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Department of Health & Social Care

Operational Response Centre (ORC)

Lessons Learned Review

Findings

Health and Social Care COVID-19 Response

September 2020

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INTRODUCTION

1.1 COVID-19 brought with it unprecedented challenges in all aspects of life, including to the work of the staff of the Department of Health and Social Care (DHSC), and that of those working in partner bodies such as Public Health England (PHE) and NHS England and Improvement (NHSE&I).

1.2 It is important to learn lessons from the Government's response to COVID-19 and this paper outlines one evaluation of how DHSC led the Health and Care Sector response to COVID-19 between January and June 2020. It offers suggestions about how we might approach future health incidents considering what we have learned in recent months

1.3 This review used a mixture of interviews with senior figures both inside the Department and key stakeholder bodies). We conducted over 40 interviews with senior stakeholders, 15 workshops with key groups, and a survey which received 276 responses from across the Department. These were all focused on 8 key lines of enquiry:

i. Preparation and planning;
ii. Incident response;
iii. Organisation;
iv. Governance;
v. Policy development;
vi. Data;
vii. Communications and engagement;
viii. People and skills.

1.4 We sought to include views from as many relevant stakeholders as possible. This review is intended to complement work underway across the Department and sector in response to the first wave of COVID-19 and in preparation for a potential second wave.

1.5 Our findings draw on the evidence we have gathered from key stakeholders, and that evidence has been used to inform key findings, which are set out below under the eight lines of inquiry.

1.6 Recommendations based on these findings can be found at the end of the paper. The DHSC Oversight Board will review progress in implementing these recommendations starting in October 2020.

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PREPARATION AND PLANNING

2.1 COVID-19 is a novel virus with unprecedented impact. We could not have anticipated the epidemiology of this disease. Planning for pandemic flu and preparation for the UK exiting the European Union strengthened our departmental preparations for major incidents affecting health and social care. For example, the Pandemic Flu Bill provided the blueprint for the Coronavirus Act.

2.2 Previous work on pandemic flu preparedness was significant in supporting the response to the COVID-19 outbreak, but the coronavirus outbreak was on a different scale and flu preparations alone were clearly insufficient. For example, pandemic flu stockpiles of Personal Protective Equipment (PPE) and medicines were not of the size and type needed for COVID-19.

2.3 It's also pertinent to note that the department's strategy for dealing with COVID-19 went from 'delay' to 'suppress', a strategy we had not previously included in pandemic flu planning.

2.4 In the early days of the COVID-19 response, it was considered by some that there was a lack of clarity around roles and responsibilities within the Department, across the arm's-length bodies and across government. Part of this was due to the unprecedented nature of the incident and the immediate challenges the Department faced.

2.5 At the beginning of the incident, the EPRR Operational Response Centre (ORC) led the initial response, working closely with the Chief Medical Officer's (CMOs) office.

INCIDENT RESPONSE

3.1 The ORC, also called the Incident Response Team, was the initial responder to the incident and was officially stood up to work on COVID-19, from 20 January 2020.

3.2 The ORC fulfilled a number of unique and specific functions which added considerable value to the Departmental response including the provision of a daily 'sitrep', the use of embedded staff from OGDs, the establishment of the Single Point of Contact (SPOC) mailbox, a daily rhythm, including a daily policy cell directors' meeting, daily national health sector call and a daily meeting with the Secretary of State.

3.3 The ORC was under extreme pressure in the early phase of the response. While a Volunteer Emergency Response Team (VERT) programme existed in the Department, meaning that trained staff with the necessary experience and skillset could have been deployed to the incident, it proved difficult to get these staff released from their "business as usual" roles because work had not been deprioritised. The ORC was under-resourced at this stage (63% shift allocation in early February) with wider deprioritisation not as swift as it could have been. In the later stages of the response, the ORC was staffed by officials

from other government departments and organisations meaning they had little relevant expertise or suitable health sector experience.

ORGANISATION (INCLUDING IT)

4.1 The unique nature of a global pandemic and tremendous pace of events inevitably led to changing expectations and the need to adapt at speed. The Department adapted with great flexibility to meet the emerging challenges of the pandemic.

4.2 Early in the response, the Strategic Incident Directors within the ORC outlined the three phases of crisis response: the first is managed by the incident response team; the second required incident response and policy cells working together; and the third engaged the whole department. There were, however, no agreed trigger points for movement between these phases identified in advance.

4.3 The development of the battleplan set the strategic direction across the Department and aligned with wider government strategy. Given the pace at which the incident was developing, staff reported some silo working and a lack of understanding of the responsibility of some teams.

4.4 Global Health Security and international engagement functions played a significant role in the response. For example, the two leading UK vaccine candidates both arose from research DHSC (though the Global Health Security Programme) is funding and we benefitted from WHO analysis and guidance.

4.5 The IT system, including the hardware, software and communications platforms, were adequate but with some room for improvement. The move to Microsoft Teams was well received but there continue to be some limitations on functionality. The lack of a collaboration document management system, such as SharePoint or Google Drive, impacted teams' ability to work at pace.

GOVERNANCE

5.1 Many respondents commented on the need for clear governance arrangements which should be established at an early stage. The Department adapted EU Exit structures for organisation and governance and used the Assurance and Oversight Board to bring the senior leadership team together. The Board focussed primarily on information sharing and the battleplan and less on policy and strategy. The need for a longer-term view was recognised by the Governance Review.

5.2 Decision making at pace within the Department was widely considered to have been successful. Senior participants noted that they were empowered to make transparent decisions and spend money. The Department was able to make financial decisions, within certain parameters, with a heightened risk appetite due to an agreement with HM Treasury. The agility offered by this different operating model should be retained, though the discipline of greater quality assurance should return.

5.3 Similarly, due to the dynamic situation, complex discussions were sometimes taken in senior meetings without a formal submission to set out accountability. While this assisted decision-making at pace, it meant there was not always a clear audit trail for rapidly evolving strategy. This improved as the incident progressed.

5.4 The initial pressure to reduce cases and lower death rates meant working (at most) one month ahead. This meant there was little space to develop long term solutions and strategies to problem solve.

5.5 Effective working level relationships with officials in the devolved administrations did not always directly translate into aligned evidence-based decisions which undermined some interventions (e.g. different policies on wearing face coverings on public transport).

5.6 Cross-government working was challenging at times given the pace and rapid evolution of the situation. The role of those embedded in the department (embeds) became increasingly significant, for example in supporting and developing requests for Military Aid to Civilian Authorities.

POLICY DEVELOPMENT

6.1 DHSC had been designed as a small strategic policy department yet the COVID-19 response necessitated a pivot to greater crisis response and operational delivery capability, which was not in existence prior to January 2020.

6.2 Our review has paid close attention to five aspects of the DHSC policy and delivery response: Adult Social Care; Personal Protective Equipment; Testing; Inequalities; Medicine Supply.

Adult Social Care

6.3 Many respondents suggested that Adult Social Care (ASC) should be better integrated into all aspects of the Department's emergency response. Silos arose between different aspects of the system, including between ASC and the NHS, as was shown in the discharging of ASC recipients who later tested positive for COVID-19 from ASC settings to NHS settings.

6.4 We have identified four specific areas where respondents indicated that action would help stand the Department in a stronger position ahead of any future health emergency.

Increased focus on ASC alongside NHS readiness

- The unprecedented speed with which this new virus emerged inevitably focused attention primarily on how the NHS would be able to cope. This prioritisation of the protection of hospital capacity, without adequate acknowledgement of key interdependencies, was to the detriment of ASC and led to difficulties in securing PPE, receiving testing, understanding the number of deaths, and producing guidance.
- The differences between the NHS and ASC were not well understood by all those working on the COVID-19 response, with ASC described as often being viewed through the prism of the NHS. Similarly, some of the new staff within the ASC teams had little understanding of emergency response, creating an additional skills gap.

Preparedness of the Adult Social Care Sector

- Some commented that emergency planning had assumed that care providers would be responsible for their own response, and a centralised government role had not been anticipated. Initial government expectation stemmed from the complex and largely private nature of adult social care in the UK.
- Though contingency plans were in place and tested, some respondents stated that the pandemic highlighted glaring omissions in strategic direction of integration and preparedness meaning that the social care system was not able to respond to a major health emergency.

Understanding and communication of responsibilities during an emergency (in the sector and the department)

- Although the roles of local and national government are clearly laid out in statutes, some considered that this became muddied during the pandemic. It was argued that central government took a more interventionist approach than it would in 'peace time', performing what would could have been considered the role of local government. It was not clear to many stakeholders the extent to which DHSC would have operational responsibilities for ASC and during the ASC peak of the pandemic, some thought that the Department was not embedded in regional infrastructure as well as it could have been.

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- The ASC Task Force will play an important role in defining a 'roadmap' for what comes next which will help stakeholders support their planning and preparations for a second wave or future emergencies. It will be important for long-term strategy to be coordinated through existing stakeholder bodies.

Working with partners and stakeholders

- Whilst civil servants working on health issues engage with NHS E/I as the executive arm of healthcare, engagement with the ASC sector is more complex. Operating nationally across 152 councils and over 20,000 providers created challenges that were not experienced in the same way in the NHS. There is a lack of briefing line of sight from local government to national government and local providers seeking support reported a lack of clarity and structure through which to obtain supplies.

- Although the decision by the CQC to put routine inspections on hold enabled providers to focus more closely on the direct provision of care, it also removed one of the Department's lines of sight into ASC and limited its direct knowledge of what was happening on the ground. CQC hold the central database of care providers and this meant the Department was largely dependent on CQC for early warning of failures and disruption to inform its decision making.

PPE

6.5 An Independent Assurance Review (IAR) of the PPE Programme has been completed. The following findings are intended to complement the recommendations put forward by the IAR

Strategy

- PPE preparation for a significant incident of infectious disease was focused on a flu pandemic, to reflect the National Risk Register. The PPE stockpile was, therefore, inadequate to meet the unprecedented scale of demand created by COVID-19.
- Given the fast pace of the incident, Departmental decisions focused on the immediate everyday operational requirements for PPE rather than longer-term planning and strategy. The appointment of a PPE Policy Director will help to address this going forward.

Procurement

- Understandably, procurement received a lot of attention where other aspects of PPE did not. The pace required meant that some purchases were made of products which

proved to be not-fit-for-purpose, stock was ordered with no estimated time of arrival and we were not well placed to understand the wider PPE marketplace.

Data

- Much of the PPE procurement was informed by forward planning using the Reasonable Worst-Case Scenario modelling rather than a detailed and nuanced understanding of PPE usage and demand. Having that nuanced data and modelling, supported by real-time data, would have enabled us to better meet requirements and avoid surpluses"

- There was insufficient data available to consider equality issues around PPE provision. A retrospective equality impact assessment is being undertaken and will help address these concerns.

Testing

6.6 While infectious disease testing is widely undertaken within the health and social care system, there was widespread recognition that the unprecedented scale of the testing requirement was challenging. Key messages include:

Delivering at pace

- The Department would have benefitted from a fuller understanding of the response by Asian countries (recognizing the contexts are very different) earlier in our planning, which might have enabled us to start to build testing systems earlier in January 2020.
- It would have been beneficial to establish Test and Trace simultaneously with an increase in NHS testing capacity in March/ April.
- The Testing programme was set up at considerable speed but was developed by policy specialists rather than those with operational delivery experience. The result was that the programme did not have the benefit of their input into the design of the management structure or governance needed in an operation of that scale.

Organisational effectiveness

- The structure of the testing pillars created silo working across health sector organisations. At the outset, the absence of a unified leadership for Test and Trace was a significant issue.
- The lack of engagement by NHSE on commercial testing meant separate testing infrastructure had to be built outside the NHS, created divisions and hampered full collaborative working.

Communications support

- External messaging on Nightingale Hospitals contributed to public perceptions of their success but the Test and Trace programme suffered from a lack of comparable communications support.

Inequalities/equalities

6.7 Although there was early evidence of COVID-19's more severe impacts on those of an older age group, particularly over 70s, there was a lack of initial evidence that COVID-19 would disproportionately affect those from Black and Asian ethnic minorities or those from more deprived areas. Future incidents or pandemic outbreaks should prioritise a greater understanding, at an early stage, of health inequalities and the differential impacts on different communities.

Medicine Supplies

6.8 Preparations and planning for EU Exit strengthened the Departments response to COVID-19. Shortages of medicines were managed through tried and tested processes and we benefitted from sound knowledge of medicine supply chains. Respondents considered that Department is well-prepared in terms of medicine supply for a second wave of Covid and concurrent End of the Transition Period.

DATA

7.1 The Lessons Learned review considered the data which was used to inform policy decisions and the incident response. We sought to understand the effectiveness of two-way data sharing across the Department, its arm's-length bodies (ALBs) and with external bodies.

- Within a department that does not, in normal times, hold and share detailed operational datasets, there was limited understanding of data governance and management process, in some cases leading to a lack of understanding about data ownership and restrictions on sharing data because legal, ethical and commercial constraints were not well understood.
- The importance of meeting statistical standards in public communications was acknowledged, as drawn to the Department's attention on more than one occasion by the Statistics Regulator.
- COVID-19 exposed the fact that we are structured to report England-only data which made arriving at UK-wide statistics difficult. A more systematic agreement on data needs between the DAs and England would make this task easier.
- While NHSE shared data on Nightingale hospitals efficiently, data sharing with NHSE was not always straightforward and some issues were escalated to senior official or Ministerial level.

7.2 Respondents suggested that there are concerns relating to DHSC's data infrastructure, specifically relating to identifying, obtaining and processing data.

- "There is no single departmental overview of the range of available datasets, their origins, ownership and structure and the governance arrangements relating to access to those datasets. NHSE created the 'Foundry' data sharing platform to partially address these issues but staff (and the Secretary of State) experienced access issues and its utility as a central resource was limited.
- During the pandemic, the Secretary of State authorised the collection of data via the Control of Patient Information (COPI) Regulations but these are only temporary. If

the Department is to examine or change the ways it collects and utilizes data for the longer-term, legal changes will be required.

- Operational and policy response to the pandemic required very detailed data that could only be sourced from patient level datasets.

7.3 There was insufficient specialist resource and analytical capacity within the Department. Although we were able to call on enough surge resource from other Departments, supported by the head of the Analysis Function across government, it took time to source and deploy that resource.

7.4 Respondents stated that data flows and a lack of understanding of data ownership combined with the rigidity and sensitivity of cross-government modelling assumptions, led to operational problems for modelling groups meaning teams were planning based on figures they sometimes considered unrealistic.

COMMUNICATIONS AND ENGAGEMENT

Internal

8.1 The Department effectively managed its rapidly evolving teams and the move to working from home. Engagement within teams was largely effective, though identifying and maintaining correct records of individuals responsible for teams or policy areas was challenging as the Department's directory quickly became out of date and was not available to those outside the Department.

External

8.2 Engagement with the DAs was largely considered to be effective at official and Ministerial level, particularly in incident response and on policy areas such as vaccination research and testing. The view of DAs and Territorial Offices was that information sharing was sometimes late and policy teams did not always have a clear understanding of issues relating to the devolved nature of health and social care.

Public Facing

8.3 The development and dissemination of guidance was sometimes delayed around clearances and publication. NHSE/I was able to put NHS-facing guidance on their website but gov.uk did not enable easy mass communication with the public.

8.4 Some respondents stated that engagement with different ethnic and marginalised groups was limited and, when it did occur, there was little opportunity for teams to get feedback on the practical implementation of published guidance.

PEOPLE AND SKILLS

9.1 In a matter of weeks, the department worked across the civil service and ALBs to import **over 1,300 people** (almost doubling the size of the department).

9.2 Despite this achievement, the department still faced a significant challenge in identifying and bringing on-board internal and external surge and crisis capacity. This reflects cross-government challenges in rapidly deploying and moving staff around the system. Below are some lessons for future scaling up of resource:

Prioritisation and Resourcing

9.3 The Department was slow to deprioritise "business as usual" work to focus on COVID-19. Staff were therefore unable to prioritise COVID-19 work and senior leaders were unable to release staff to join the emergency response.

9.4 In preparing for EU-Exit, the department established and trained staff to form a Voluntary Emergency Response Team (VERT) that could be quickly stood up in an incident. This did not work well in practice as senior leaders were unable to release VERT trained staff. The Department now has an unprecedented number of staff trained through experience of incident response and we should seek to maintain and utilise this expertise in future emergencies. An alternate model of deployment should be established.

Roles, skill-matching and induction

9.5 Most staff who responded to our survey felt that their role adequately suited their skill set but it is not clear that peoples' skills and experience were strategically considered in the allocation of roles. This was particularly important outside the more established professions (such as HR and Finance), where teams expressed their requirements in terms of grade rather than skills and, as a result, some civil servants were allocated according to grade rather than experience.

9.6 Clinical expertise was invaluable in informing decision making throughout the response. Clinical advice was thorough, sound and reasoned. Limited capacity did, however, put increased pressure on a limited number of individuals.

9.7 Generally, staff appreciated the induction materials provided by HR and recognise that formal induction was unlikely to be possible given the pace of movement. However, a lack of consistent induction practices for new starters made it difficult for staff to step straight into roles effectively. This was compounded by the move to working from home which left some staff feeling they were missing information they might expect to hear in the office. Teams who set up small project management offices specifically related to onboarding new joiners reported more successful onboarding.

9.8 The response was well staffed at SCS and junior grades but effective 'middle management' was considered missing across the Department which created a 'bottleneck' of decision-making responsibility. This also compounded the lack of induction and formal line management experienced by new starters.

Ways of working

9.9 The transition to working from home was considered a real success. 91% of survey respondents strongly agreed or agreed with the statement 'my team transitioned well to

working from home after lockdown restrictions were introduced'. Working from home created a more level playing field between Leeds, London and those who usually work from home. HR toolkits on working from home, wellbeing and managing remotely were helpful but not always shared with staff by senior leaders.

9.10 There is a recognised need for core incident response roles to be office based but, in future, more careful consideration should be given for which roles are critical to reduce pressure on staff with shielding responsibilities.

9.11 Shift working assisted with productivity and reduced burn-out but reduced continuity and the introduction of shift patterns to some teams and not others led to unsustainable demand on non-shift teams.

9.12 Job shares, primarily introduced for senior staff, were successful and could be implemented more widely in future incidents. Consideration should also be given to Ministerial job-shares in an incident. The most successful 'job shares' were those where at least one of the pair had existing expertise in the work area.

Wellbeing

9.13 Staff interviewed and surveyed for this exercise reported that they felt supported with their own wellbeing at the beginning of the pandemic but less so as it progressed. Responses from the 2020 cross-government pulse survey help to give a fuller picture. Most respondents felt supported by their managers through this period and in the week before the survey most felt okay or positive. However, almost half of respondents were unsure about how to access wellbeing support.

9.14 Only a small percentage of respondents did not yet have access to the workplace adjustments they need and reported being unable to work at all from home. Nonetheless, during this exercise, several staff working directly on COVID-19 raised concerns about guidance for staff with caring responsibilities, identifying and supporting staff at risk of work-related stress and tackling feelings of isolation and loneliness when moving to working from home were all raised.

9.15 Contracted staff (e.g. IT and security) reported that did not feel they were protected or listened to as much as non-contracted staff and there were no formal routes to raise concerns about a lack of PPE or regular contact with shared equipment.

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RECOMMENDATIONS

10.1 The findings from this review have been turned into a list of actionable recommendations. These recommendations are practically focused, with many achievable in the next few months.

Planning and Preparation

Recommendation	Responsible post	Owner	Deadline
3.1 Carry out high quality and large-scale exercises focusing not just on flu but other communicable diseases (e.g. Vector-transmitted diseases, Coronaviruses) and general pandemic preparedness. These must include all affected participants, with a range of epidemiologies and a breadth of scenarios. A list of recommendations must be made available after exercises and disseminated across the health and social care system.	Director, Emergency Preparedness and Health Protection (EPHP)	Emma Reed	Ongoing
3.2 Develop a process for determining which disease/generic preparedness we need to be preparing for.	Director, EPHP	Emma Reed	January 2021
3.3 Need to establish incident response communications strategy with OGDs. All relevant departments across government must in the future be involved in pandemic planning.	Director, EPHP	Emma Reed	October 2020
3.4 Each policy cell to establish a strategy of working in the event of an incident e.g. exactly what staff/expertise would be required, team management structures and organogram.	Directors		October 2020
3.5. Increase capacity and expertise within the department in general, but on health security more specifically, in order to have greater resilience within the department for crises such as these.	Director, EPHP	Emma Reed	November 2020 and ongoing

Incident Response

Recommendation	Responsible post	Owner	Deadline
4.1 Amend the incident response playbook, considering the points raised in this report.	Director, EPHP	Emma Reed	November 2020
4.2. Formalise the knowledge and skill-set necessary for a health and social care incident response, particularly at more senior levels. Formalise the same for individual teams within an incident response team. Develop a strategy alongside this for skill-to-role-matching.	Director, EPHP	Emma Reed	October 2020
4.3. Develop an EPRR-specific induction pack, including clear role descriptions.	Director, EPHP	Emma Reed	October 2020

4.4. Clear responsibilities of the ORC to be given on an organogram and distributed around the department and ALBs as soon as an incident is stood up. Establish clear mechanisms for communicating organisational structures and roles to all staff involved in response.	Director, EPHP	Emma Reed	Ongoing
4.5. Create a list of contacts in the ORC that can be accessed within the department and by outside stakeholders. This list to be updated regularly in an Incident.	Director, EPHP	Emma Reed	October 2020
4.6. Establish approaches and systems for filing and visual management within the ORC.	Director, EPHP	Emma Reed	November 2020 and ongoing
4.7. Work up an approach to shutting down an incident team: describing when to do it, and how to do it.	Director, EPHP	Emma Reed	November 2020
4.8. Ensure that the following points around embeds are built into the 'play-book' for an incident response: a clear description of the role of the embed; the point that embeds are to be clearly established at the start of a future crisis response; the power for ALBs and teams across the department to nominate themselves for inclusion.	Director, EPHP	Emma Reed	November 2020
4.9. Refine and record daily rhythm practices established during the COVID-19 ORC. Include these practices in the 'play-book' for an incident response as an example, though with the caveat that each incident is different.	Director, EPHP	Emma Reed	November 2020
4.10. Build 'establishing a SPOC and action trackers immediately' into the Incident Response playbook.	Director, EPHP	Emma Reed	November 2020

Organisation

Recommendation	Responsible post	Owner	Deadline
5.1 Agree roles and responsibilities and an approach to coordinate any future incident response throughout the department at the outset including how various workstreams will be coordinated	Director, EPHP	Emma Reed	September 2020
5.2 Establish a clear process identifying the triggers required for moving from one phase of incident response to another, with a cross-department understanding of when the whole department needs to be engaged.	Director, EPHP	Emma Reed	September 2020
5.3 Fully expand the functionality of Microsoft Teams and provide training to ensure optimal use of the platform.	Director, Workplace and Transformation	Name Redacted	Phased rollout from August 2020
5.4 Consider and assess potential IT platforms or services to implement across the department that enable collaborative editing and provide training to ensure optimal use of the platform.	Director, Workplace and	Name Redacted	During 2021

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	Transformation		

Governance

Recommendation	Responsible post	Owner	Deadline
6.1 Ensure that guidance on ensuring that records are correctly maintained is built into the induction for all new starters.	Director, Workplace and Transformation	Name Redacted	Link to Induction recommendation.
6.2 Establish a clear expectation from the beginning of an incident for the decision audit trail, to be agreed and shared across all teams within the department.	Director, EPHP	Emma Reed	Next Time an Incident Occurs
6.3 Ensure that leadership structures within the Incident Response, wider Department and its Arms' Length Bodies and the devolved administrations are clear and transparent from the beginning, with clearly defined and agreed roles and responsibilities	Director, EPHP	Emma Reed	Next Time an Incident Occurs
6.4 Develop a process to keep people across the department up to speed with what is happening and provide a wider context to their work.	Director, EPHP	Emma Reed	Next time an Incident Occurs
6.5 To support longer-term decision making there is a need for a strategic COVID-19 board. The governance review currently underway should consider these findings to work through the detail required to deliver this, including details on membership.	Director, COVID-19 Programme	David Whineray	September 2020
6.6 As part of recommendation 6.6 there should be greater clarity around governance arrangements and linkages with programmes within the department such as Test and Trace.	Director, COVID-19 Programme / Director Ministers, Accountability and Strategy	David Whineray/ Hugh Harris	September 2020

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Policy

Adult Social Care

Recommendation	Responsible post	Owner	Deadline
7.1 Ensure that ASC is fully integrated and embedded within policy areas across the department on an equal footing to the NHS.	DG for Adult Social Care (ASC)/all DGs	Michelle Dyson/ExCo	October 2020
7.2 Establish a process to ensure that ASC is fully linked into the ORC from the beginning of an incident	DG for ASC/ Director, EPHP	Michelle Dyson/ Emma Reed	October 2020
7.3 Establish clear and transparent lines of responsibility to produce guidance which can be shared with the sector	DG for ASC/Director COVID-19 Programme	Michelle Dyson/ David Whineray	October 2020
7.4 Establish processes to ensure the diverse voices of adult social care are engaged from the beginning of future incidents	DG for ASC/ Director, EPHP	Michelle Dyson/Emma Reed	October 2020
7.5 Further develop understanding of the broader ASC sector within the department, within and outside the ASC teams.	DG for Adult Social Care (ASC)/all DGs	Michelle Dyson/ExCo	January 2021
7.6 Ensure that ownership of incident response in ASC is clearly understood across the department and that ASC is embedded within local and regional incident response infrastructures.	DG for ASC/ Director, EPRR	Michelle Dyson/ Emma Reed	October 2020

Personal Protective Equipment

Recommendation	Responsible post	Owner	Deadline
7.7 Institute the seven recommendations made by the independent assurance review in full, with a Director ensuring they are properly embedded into the PPE programme, by remaining in the team for the duration of their implementation.	Director, PPE Policy	Peter Howitt	September 2020
7.8 Future stockpile must be based on planning for multiple pandemic scenarios.	Director, EPHP/Director, PPE Policy	Emma Reed/Jonathan Marron	March 2021
7.9 The department must produce a longer-term strategy for PPE which includes issues such as environmental concerns.	Director, PPE Policy	Peter Howitt	October 2020
7.10 A sustainable operating model should be developed on where responsibility for PPE delivery sits within the health and care sector, to be in operation from April 2021.	SRO PPE programme	Jonathan Marron	January 2021

7.11 Produce clear guidance on the procurement of PPE, including specific guidance for crisis situations. This must follow the appropriate recommendations of the IAR with emphasis on audit trails and financial controls.	Director, Commercial	Melinda Johnson	November 2020
7.12 Institute a more rigorous orders management process and vetting of PPE suppliers before purchase orders are made, including clarity over ETAs and internal coordination around them. In line with IAR recommendations, establish a succession plan and a contingency/ surge plan, alongside a contracts database that is maintained.	SRO PPE programme	Jonathan Marron	November 2020
7.13 Adopt a proper governance/ controls structure, with a single Senior Responsible Official, a critical path, delegative authority, and financial governance.	SRO PPE programme	Jonathan Marron	October 2020
7.14 Ensure that PPE within adult social care settings is adequately addressed in the ASC winter plan and the PPE mid- to long-term strategy.	Social Care Director/Director PPE Policy	Stuart Miller/Peter Howitt	October 2020
7.15 Provide DA/CD colleagues with named officials who act as a single-point-of-contact.	Director PPE Policy	Peter Howitt	September 2020

Testing

Recommendation	Responsible post	Owner	Deadline
7.16 The department should develop a coordinated testing strategy which includes ASC; moves beyond a focus on achieving targets and has a clear framework for organisational structure and governance, including clear roles and responsibilities.	Director, Testing Policy	Gila Sacks	September 2020
7.17 Health inequalities must be considered as part of all policy decisions on testing, and scientific evidence which informs policy decisions must be communicated accurately.	Director, Testing Policy	Gila Sacks	September 2020
7.18 Ensure that testing is addressed in the ASC winter plan.	Social Care Director/Director, Testing Policy	Stuart Miller/Gila Sacks	September 2020
7.19 Steps should be taken to ensure that future testing policy work does not operate in silos and is communicated effectively between teams.	Director, Testing Policy	Gila Sacks	October 2020

Inequalities

Recommendation	Responsible post	Owner	Deadline
7.20 Future work on COVID-19 should consider inequalities from the outset, including age, income and ethnicity, referencing this appropriately in submissions	All DHSC SCs	All DHSC SCS	Ongoing (use Submissions Review process)

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alongside the requirements of the Public Sector Equality Duties			
7.21 In work on future incidents and emerging health threats it should be assumed (until evidence emerges to the contrary) that ethnic minorities and lower income backgrounds are disproportionately affected, and policies developed accordingly. Other factors such as age or apparently unrelated health factors, such as obesity, must also be considered.	All DHSC SCS	All DHSC SCS	Ongoing
7.22 The Inequalities/Equalities Policy Certificate has been updated to reflect COVID-19 content. There should be a concerted push for uptake of this training.	Director	Mark Davies/ Hugh Harris	Report on uptake December 2020

Medicine supply

Recommendation	Responsible post	Owner	Deadline
7.23 The Department should build on its EU Exit preparations to develop and maintain its own stockpile of coronavirus medicines.	Director of Medicines	Liz Woodeson	December 2020

Data

Recommendation	Responsible post	Owner	Deadline
8.1. In developing the Data Strategy or Health and Social Care, NHX should consider setting out the existing legal and administrative processes and potential improvements to the legal framework for the sharing of data across the health and social care family, including DHSC.	NHSX Director of Strategy/Director of Analysis	NHSX/Chris Mullin	November 2020
8.2. The Department's Data Policy Team, based in NHSX, should develop an intranet presence outlining their role and responsibilities; how departmental teams can access data; and create a mailbox for departmental queries.	NHSX Director of Strategy/Director of Analysis	NHSX/Chris Mullin/NHSE	December 2020
8.3. The Health Data Leadership Group established by NHSX bringing together data leaders across health ALBS and DHSC, should support the sharing of best practice and resolution of data sharing issues	NHSX Director of Strategy/Director of Analysis	NHSX/Chris Mullin	October 2020
8.4. Conduct a review into effective working with DAs and CDs to identify and share best practice in application and use of data, including an investigation into best practice in data linkage and effective re-use. Consider scope for UK-wide statistical approaches in areas where devolved policies are sufficiently aligned.	Director of Analysis	Chris Mullin (working with Sophie Eltringham)	December 2020

8.5. NHSX to work with NHSE and NHSD and the health analytical community to consider the technical infrastructure required to support data sharing and analysis.	NHSX Director of Strategy	NHSX	April 2021
8.6. Training to be developed and offered to the department on data, including how to recognise when numbers need rigorous statistical analysis and analytical governance.	Director of Analysis	Chris Mullin/Policy Improvement Team	December 2020
8.7. Increase the amount of analytical and statistical resource within the department.	Director of Analysis/ Director of HR	Chris Mullin/Jenny Richardson	Ongoing
8.8. Re-examine the way the Department can adapt its rigorous approaches to modelling during crisis response.	Director of Analysis	Chris Mullin	October 2020

Communication and Engagement

Recommendation	Responsible post	Owner	Deadline
9.1 Respond to feedback regarding difficulty identifying and maintaining correct records of individuals responsible for areas of work. Seek to find live, creative solutions to map key contacts across the department, ALBs and other departments.	Director of HR/Director of Communications	Jenny Richardson/ Wendy Fielder	October 2020
9.2 Establish a clear UK wide incident response strategy for engagement and decision-making during incident response and rapid policy development; setting out how structures operate, the type of engagement expected and how the department, DAs and TOs should be joined up to coordinate UK-wide policy decisions.	Director, COVID-19 Programme	David Whineray	November 2020
9.3 Offer training for every grade on engagement with devolved administrations and the role of Territorial Offices in policy development. This training should be made mandatory for incident response and policy staff working on UK-wide policy. This could be done in conjunction with Cabinet Office.	Deputy Director, Union	Sophie Eltringham	November 2020
9.4 Engage with media regularly to ensure transparency of government actions, even if the message is not solely reassuring.	Director of Communications	Wendy Fielder	Ongoing
9.5 Ensure future guidance processes are established early with clear co-production and feedback loops for respective policy teams and, where possible, direct engagement with sectors Also, explore the best ways to disseminate guidance to the public and key sectors.	Director, COVID-19 Programme	David Whineray	November 2020 and ongoing

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Chapter 10 People and Skills

Recommendation	Responsible post	Owner	Deadline
10.1 Develop formalised process (with ExCo, the Joint Biosecurity Centre, Ministers and others) for triggering de-prioritisation of BAU work to focus on COVID-19 and other incidents.	Director, Ministers, Accountability and Strategy	Hugh Harris	October 2020
10.2 Establish formal reprioritisation mechanism to be run on a weekly basis during a large-scale incident. Identify triggers of when to scale-up or scale-down resourcing and reallocate existing resource, according to changing demand on teams across the department.		Incident Oversight Board	October 2020
10.3 Establish and maintain a live list of people from across DHSC, ALBs and OGDs with the skill set and experience for future responses, supplementing the existing VERT list. Consider implementing a formalised 'secondary role' in incident response for such staff to improve uptake when called upon.	Director, EPHP	Emma Reed	October 2020
10.4 The department's HR function should regularly refresh induction materials to ensure that the most appropriate induction content is ready to use immediately once an incident occurs. These induction materials should seek to include more information about the adult social care sector (further detail on the adult social care sector can be found in section 7A). It should also establish a systematic way of ensuring all new starters are invited to induction events from the start of an incident, as well as regularly communicating the presence of induction materials to all staff. All team leaders should seek to familiarise themselves with updated induction materials and establish formal procedures/persons responsible for onboarding new staff.	Director of HR	Jenny Richardson and Directors (inc ASC DG)	October 2020 and ongoing
10.5 Improve skill-to-role matching by ensuring teams requiring resource are explicit in the requirements of the role and new joiners are systematically asked about relevant skills and experience. Recruit specifically for specialist skills where needed, including analysts, clinicians and data-scientists.	Director of HR	Jenny Richardson and Directors	Ongoing
10.6 The department should ensure that, in a crisis, 'middle management' roles (Grades 7 and 6) are appropriately resourced and that line-management structures are more formally agreed to support new staff.	Director of HR	Jenny Richardson working with Directors	Ongoing

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10.7 Establish a reduced skeleton team of roles requiring in-office working sooner in an incident where minimizing social contact is necessary, and support staff to work safely in the office or from home according to government guidance as soon as it is released.	Director, EPHP	Emma Reed	October 2020 and Ongoing
10.8 Establish alignment across the department between working patterns. Those teams not needing or able to move fully to shift-working should seek to establish some shift-working within their team to protect staff. Teams moving fully to shift-working should assign standard hours to some staff to ensure continuity across shifts.		Incident Oversight Board	Ongoing
10.9 Formalise triggers to implement job-shares more quickly and widely across the department in an incident, including for ministers.		SoS (Ministers) and Exco (Officials)	November 2020
10.10 Ensure existing guidance on working from home, wellbeing and managing remotely is regularly disseminated and applied by team leaders as standard. Ensure there is clear guidance (and knowledge of this guidance) for staff with caring responsibilities that will be exacerbated by health crises.	Director of HR	Jenny Richardson	October 2020
10.11 Ensure that the safety of contracted staff is prioritised as much as that of non-contracted staff, including through the provision of appropriate PPE. Establish formal routes of communication and escalation of issues for contracted staff.	Director, Workplace and Transformation	Name Redacted	October 2020 and ongoing