication with PHE, PHE submits an independent proposal simultaneously, and once an academic institution is chosen they work officially with PHE to create a final proposal? So this is not like an HPRU?

The process for the commissioning of the RRT is different than the HPRU process. Both PHE and academic institutions will independently submit their respective applications by the application deadline (17 December 2015). The Selection Panel will use the selection criteria outlined in the application document to triage applications in January 2016. Triaged applicants will subsequently be invited to interview by the Selection Panel. PHE will also be interviewed during this session. The Selection Panel will make recommendations on which
academic institution should be selected and will advise on the division of activities between the selected academic partner and PHE. Then, the selected academic institution and PHE will create a joint proposal based on the recommendations of the selection panel. This joint proposal will receive final sign off from CMO. Further details will be available after the submission deadline.

34. So in essence, is a selection criterion how well an academic institution’s proposal sits alongside PHE’s?

No, all applications will be evaluated first in terms of strengths and weaknesses of the proposal. After an academic institution is selected, then the Selection Panel will produce recommendations the division of activities between the selected academic partner and PHE.

35. Will PHE have a role on the Selection Panel?

No. The Selection Panel will be an international independent panel.

36. What is a Key Researcher and how many may the application include?

Key Researchers are researchers working within, and contributing to, the proposed Rapid Response Team as a means of demonstrating the capacity of the university. Thus, despite the guidance in the brief, it is our strong expectation at this stage that Key Researchers will only come from the applying university.

The number of Key Researchers in each application has no restrictions and is for the applying team to decide.

37. Who makes up the core deployable team, and may we apply for all ten positions?

It is expected that the core deployable team will involve up to ten members of staff with the capacity to draw upon specific skills from additional staff if required. It is expected that the core team will include one logistics/data administrator to support the public health specialists while deployed. Applicants will need to justify the costs of other staff and skills needed in the core team to undertake the operational work of the RRT.

38. May we apply for positions on the RRT operations team (Director of the RRT, Programme Manager, or the Deployments Manager)?

It is permissible for academic applicants to apply for the Programme Manager or the Deployment Manager posts, provided a strong case is made for these in their operating model. However there is a benefit in going to open advertisement for these roles with the skill sets required for this work. An advertisement for the post of Director will be made open once the final division of activities and budget is agreed. Academic partners will be eligible to apply for this post.

39. Please explain the process for choosing the Director: Where will they be based, how will they be chosen, and can they be from an entirely different institution than the selected academic bidder and PHE?

A decision on where the Director will be based will be made once the academic partner has been selected, the proposals have been reviewed, and the guidance on the division of activities has been suggested by the NIHR review panel. The Director will be appointed through an open advertisement and it is envisaged he or she will have an honorary contract
with whichever institutions he/she is not directly based in. As such, he or she can be from the selected academic institution, PHE, or a different institution altogether.

40. Can the team have joint or co-Academic Leads?

No. The RRT will be led by a single academic lead, who will have a contractual relationship with the academic partner and who will work in partnership with the Director of the UK Rapid Response Team.

41. We have looked at how institutional approvals work in the submission system and seen the section that requires a wet signature. It looks like this is only signed by the lead institution; I couldn’t see an option for collaborating institutions to sign anything. If we decide to work with a collaborating institution, do they need to provide institutional approval too?

Because you are encouraged to detail only those academics from your university at this stage, a wet ink signature is only required from the applying university.