The Association of Directors of Public Health

UK Covid-19 Inquiry: Survey of Directors of Public Health Summary Report

INTRODUCTION

In January 2023, the UK Covid-19 Public Inquiry Team asked ADPH to conduct a survey of Directors of Public Health (DsPH) as part of a Rule 9 Request for Module 1. This survey covered questions regarding pre-pandemic preparedness and planning at a local level to be used to draw lessons for the future. The survey questions were written by the Public Inquiry Team in collaboration with ADPH, following this ADPH was then responsible for distributing the survey.

The survey was shared with 160 DsPH on 15 February 2023 via Survey Monkey, and closed on 31 March 2023. In total, 124 responses were received from DsPH and their teams (a 78% response rate), some of which are joint responses representing more than one local authority/health board. In total 135 local authorities/health boards were captured within the survey.

The responses shared below are grouped into the main sections of the survey and DsPH answers have been presented as a summary. Where appropriate graphs displaying quantitative findings have been included. For more information on ADPH's rationale and approach to the analysis, please refer to ADPH's Member Survey Analysis Methodology document.

Throughout the document, we will use DsPH to refer to all UK DsPH unless explicitly specified eg DsPH in Scotland.

There are many acronyms used throughout the document, when reading please refer to appendix 1, which contains a list of acronyms.

For the full list of questions that were shared with DsPH, please refer to appendix 2 which contains the questionnaire in full.

General role and response to the Covid-19 pandemic

The DsPH who completed our survey had served at their current organisation, on average for 4 years and 1 month. With the newest appointed DsPH having served only 1 month in post, and the longest serving DsPH serving 9 years and 11 months. [Question 1] The DsPH had served in total (including their previous roles) on average for 6 years and 1 month. With the newest appointed DsPH having served 2 months in post and the longest serving DsPH serving 22 years. [Question 2] The vast majority of DsPH were answering on behalf of only one local authority, with seven DsPH answering on behalf of two local authorities and two DsPH answering on behalf of three local authorities. [Question 4] 72% of DsPH sat on a senior executive team in their organisation, whereas 28% of DsPH did not. [Question 5]

Please see to right, the total responses divided by each region (including the devolved nations and British Crown Dependencies or Overseas Territories).

Further please see the chart below which shows the regional percentage completion.

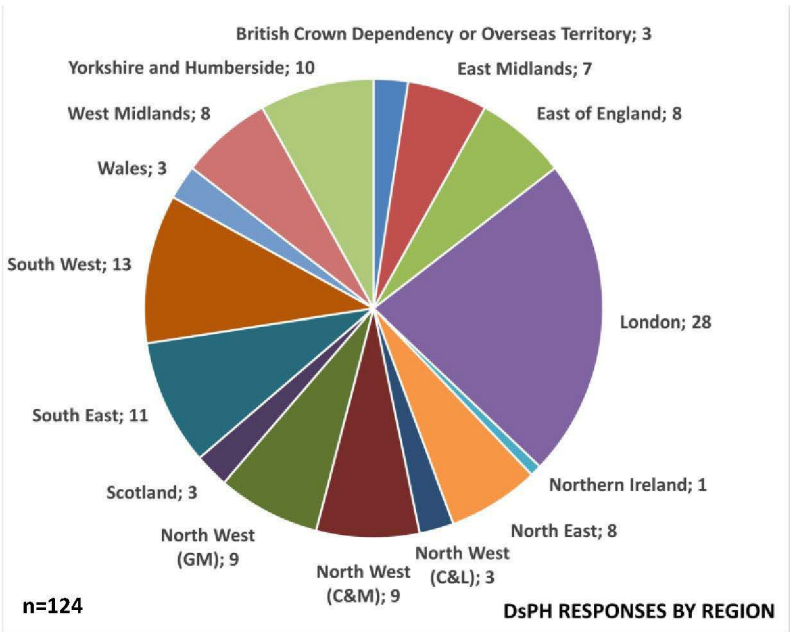

Figure 1: DsPH responses split by region [Question 3]

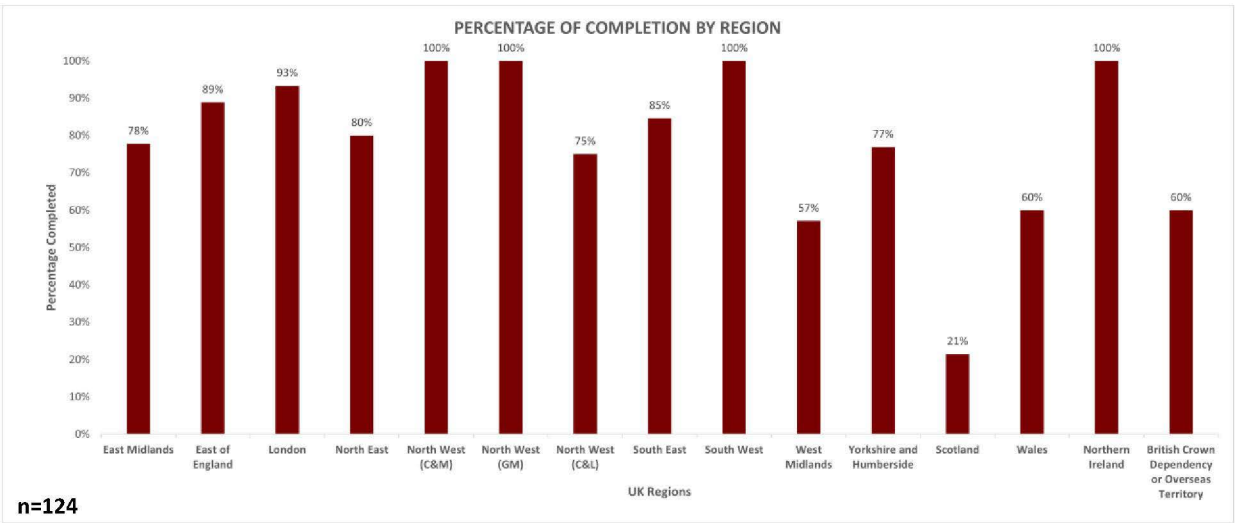

Figure 2: DsPH percentage of completion split by region [Question 3]

Most DsPH considered their role during a pandemic somewhat or significantly defined. Usually, the answer to this question was structured around an influenza outbreak, as the majority of the planning before January 2020 took place around a possible influenza pandemic. Many DsPH stated their role was specifically defined in their local pandemic plans.

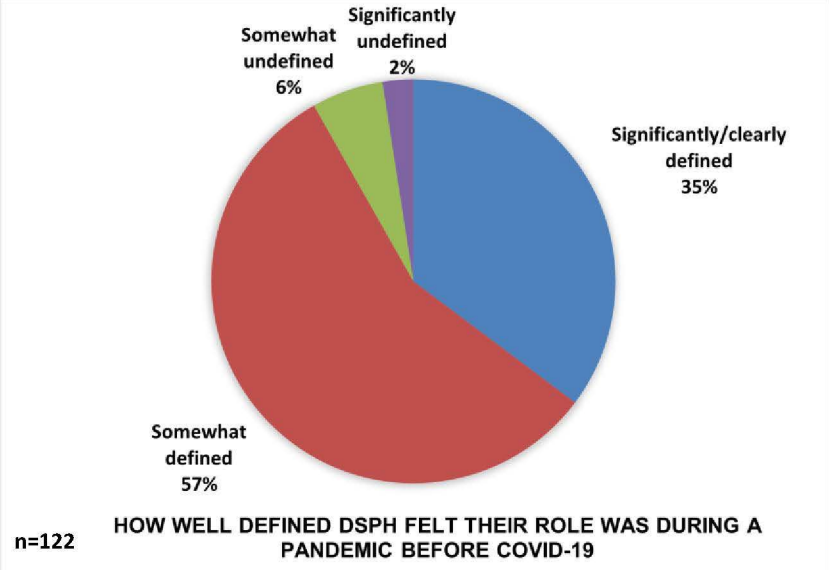

Figure 3: How well defined DsPH felt their role during a pandemic before Covid-19 [Question 6]

Several key national documents referred to DsPH in both the planning and the response phase of a pandemic, such as the DHSC's Influenza Pandemic Preparedness Strategy 2011 and the DHSE/PHE guidance Directors of Public Health in local government: roles, responsibilities and context 2013 (updated January 2020). DsPH felt their role was well understood by LAs but there was less understanding in national government, such as in the Home Office and Department for Education which may have been less familiar with pre-existing pandemic plans. In Scotland, pandemic preparedness guidance was in place which could be used to define the DPH role. Similarly in Wales, the DPH role was clearly described as part of the Communicable Disease Outbreak Control Plan for Wales. Both Scottish and Welsh DsPH felt their role was less well understood by the national and local governments in both countries respectively, a key difference compared to DsPH in England. However, DsPH in Northern Ireland felt the role was clearly defined, as a result of the DsPH sitting directly within the Public Health Agency in Northern Ireland.

Many English DsPH also referred to the Health and Social Care Act 2012 and how this outlined their role in LAs. One DPH highlighted that DsPH led the H1N1 swine flu pandemic response in 2009 whilst the DsPH were in the NHS in a Primary Care Trust at that time.

The DPH role has always been about providing the local leadership, and implementing national guidance in the light of an understanding of the local situation and population, as well as developing local activity and plans – similarly to other DPH responsibilities and this is what happened during the Covid-19 pandemic. Some DsPH (approximately 5%) stated that the role became more defined during the pandemic or took on additional responsibility/accountability because of the scale of Covid-19. [Question 6]

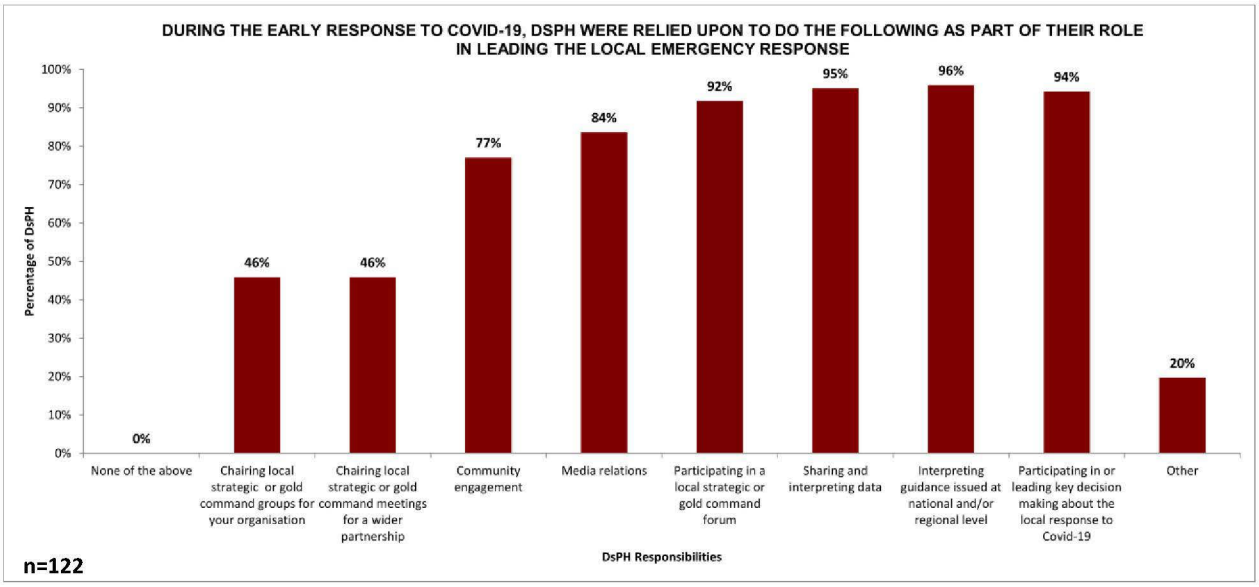

Figure 4: Which activities DsPH were relied upon to do as part of their role in leading the local emergency response [Question 7]

DsPH were not always clear about how to answer question 7, highlighting that some of the responses above relate to the 'early response' to Covid-19 and encompass February/March 2020 which is out of scope for this module specifically.

In the very early stages of the pandemic, most DsPH were leading the Covid-19 response themselves with a very small team and prior to February 2020 there was little guidance or data sharing from the National Government. This was true across the devolved nations as well. As the pandemic unfolded it took DsPH some time to establish visible leadership and develop a public health portfolio that went beyond just statutory functions.

Many DsPH mentioned their roles in LRFs or Gold Command groups in the early stages of the pandemic, which was in part as a result of the pre planning before January 2020. [Question 7]

The majority of DsPH felt that initially, there were very limited routes available to them to engage with the national approach and that, during those initial stages of the pandemic, it is widely felt that the local voice was not heard. Guidance was seen as being very 'top down' with DsPH finding out updated information at the same time as the public during the 5pm press briefings.

It is largely acknowledged that as the pandemic progressed, routes became increasingly available and local and regional meetings with PHE, LRFs, JBC and regional conveners were cited by many respondents as being their main route for receiving information and feeding back local intelligence.

Meetings with the CMO, as organised by ADPH, were seen as a "step-change" and "invaluable" in engagement with DsPH, with one DPH describing them as an "extraordinary positive step forward"

allowing for two-way dissemination of information. Note these meetings began in on 31st January 2020, outside of the scope of Module 1.

However, many respondents reported that while these routes did open up, it was unclear as to what extent their views and experiences were listened to or acted on by the system.

There were regional variations to the response to this question, with DsPH from London citing the London level regional meetings as being very valuable.

DsPH from Wales, said that they were able to inform the national response and were "extensively" engaged with managing the Welsh response, having direct engagement with the CMO for Wales.

The Crown Dependencies were able to use multiple sources of guidance to implement an effective local approach, drawing on UK and international advice and also felt involved in decision making, being able to use local evidence and experience to inform policy. [Question 8]

Local risks, surveillance and local arrangements

When outlining what systems were in place to monitor, communicate and interact with relevant bodies about emerging disease prior to January 2020, many DsPH referred to there being few or no data sharing arrangements at a national level and being reliant on individual communications about specific cases and just high-level summaries of larger data. However, two respondents referenced local multi-agency data sharing agreements.

The vast majority of DsPH cited their LHPN which brought together CCGs and PHE, as being their main point of contact to monitor, communicate and interact with relevant bodies about notifiable diseases and/or outbreaks. There was also widespread mention of LRFs, LHRPs, NOIDS reports, as well as various local regular surveillance reporting and meetings between DsPH, Environmental Health and others. Outbreak Control Teams and Local Emergency Planning groups were also referred to regarding bodies working together to respond to any outbreaks.

Several DsPH also noted ADPH Regional Network meetings as a route to share information about – and learn from – emerging diseases and trends.

In Scotland, the SHPN provided the route for information on outbreaks and in Wales, PHW coordinated and reported on surveillance. In Northern Ireland the Public Health Agency, within which the DsPH sits, are responsible for providing information. Therefore it was easy for the DsPH to access this information from within their own organisation. [Question 9]

When DsPH discussed what systems were in place to advise and communicate with the public about emerging diseases and other risks to public health, they highlighted that communications support was dependent on the situation and ranged from local to regional and national organisations/bodies. DsPH described these channels as mature and established prior to January 2020, and that communications were both reactive and proactive.

At a local level, LRFs/BRFs, HWBs, HPBs and LAs were used to communicate with the public. Whereas at a regional and national level, NHS/CCGs and PHE channels were utilised to communicate. DsPH described these as being organised 'top down' with PHE leading the communications and smaller organisations such as LAs following their guidance as required to cascade this down to a local level.

Examples of how DsPH communicated included via digital channels such as social media, via community hubs such as schools, nurseries etc and publishing items in traditional media such as press releases.

In Scotland local NHS communication teams communicated with the public and amplified any nationally available communications and in Wales PHW would usually lead a response for the LHB to then cascade particular communications in the local area. [Question 10]

Co-operation: Active engagement with LRFs and LHRPs

The majority of DsPH (over 90%) outlined the following happening five to ten years before January 2020: having a LRF which meets at least every six months, DsPH attendance at LRF meetings or ensuring effective representation, LRF meetings being used to deliver CRR, systematic, planned and coordinated approach to civil protection duties. A small minority (less than 4%) of respondents stated that these did not happen at all in the last 11 years. [Question 11]

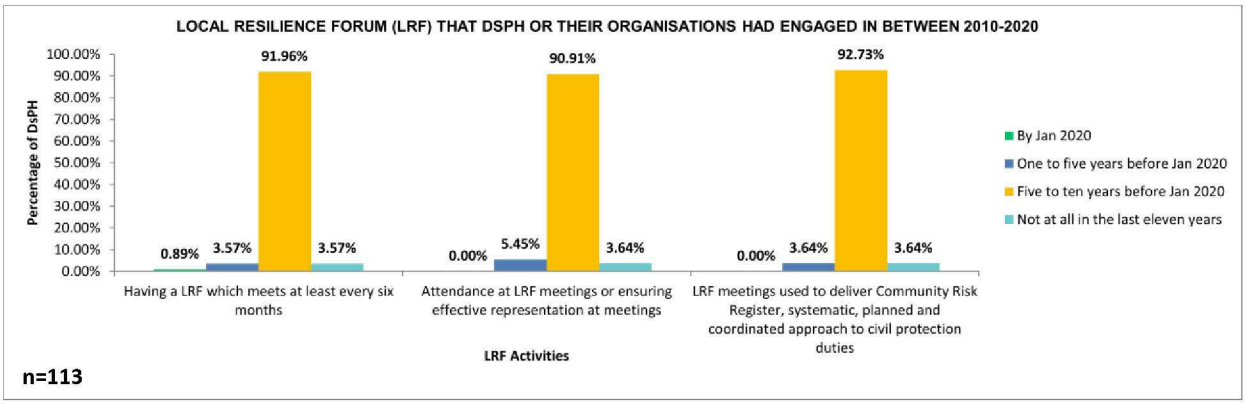

Figure 5: Local Resilience Forum activities that DsPH or their teams engaged with between 2010 – 2020 [Question 11]

Similarly, the majority of English DsPH (over 85%) outlined the following happening five to ten years before January 2020: LHRP being established, LHRP meetings being used to facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning and LHRP meetings being used for preparation of multi-agency plans, protocols and agreements and coordination of multi-agency exercises and training.

Notably less than half (47.78%) of DsPH were co-chair of their LHRP in the last five to ten years, with nearly a third (31.11%) never being co-chair in the past 11 years. [Question 12] DsPH expand on why this is the case in the later section on LHRPs.

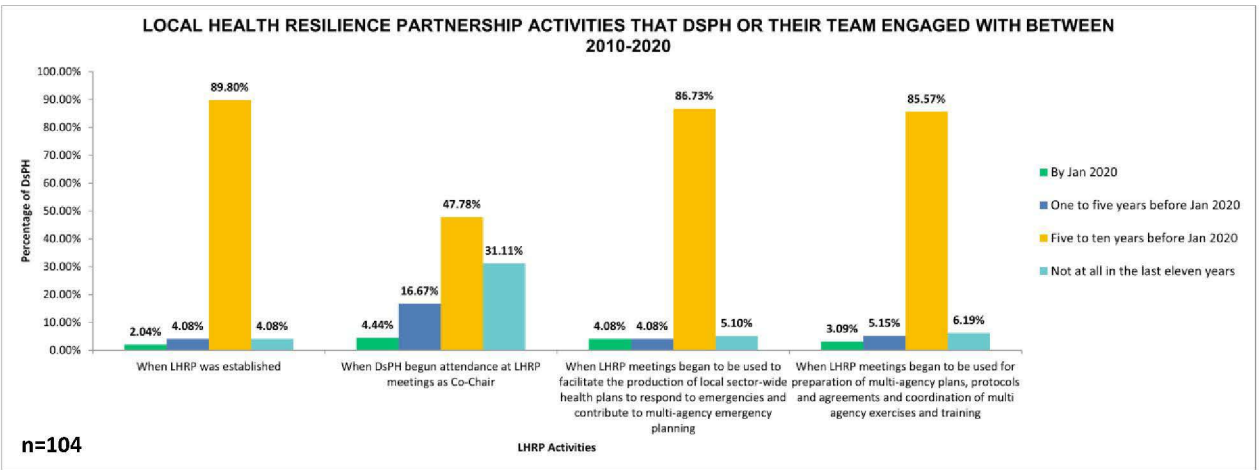

Figure 6: Local Health Resilience Partnership activities that DsPH or their teams engaged with between 2010 – 2020 [English DsPH Only] [Question 12]

Preparedness

The majority of DsPH (69.75%) either agree or strongly agree with the statement below.

'My organisation's preparations for an influenza-like pandemic and other emergency planning by 21 January 2020 meant that it was able to adapt and respond well to the Covid-19 pandemic.' [Question 13]

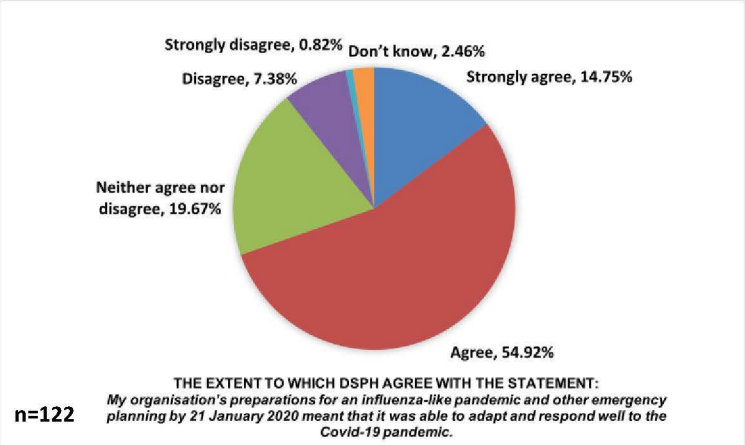

Figure 7: The extent to which DsPH agree with the statement; 'My organisation's preparations for an influenza-like pandemic and other emergency planning by 21 January 2020 meant that it was able to adapt and respond well to the Covid-19 pandemic.' [Question 13]

Simiarly, most DsPH (80%) agree or strongly agree with the statement, 'These interactions and forums provided sufficient two-way professional routes to share intelligence in a confidential space.' [Question 16]

With the second biggest majority of DsPH strongly agreeing to this statement. [Question 16]

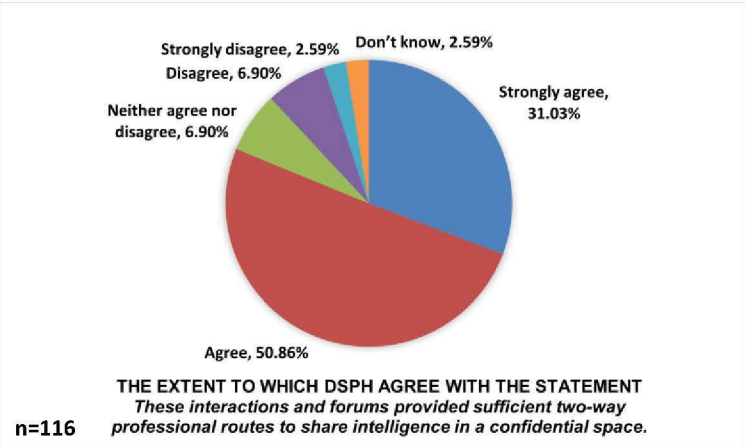

Figure 8: The extent to which DsPH agree with the statement; 'These interactions and forums provided sufficient two-way professional routes to share intelligence in a confidential space.' [Question 16]

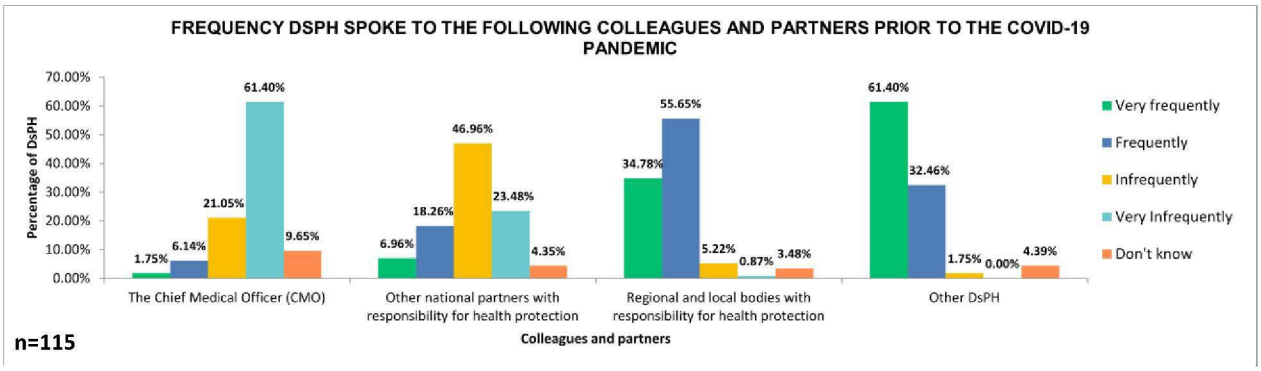

Figure 9: The frequency DsPH spoke to colleagues and partners prior to the Covid-19 pandemic [Question 14]

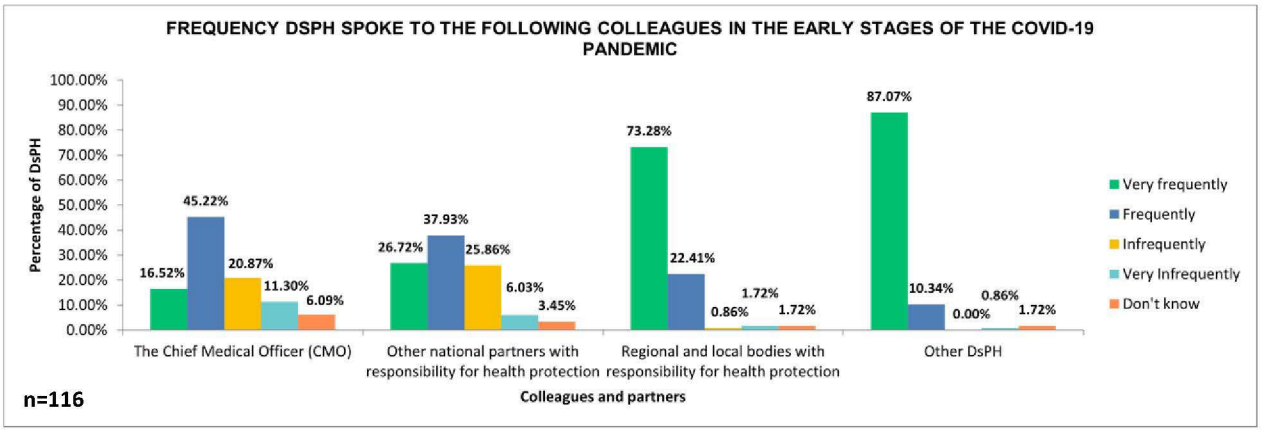

Figure 10: The frequency DsPH spoke to colleagues and partners in the early stage of the Covid-19 pandemic [Question 15]

The frequency of which DsPH spoke to colleagues and partners changed in the early stages of the Covid-19 pandemic compared to prior. Generally, across all of the colleagues and partners this trend increased in the early stages of Covid-19. DsPH also shifted to talking more with more senior officials such as the relevant CMO. DPH in Northern Ireland stated that they always had a good relationship and regular communication with their CMO, likely as a result of its countrys size. [Questions 14,15]

Planning

DsPH provided an overview of how they and their teams discharged at a local level, the civil protection duties conferred by the CCA 2004 and associated Regulations. These have been divided into subheadings below.

Risk assessment

DsPH identified and assessed health risks to different population through interpreting epidemiology and other health intelligence. They provided feedback to or helped compile risk registers at community, local and national levels which were reviewed and refreshed at a regular basis. Pandemic influenza had been on the register for an extended period during Covid-19 to reflect national strategic threats. They also provided support for risk assessment for the local authority, partnership and specific high-risk settings (eg schools and care homes).

Many DsPH emphasised the importance of cooperation and risk assessment discussion with local partner agencies and stakeholders. They carried out multi-agency risk assessments at different platforms, such as LRF, LHRP and BRF. At a local level, they worked closely with different teams such as the EP team, EPPR team and the Risk and Business Continuity Team.

Assessments by DsPH of the risk of emergencies informed contingency planning and contributed to the development of emergency plans such as pandemic flu preparedness plan and Excess Death plan. DsPH also provided input to Councils' corporate response and ensured that internal corporate risk management processes included an assessment of risks to continuation of services. They provided training for staff and managers for the individual, settings and services risk assessments. This was important to maintain business continuity and minimise transmission for frontline services while also protecting individuals who were vulnerable due to a health condition, smoking habits, ethnic minority background and a combination of such factors.

In addition, councils responded to Freedom of Information Act requests for copies of risk assessments, such requests being considered in line with the councils' obligations under Regulation 27 CCA 2004(Contingency Planning) Regulations 2005.

The core DPH role has stayed the same despite the reform of the public health system in England. Prior to the transfer of Public Health to local authorities, DsPH had a similar role in the local PCT/CCG system. It is usual for local authority public health teams to have a named consultant with responsibility for health protection, including attending relevant local and regional meetings. However, both the scale of public health cuts and centralisation of health protection within the HPA has undermined health protection and intelligence capacity at a local level. As a consequence, for example, consultants often have portfolios covering multiple public health topics of which health protection may be just one.

In Wales, different LHB's Executives play a direct role into LRF and hold the Executive portfolio for emergency planning – it is not always the DPH. [Question 17]

DsPH outlined the general process for developing risk assessments on a local level beginning by

acknowledging the use of the National Security Risk Assessment to inform the CRR for risk assessment. The risk assessment is developed through advice from SCG groups (LRF, BRF etc). The organisations determine and evaluates regional risks that might result in emergencies. The top risks are then listed in a CCR along with the likelihood that they will occur and steps that can be taken to mitigate them. The register's function is to track and manage risk, which guides the emergency preparedness team's activities.

The national security risk assessment is periodically reviewed as a guide for the CCR, which serves as the foundation for local training and exercise programmes. The CRR offers a specialised strategy for risk or, in some situations, assesses the preparedness plans. Two versions of the CRR are produced; a closed version which contains sensitive information used to assess capability gaps and the need for emergency plans, and a public version. The risk is reviewed on whether they require specific plan or whether they can be managed under generic plans. Reviewing the risk register allows members to understand the different levels of consequence and how they can deal with the different scenarios.

It was noted by some DsPH that some organisations use the Risk Assessment Working Group to develop their risk assessment. The Local risk assessment which can also be developed by multi agency partners such as EPPR, Environmental Health and safety team can be shared at a regional level through a Risk Assessment Working Group for review and sign-off, such as Cumbria RF, Cheshire RF each sharing their risk assessment via the North West Risk Assessment Working Group to ensure validity of risk. The review from the working group leads to the development of a CCR.

Individual agencies can choose to adopt the national risk assessment if there are no data or indications of considerable local variance, but they can also choose to enhance it with their own local risk evaluations. The local authority Public Health team conducted the local risk assessment of outbreaks to inform management and control strategy, in certain scenarios, such as reaction to acute response health protection work. With the use of this local risk assessment, it ensured that strategies were created to manage risk based on the requirements of the local community and to consider changing or reoccurring incidents. [Question 26]

Emergency planning

DsPH played a key role in emergency planning. They helped manage and prevent major emergencies through anticipation, assessment, prevention, preparation, response, and recovery.

DsPH carried out their emergency planning functioning at both local and regional levels through existing coordination mechanisms. They worked closely with HPB, LRF, BRF, NHS, other DsPH in the region and local partner agencies and contributed to the development, review and testing of multi-agency emergency plans (see ADPH Guidance Document for DsPH on Major Incidents in Appendix 3).

At the local level, different regions and local authorities have different organisational structures and arrangements on emergency planning. For many, the statutory duty of emergency planning was discharged by EP Team/Resilience Team/EPRR Team which produced planning, training and exercising. DsPH maintained close collaboration with these two teams and developed and reviewed emergency plans with them. In some places, DsPH lined manage EP/Resilience function for local authorities. In London, a

list of volunteers is maintained by the contingency planning team to support emergencies.

DsPH also contributed to Gold On-Call rota for local authorities. DsPH and PH teams took an active role in contributing to different duties within Emergency Response Teams such as trained Resilience Advisors and volunteers for rest centres, etc.

DsPH provided advice on risks to the health of the population in terms of emergencies and emergency planning in response to relevant risk registers. They oversaw the plans and ensured the validation and exercising of emergency plans. They also shared information with other responders to enhance co-ordination.

Even before Covid-19, there has already been regular review and update of the suite of emergency plans that serves different purposes with the contribution of key teams such as health protection. Covid-19 led to the activation and adaptation of various plans. In Greater Manchester at a regional level, GMRF maintains a register of plans (circa 80) which would support the response to an influenza pandemic, other infectious disease emergencies and other incidents. Each plan goes through a periodic cycle of review. In Scotland, DsPH act as executive lead and oversee Major Incident plans together with a suite of other emergency plans.

In executing the emergency plans, many DsPH pointed out the need to ensure appropriate senior level command and decision making 24/7. It was important for them to ensure robust communication mechanisms and appropriate EOC facilities to control and coordinate the response to an emergency. They also took measures to ensure relevant response staff were trained to an appropriate level for their role in response.

To ensure the proper functioning of the plans, DsPH played a key role in developing emergency preparedness/planning exercises, simulations, training and workshops, often with other agencies. They tested plans using desktop/ table top and live exercises around health protection and pandemic scenarios. These exercises ensured validation of plans and gave responders an opportunity to rehearse their skills. There is a systematic and continuous process for updating plans, reflecting lessons learned from exercises and emergencies, as well as changes in organisation and key personnel.

Some DsPH found it important to establish good working relationship with EP. However, this relationship has never been formalised. Many DsPH recommend that a reiteration of DPH role in legislation would be helpful. [Question 18]

Business continuity management

Business continuity management has been carried out as part of council public health business as usual. To ensure business continuity, each local council maintains a business continuity plan which is regularly reviewed, tested and updated. It ensures compliance with the CCA (2004) and is aligned to the International Standard, ISO22301:2019 and reflects best practice as defined by the Business Continuity Institute. Service Recovery Plan was also developed.

DsPH and relevant public health officers work closely with other teams (eg CCU, EP team, EPPR Team) to

provide advice on issues related to health protection or other public health concerns in line with corporate policy. They take account of the risks raised on RRs. And they ensure that corporate business continuity plans have a section on pandemic planning assumptions. DsPH review and update their business continuity plans in collaboration with local partner agencies and other responders to enhance coordination. Some DsPH collaborate with each other regionally and complete their business continuity management duty under the auspices of the LRF and local HPB.

DsPH also develop plans for public health teams and other teams where they have responsibility (eg critical services). Some DsPH worked closely with social care colleagues to support care providers in winter planning including business continuity planning prior to the pandemic. Some DsPH (eg London) also contributed to the preparation of local NHS continuity plans. Furthermore, as a commissioner of a range of public health services, the Council worked with public health providers through contract management mechanism to assure that sufficient business continuity management measures were in place in respect of vital healthcare services during the pandemic.

The business continuity plans facilitated rapid decision making during Covid-19. They plan for a number of scenarios (eg sickness absence due to flu pandemic, loss of accommodation/ building, loss of power, loss of 3rd party suppliers, loss of IT/ utilities), and during Covid-19 they helped identify risks and appropriate mitigation actions/contingency measures. During Covid-19, each service was required to refresh their plan in the context of Covid-19 paying particular attention to the anticipated impacts. There was also a change of business model to facilitate home/mobile working for large numbers of employees where possible.

The business continuity plans also facilitated arrangements to maintain critical functions/essential services during Covid-19. They helped prioritising services and identifying which services were business critical and therefore needed to be kept running, which could be stood down to redeploy staff resource to support the wider local pandemic response. This enabled effective reallocation of staff and resources.
To ensure the proper functioning of the plans, BIA is carried out for all essential functions annually with DsPH contributing their public health perspective. Regular training and exercises have been provided on business continuity management. BCP has been carried out.

However, some DsPH found challenges in business continuity management. DsPH from British Crown Dependency or Overseas Territory said there were virtually no plans in place prior to 2020. DsPH from Scotland said business continuity management 'was more tricky, completion of plans always required chasing'.

One DPH said,

> 'Business continuity plans were not robust enough for a pandemic despite being highest strategic risk on the risk register. Most BC plans focused on loss of staff and loss of premises; whereas the impact was on the ways of working social distancing, risk assessments and stringent infection control. The list of vulnerable settings for the emergency planning function were different to the list of vulnerable settings (communities and care settings) for the pandemic.'

[Question 19]

Maintaining public awareness and arrangements to warn, inform and advise the public

DsPH have been trained in communication and media and risk communication to the public. They acted as an expert resource and a spokesperson in crafting briefings and interpretation of technical information, and they ensured that Communications & Engagement was discharged appropriately in line with statutory requirements. During Covid-19, DsPH were also part of the Gold command structure within the local authority and Public Health Consultants were part of the Silver command structure. They influenced the communications strategy to the public and businesses in line with existing processes for proactive and reactive local communications.

During early days of the pandemic. DsPH and PH Teams worked closely with local, regional and national communications team and emergency planning teams to establish communication lines and roles and responsibilities. At a local level, DsPH collaborated closely with different teams such as CPU, Council CRG and Warning and Informing Groups. Communication plans, processes and systems were developed as part of local PH comms plans and local influenza pandemic plans. Early involvement of elected members in communication plans was crucial. Multi-agency, joint communications arrangements have also been made at HWB, LRF/BRF, across LAs, the NHS, PHE (or later UKHSA) and VCS organisations. These practices were built on the foundation of business-as-usual communication and engagement arrangements which have been used in other emergencies in the past (eg cold weather, heatwave, annual flu).

In Wales, communication and engagement were done as part of communicable disease management with their respective local organisations and PHW pre-pandemic. During Covid-19, this was done through their regional Incident Management Team (local authority areas with the Health Board), and collectively with PHW nationally where appropriate.

The objective of public health communication was to raise public awareness and to warn, inform and advise the public in relation to potential emerging pandemic threats identified through national and international surveillance. Information on emergency preparedness matters was made available to the public, partner agencies and members. Local communications were largely based around information received from NHSE and PHE and consistent with regional and national communications. As a result of all the communications being provided at a national level, the NHS communication at a local level was often poor at providing information.

Public health teams in local authorities can communicate warning and informing messages in a variety of format, including the council's general print and media channels, resident newsletters, websites, social media, dissemination of printed and electronic materials, via links with local elected members, via links with community and voluntary organisations and groups, via links with businesses, and via direct engagement with workforces, community groups and settings (from early years/schools to care homes). The public version of CCR also informed the public of key emergency risks and how to prepare for these risks. Extra efforts were made to reach communities not previously reached. [Question 20]

Co-operation and information sharing

DsPH cooperated with partners (Category 1 and 2 responders and other responders) through platforms

such as BRF (London), cross-borough chief officer forums (London), LRF, LHRP, HPB, HWB, SCG, TCG, regional DsPH network, Local Outbreak Control Board, Covid-19 Health Protection Board, system wide county Silver and Gold groups and other regional coordination networks to tackle health inequalities and respond to emerging situations. They also had regular communication and information sharing with NHSE and PHE Health Protection teams and relied on PHE for more timely information related to infectious diseases. Some found cooperation and data sharing in global networks good (eg the Resilient Cities Network and the United Nations Making Cities Resilient programme). Some used international sources of information (eg WHO, John Hopkins University).

In London, DsPH and their PH teams worked through borough and London-wide arrangements to cooperate and share information with other agencies in order to deliver their civil protection duties. They said the work arrangements across the councils were good. In West Midlands, partnership arrangements were in place across three neighbouring authorities with a single resilience team (CSW Resilience). Joint planning and delivery mechanisms were in place between local NHS and council.

On the other hand, in Wales, information flows were already established between Local Health Boards and Public Health Wales as they are both NHS bodies. There has been sharing of information between NHS and local authority. National (Wales) information governance arrangements were also in place for the sharing of information between LHBs and local authorities regarding TTP. In Northern Ireland, information and data sharing was also better than in England, as the DsPH sit within the Public Health Agency so have an easier time accessing information, as its being shared to them within their organisation.

Many DsPH highlighted the importance of existing cooperation channels and data sharing agreements mechanisms in facilitating effective response during Covid-19. Even before Covid-19, DsPH shared information with other local responder organisations both ahead of and during any emergency as required. They also coordinate with other responder organisations to enhance coordination and efficiency when planning for, responding to and recovering from an emergency. Local authorities typically have an information governance function, although its capacity to support DsPH will vary. The DPH is also the Caldicott Guardian for the Council. They contribute and advise through standard planning and incident response arrangements. Other arrangements with regional agencies were led by the public health team, ensuring strong links were maintained with regulatory services.

DsPH also emphasised the importance of learning from previous public health emergencies. London for instance learned from the experience of swine flu and found data sharing between councils and NHS bodies was vital to identify high risk patients/clients/residents. They developed a data sharing process to enable fast tracking of requests between local organisations only.

Additional funding was provided during Covid-19. In North West (C&M), later in the pandemic, additional funding was allocated to intelligence and data which enabled daily updates on cases, admissions and deaths, so DsPH could identify hot spots and outbreaks quickly. DsPH found sustainable funding important as they said sometimes they were asked to take on additional work without it being adequately funded.

Data sharing was a key challenge in the early stages of the pandemic. DsPH in London said PHE Regional team has been quite effective in establishing data sharing protocols relatively quickly in Covid-19. DsPH in

North West (GM) also said the initial barrier in data sharing was resolved nationally by sharing individual level test results with local areas. However, DsPH in North West (GM) said despite this arrangement, it was not possible to identify cases testing positive who lived in one part of GM and worked in another part of GM.

Data protection requirements could be an obstacle to data sharing too. DsPH in East Midlands observed that there was a willingness to try to share information locally, but this was sometimes difficult to achieve due to data protection requirements. Organisations or even individuals may even have different interpretations of data protection requirements, causing more barriers in data sharing. Robust and complete data and intelligence flows are needed across organisational boundaries in a timely manner, including the NHS, UKHSA, OHID and LAs.

DsPH have consistently found information sharing an issue long before the Covid-19 pandemic. For English DsPH data sharing was massively affected by their move from the NHS to LAs in 2013 and still has not been fully rectified. Even once the Covid-19 pandemic began, data access for DsPH (such as individual case data) still took longer than it should have. Despite the progress made on information sharing during the pandemic, and the demonstratable impact, DsPH still face significant challenges to accessing information.

DsPH in devolved nations faced other challenges. DsPH in Scotland said although data sharing agreements were in place to a point, there was limited confidence in those arrangements. They said there were examples of partner organisations (police) withdrawing some data sharing arrangements. [Question 21]

Planning (Continued)

When DsPH provided an overview of the principle of subsidiarity in the context of emergency planning and the role of local responses, some cited the 'The principle of subsidiarity which is based on one of the principles of effective emergency response and recovery under the Civil Contingencies Act 2004', which stipulates that decisions should be taken at the lowest appropriate level with coordination from the highest level (page 14, version 5, 2013).

It involves local response to emergencies such as the provision of resources and coordination while allowing for support and guidance from the central and national level when required. Local authorities are Category 1 responders hence, they have the responsibility of preparing and responding to incidents by working closely with their local emergency responders. This principle stipulates the formation of SCGs and command and control structures to respond to emergencies with support from the national level. Most local authorities, hence, managed response during the incidents using the Gold, Silver and Bronze command structures.

This is based on a multi-agency structure such as BRF/LRF working together to carry out risk assessment of the issues and share plans. This involves discharging of responsibilities to the emergency planning and resilience team. The response to Covid-19 required a multi-agency response to achieve a consistent approach. The LRF/BRF established different cells to ensure the delivery of the actions at the local level. The DPH has the oversight of the response cell and responsibility for the duties in relation to health protection.

The nature of the pandemic as opposed to other incidents, meant that local authorities had to take an active approach to protect the health of its population. Hence national policies are used as guidance to plan the response. The goal of the subsidiarity principle is to ensure some level of independence for the local authority in terms of emergency planning and response. As Category 1 responders, they were required to manage local response.

It is significant to highlight that DsPH found the national policies to be constrained, and that the time needed to prepare locally for the delivery of the activities was limited due to the implementation process. DsPH found these policies inhibiting, not empowering. Because of the national guidance system, decisions were frequently made without consulting local organisations appropriately, for example, when PPE was not readily available or there weren't enough resources to meet national guidance. Better understanding of the value of the local perspective is required, with local representation being present when guidance is prepared. [Question 22]

DsPH cited the CCA 2004 which describes the discharge of duties amongst partners within the subregion level when outlining where they sat within the emergency planning structures in their local area. These duties are localised within the Civil Contingencies Group which also comprises of a lead DPH for each council. The DPH sits within this group to share plans and views at the subregional level. Hence, DPH had roles across emergency planning and public health.

The lead for public health emergency response is one of the entities where the DPH role in emergency planning rests. As part of the emergency planning response, the DPH presided over strategic planning groups such as tactical coordination groups and SCG. This entails serving as the chairperson, co-chairperson, or members of incident meetings for the LHRP, LRF, BRF, and HPBs.

The DPH's leadership positions within their council and advisory roles within emergency planning became more strategically important. Their roles as members were more consultative, offering public health advice and participating in the decision-making process, which required them to deliver information such as 'local updates, map the area's infection rates and testing uptake (positivity), addressing inquiries about risk management, and offer clinical advice where it was most needed' North West (GM). [Question 23]

When describing the key roles and responsibilities that DsPH had in regard to EPRR, there was a general consensus the primary responsibilities of organisations in the health sector, including local authorities have been outlined in the document Health Emergency Preparation, Resilience and Response from April 2013: The DPH key roles within EPPR is to plan and take decisions to protect the health of its population. This included:

- Acting as advisor in relevant groups as well as leadership for local public health emergency response to fulfil their responsibility as a Category 1 responder under the CCA.
- The responsibility of developing Influenza and pandemic preparedness plans and testing the plans to ensure that resources are in place to respond to public health emergencies.
- Providing initial leadership with the relevant national public health agency for the response to public health incidents and emergencies.
- Escalation of issues and concerns to relevant organisation.
- Risk assessments and management to inform contingency planning.
- Completion of assessment and advice on business continuity during incidents.
- Cooperation, communication an and co-ordination with local communities and other organisations to enhance efficient emergency planning through the LRF/LHRP. These groups provided a forum for joint planning and working for emergency preparedness and response. The local health resilience partnerships were established to deliver the EPRR strategy. [Question 24]
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As part of their crucial role in preparing for a pandemic outbreak, DsPH worked with local resilience forums like the BRF, LHRP, GMRF, and CRF to develop, approve, and review a pandemic influenza plan. It was noted that due to significant risk associated with pandemic influenza, proper planning has been previously available to handle incidents. However, in their capacity as DPH, they constantly reviewed the pandemic influenza plans in order to prepare for new, developing infectious illness.

As a result, DsPH had the role of participating in exercise delivered by PHE to test the pandemic influenza framework and the pandemic flu plan. The evaluation and recommendations following this test is shared at the SCG meetings to ensure a consistent approach to managing major incidents.

Furthermore, developing and reviewing the pandemic plan involved ensuring accurate training of the local

PH team to respond to major incidents. It was recognised by DsPH that their role in developing pandemic influenza plan involved coordination, communication and maintaining key relationships with external stakeholders such as PHE, NHSE, Police, Fire Brigade, Ambulance service and CCG to carry out risk assessment and respond to major incidents to ensure business continuity.

Nevertheless, in some situations, DsPH played a more strategic role in preparing for the outbreak. For example, in PHW, the Consultant in Communicable Disease and Consultant in Health Protection can take the lead in responding to major incidents while the DPH played a supporting role. [Question 25]

Most DsPH reported that local working groups used the NRR combined with local intelligence to inform the LRF and CCR. This was then used to develop the local emergency planning response.

It was noted by several DsPH that the highest existing risk was based on an Influenza pandemic and so not entirely applicable to Covid-19. One respondent reported that the guidance for the management of excess deaths more accurately reflected the response required. One DPH also stated that the asymptomatic spread of Covid-19 was not anticipated within the Influenza plans, so this created additional pressure on managing the pandemic.

One respondent noted that the Government's RWCS were used to help inform planning when they were made available, but that there was a 'reluctance to share' them, which 'hampered planning.' [Question 27]

Local Resilience Forums (LRFs) as a mechanism for coordinating local emergency preparedness

Many DsPH have cited the CCA 2004 as LRFs are a requirement of this act when describing how LRFs are constituted. Each police area has a forum to coordinate emergency response and undertake emergency planning and resilience work on a single or multi-agency level. It is the single forum for key partners and stakeholders to discuss, agree and action emergency planning and resilience-based activities that promote the appropriate response to incidents which affect the area.

The purpose of LRFs is to provide a forum for the emergency services, council, the NHS, and other Category 1 and 2 responders under the CCA and other partners to discuss the wider aspects of the development and maintenance of local multi-agency EPRR.

In Scotland and Wales, the formation of LRFs is similar other than an example of an LRF covering an entire region, including numerous health boards and local authorities. In Northern Ireland, equivalents of the LRFs also exist, with similar multi-agency structures. Note that the civil contingencies act sets out specific arrangements for the London region. In addition to local resilience forums in each borough, which local Directors of Public Health attend, there is a London resilience forum which was attended by the Regional Director/ Health Protection Lead at Public Health England/ UKSHA in London. [Question 28]

DsPH outlined a number of roles that LRFs undertook that are consistent throughout many local authorities. The governance structure for many LRFs were expanded, they developed multi-agency plans and delivered emergency management, risk assessments and resilience arrangements. This is similar to the function they would exercise pre-pandemic, but with a pandemic focus.

Many DsPH noted that LRFs acted in accordance with Emergency Preparedness, the statutory guidance accompanying the CCA 2004 which states that LRFs provide a local forum for local issues, they help coordinate risk assessment through production of the CCR, they facilitate Category 1 and 2 responders in the delivery of their CCA duties, they help deliver government policy by coordinating responses to government initiatives, and help determine a procedure for the formation of a SCG by the relevant local responders at the time of an emergency.

In Scotland and Wales, LRFs undertook similar roles as described by England-based DsPH, with a focus on situational awareness and multi-agency planning. Similarly in London, BRFs run emergency preparedness exercises to test plans in place to respond to local partnership-wide emergencies; refine and update response plans; facilitate co-ordination and communication between members to allow partners to be alerted to incidents and emergencies. [Question 29]

LRFs acted as an interface between central, local and regional bodies primarily by being the conduit for information, acting a structure to efficiently communicate both up and down between levels of government. LRFs are the overarching interface between multi-agency partners, for some DsPH this is their primary mechanism to meet with partners such as DLUHC, NHS or the Environment Agency. For DsPH

these meetings act as an important channel to escalate concerns at a local level to the regional and national level. LRFs also provided national and regional partners to communicate down to the local level through LRF meeting reps and information cascades. The role of the LRF is also one of assurance to the national/regional bodies that plans are being communicated and coordinated at the local level.

LRFs did not always offer the best channel to cascade information, as information did not always reach DsPH through these channels the way it should, with one DPH stating,

> 'The LRF is intended to serve as the conduit of information between the central and local tiers of government allowing exchange of information, data and guidance as it pertains to the incident. It is, however, not always the best mechanism to achieve this in certain situations or for certain elements within a response with existing groups, such as ADPH, ADASS, LHRP's etc being better established to fulfil this function.'

In Scotland and Wales, LRFs acted largely the same as in England. Some DsPH felt these channels of communication were good, whereas others felt more could be done to improve understanding of the communication responsibilities between regional and local partners. [Question 30]

Prior to the pandemic, DsPH noted that the frequency of LRF/BRF meetings generally ranged from monthly, quarterly or twice per year. However, during the pandemic, the volume of these LRF/BRF meetings increased, with DsPH reporting that the forum would meet on a daily, weekly or monthly basis.

Meeting volume would vary during the pandemic dependent on the risk level. It was routine for forum meetings to be scheduled weekly throughout the pandemic, however, reacting to major incidents, LRFs would meet on occasion at short notice, on a daily basis.

In Scotland and Wales, similarly to England-based DsPH, meeting volume increased during the pandemic, but generally frequency was daily or weekly. [Question 31]

Not all DsPH were members of an LRF, however, those that were had the responsibility of advising and providing guidance on emergency planning and response matters relating to health protection and other public health issues.

Representatives from other fields would feed into discussion in the forum, providing intelligence and actions were agreed to manage and mitigate risk as far as possible. The forum would review documentation and strategies, such as the influenza pandemic plan. Specific to the pandemic, DsPH provided regular updates to the LRF on the key issues, such as sharing high-level activity data including case rates, comparison with other boroughs, London and England as well as initiatives to deal with the pandemic, including any risks or issues and asked the LRF for support as required. [Question 32]

Local Health Resilience Partnerships

London DsPH stated that DsPH as co-chair of LHRP was not typically in place in the London region as one DPH chairs the entire region as part of the London Health Resilience Partnership. DsPH from other regions also either did not always co-chair a LHRP or this role was distributed amongst multiple LAs. As a result of this, some DsPH felt LHRP Emergency plans were often developed in isolation and they were then consulted on these afterwards, which didn't necessarily get the best result. This question was not applicable to DsPH from Scotland, Wales or Northern Ireland.

Of the DsPH who could provide insight on facilitating the production of health sector wide emergency plans, they described their involvement with content formation as well as consulting on plans, testing them and amending as needed. Many DsPH described the role as both assurance and facilitation. Some DsPH referred to the LHRP Terms of Reference Document or the Health Emergency Preparedness, Resilience and Response Guidance as an outline of the structure and responsibilities of LHRPs. DsPH were responsible for the plans meeting the nationally determined/NHS core standards, providing leadership and strong collaboration. Support was provided to the NHS, CCGs, Local Government and PHE in ensuring that member organisations developed and maintained effective health planning arrangements for major emergencies and major incidents. Specifically, to ensure that arrangements (including trigger mechanisms and activation and escalation arrangements) were in place for providing and maintaining health representation at multi-agency controls (SCG/TCG) during actual or threatened emergencies. [Question 33]

Of the DsPH who did contribute to multi-agency plans, they described their role as leader on the public health input into multi-agency plans alongside other public health colleagues. If co-chair of LHRP, the DPH together with NHS England and PHE (now UKHSA) represent the health sector on LRFs, to ensure that health organisations are included in multi-agency plan development, training and exercising. DsPH were part of formal plan development and testing and had responsibility to ensure that local planning is based on the Integrated Emergency Management Principles and Joint Emergency Services Interoperability Principles as issued by HM Government. All Category 1 organisations are required to engage with multi-agency plan consultations, training and exercising. Alongside being a consultee on a range of multi-agency plans, DsPH also participated in strategic level exercises, training and debriefings. DsPH fed into these plans via various pathways including their Health Protection teams, LHRPs, LRFs, and through CCGs.

Once again, some DsPH referred to the LHRP Terms of Reference Document or the Health Emergency Preparedness, Resilience and Response Guidance as an outline of the structure and responsibilities of LHRPs, highlighting this item from the ToR, 'Organisations within the LHRP are required to work cohesively to ensure that plans are in place for an effective health response to a major incident.' [Question 34]

Planning (Continued)

When describing their role in collaborating with NHS Boards and public health agencies to plan and prepare for emergency situations, many DsPH cited the Health Emergency Preparedness, Resilience and Response Guidance from April 2013 which states 'Organisations within the LHRP are required to work cohesively to ensure that plans are in place for an effective health response to a major incident.'

DPH were a key contributor, providing both oversight and assurance to partners (such as the LHRP, LRF/BRF, Councils and various other organisations/boards that they participated in locally) with regard to EPRR. The DPH role was to provide leadership, ensure communication and manage stakeholders. Some DPH also supported beyond the local level to develop emergency plans at a regional level. DPH drew attention to the fact that all Category 1 responders have 24/7 on call arrangements in place, and these are known and detailed in all pandemic plans. Although these 24/7 call arrangements were facilitated at a local authority level in some areas, largely these were facilitated by PHE because of lack of local funding for this service.

DPH and their wider public health teams are involved in robust planning, preparation, and participation in emergency planning exercises. Using available guidance for local action relative to local risk and need. However, one DPH stated,

> 'In more recent years this has felt much more like an NHS driven role with PH more on the sidelines.'

A key point of learning from the pandemic was that the current LHRP/ LRF structure would benefit from a review to ensure that roles and responsibilities are well-understood and there is cohesive approach to emergency planning across all sectors and government departments at national level. Multi-agency testing across the NHS, local government, PHE/ UKHSA would benefit from more coordination as would national resilience coordination arrangements across DLUHC and DHSC/ UKHSA. [Question 35]

When outlining which core elements of local arrangements that they would expect to be in place, DsPH referenced relevant local arrangements and response systems in line with national guidance. While some DsPH explained the national guidance Health Emergency Preparedness, Resilience and Response from April 2013, 'Organisations within the LHRP are required to work cohesively to ensure that plans are in place for an effective health response to a major incident.'

Others referenced elements that are required when putting this into practice, with the following core themes:

- Communication
- Cohesion
- Coordination
- Good relationships
- Clear governance, roles and responsibilities – including on call arrangements
- Testing
- Protocols

- Intelligence sharing
- Surveillance
- Planning
- Shared learning

[Question 36]

DsPH felt that local partnership arrangements are critical to ensuring an effective response to meet the needs of particular populations, as they can be delivered at speed (because they are local). These vital arrangements also ensure that resources can be allocated efficiently and that all agencies know what their role is and are able to follow pre-existing processes.

As a DPH noted,

> 'Infections do not recognise organisational boundaries and no single organisation is able to manage an outbreak effectively.'

One DPH found that having the plans in place was more helpful in that it gave knowledge of key partners, than it was in providing a structure for the response, while another said that the relationships formed throughout the development of plans was where the 'real work happens.'

It was noted by one DPH that while the local arrangements are very important, they are not effective without a regular flow of information from the centre and some respondents said that not having effective plans would lead to delays or errors, and, in the case of Covid-19, would have meant faster transmission. [Question 37]

When discussing their responsibilities in relation to ensuring effective and tested plans were in place for infectious diseases, many DsPH referred to their statutory responsibilities (especially those around leadership) and role in key organisations such as LHRPs, LRFs/BRFs and HPBs. It is a statutory and core requirement of all DsPH to gain assurance that systems and processes are in place and are able to provide an effective response should an incident occur. Given the role that PHE and other system partners had, regular DPH engagement and dialogue with them was extremely important. DsPH emphasised their role was at a local level, compared to the role of PHE (now, UKHSA) at a national level.

Many DsPH also highlighted that before Covid-19 they largely focussed on planning and preparation for Influenza, as that was what national planning and guidance assumed was the most likely pandemic event. These were useful for DsPH to begin their response to Covid-19 as Influenza is also a respiratory virus, however once the scale of the pandemic unfolded, the plans were never developed to cater for the scale seen with Covid-19.

As the principal advisor on all health matters to elected members and officials, DsPH played a key leadership role across both the frontline and strategic aspects of health protection and the wider public health system. As part of this role, DsPH ensured that effective and tested plans were in place for the wider

community in order to protect the population from health risks. In doing so, DsPH worked cohesively with other organisations within the LHRP to ensure that plans were in place for an effective health response to a major incident.

DsPH ensured that robust and appropriate processes and systems were in place locally for responding to incidents of infectious diseases. It was also important that local processes aligned with the role of national bodies in respect of infection prevention and control and outbreak management, such as PHE.

A key recommendation was that for future planning there is a need to clarify and codify the multi-agency leadership role of UK and national public health agencies around infectious disease incident and outbreak management, particularly in large scale incidents and outbreaks. To do this well, there needs to be clarity with other key agencies and government departments (eg DHSC and DLUCH) around the role of national public health agencies and they need to be adequately resourced and appropriately skilled to take on this role. [Question 38]

Whilst outlining how they escalated concerns on plans being robust, tested or implemented appropriately, DsPH referred to their statutory duty to protect and promote the health of the population, which includes highlighting when things are not working, especially if it impacts on health. DsPH highlighted again their responsibility around assurance. However, one DsPH stated that their responsibility to escalate concerns was not clearly understood either within the groups/organisations they were part of. DsPH responsibility is first and foremost to the health of the population, and it is their role to highlight failings or concerns.

In practice this means that DsPH provide strategic challenge to health protection plans/arrangements produced by partner organisations, scrutinise and as necessary challenge performance, escalate any concerns to LHRP if necessary, receive information on all local health protection incidents and outbreaks and take any necessary action, working in concert with national organisations and the NHS and contribute to the work of the LHRP.

Generally, to whom DsPH escalated concerns depended on what the specific issue was, however there were a variety of reporting channels available to DsPH. For local issues, escalation could happen via the LRFs/BRFs or LHRPs to local or regional health leads. There was a slight distinction in answers depending on whether DsPH were co-chair of their LHRP, as those who were co-chair felt they had a more direct line of communication.

Regional forums also presented opportunities to report, record and escalate concerns. For some DsPH, other channels were utilised such as HPFs or HWBs. Some DsPH stated they escalated concerns if not resolved up to their CCGs, NHS Trusts, or PHE and also to a national level if necessary, including the Secretary of State. [Question 39]

A number of forums existed informally and formally at a local, regional and national level where concerns could be raised in respect of the adequacy of plans or response capacity.

If issues were local and defined DsPH could raise concerns directly with the relevant organisation and their management structure. At the most local level these forums largely were HPB/HPCs or sub-regional DPH meetings/LHRP meetings.

Regionally, concerns could be raised to the Regional Director of Public Health and in LRF/BRF meetings. Plans could also be brought to the Health Select Committee should that be necessary following reports from HPC being presented to the HWB.

Depending on the concern, DsPH could also liaise directly with leaders and chief executives within Local Authorities or their host organisation. Some DsPH mentioned being in contact with LA Gold or NHS Gold. Concerns could also be raised to the CCG board and Regional Directors. Escalation also occurred via the subcommittees of the LRF enabling issues to be raised through to SoS and ministers should there be a serious concern.

Finally, DsPH could raise concerns within their regional DPH networks, or through ADPH at a national level. If needed, this could be escalated even further to PHE or NHS when required. [Question 40]

There is no specific framework for DsPH to hold organisations to account for preparing for or responding to infectious disease outbreaks. In practice, this would be monitored through the Local HPB, with escalation to PHE (now UKHSA) or the relevant public health agency in other parts of the UK, at regional level and to the LHRP. Many DsPH cited either multiagency plans or relationship management as their main methods to get organisations to comply with their advice.

As a DPH outlined,

> 'This is the challenge of the role of DPH whereby acting with responsibility but not direct authority over other organisations.'

Some DsPH referred to either the Health Emergency Preparedness, Resilience and Response Guidance or the guidance document Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities Act, published jointly by PHE/LGA, which outlines their responsibilities in this area.

Multi-Agency partners have a responsibility to assure DsPH and respond appropriately to advice of DsPH in the preparedness, resilience, response and recovery of pandemic and other health protection related incidents. These partners remain accountable to DsPH via the LRF/BRF or HPF/HPB, including reporting adverse impacts should the DsPH advice go unheeded.

That said, many DsPH stated they did not need to worry about compliance and escalation and that there was excellent engagement and response to advice provided within their local area. Partners locally are more likely to actively seek public health input than resist or ignore it. DsPH maintaining trusted relationships ensures that the situation such as that described in the question rarely occurs, and when needed advice could be challenged or debated.

Local authorities (but not specifically DsPH) have some statutory duties in relation to controlling the risk associated with communicable diseases and other public health risks such as food poisoning outbreaks. The local authority can only act within the specific remit of the 1984 Public Health Act. Responsibility for planning and preparedness for a major incident sits within the CCA. One DPH stated that the pandemic demonstrated that there is a lack of clarity around the interaction between the Public Health Act (1984) and the Civil Contingencies Act, specifically, at what point does an outbreak which can be managed within the 1984 Act become a Major Incident, triggering the activation of an Emergency Response process. [Question 41]

When highlighting the extent emergency plans and risk assessments took into account and planned for the risk factors potentially affecting specific groups, specifically those with protected characteristics under the Equality Act 2010 and those in equality categories under the Northern Ireland Act 1998; most DsPH stated that their local emergency plans and risk assessments did take into account 'vulnerable groups'. However it was felt by many DsPH that there was not sufficient detail in these plans for when the Covid-19 pandemic then began to occur at scale (note that for the UK this is after January 2020). DsPH made clear that the LA and LRF partners hold secure information on vulnerable people so that it can be accessed quickly in an emergency. Many services work with groups of different protected characteristics and this information will be held on centralised list which contains a record of who has access to which information.

DsPH highlighted that 'vulnerable groups' vary in relation to the nature and type of emergency. Examples given that were frequently included were: disability, pregnancy & maternity, people living in residential care and nursing homes, homeless and vulnerably housed people, those experiencing mental health issues and survivors of domestic abuse and those experiencing socio-economic disadvantage.

Some DsPH stated that their emergency plans took account of some but not all vulnerable groups, or did not specifically align to the groups featured in the Equality Act of 2010. Frequently, DsPH highlighted that race, ethnicity, religious beliefs, gender reassignment or sexual orientation were not factored into their emergency plans. It should be noted that there was variation on which groups were featured depending on the local area the DsPH was working in, so some plans for example did take these factors into account. Many DsPH did draw attention to the fact that these plans are frequently reviewed, or because of the Covid-19 pandemic now are being re-reviewed.

One DPH stated,

> 'On reflection it would have been helpful to have further national guidance on this area of planning. Equality Impact Assessment has been more deeply embedded in our local practice since the pandemic.'

In Wales, these issues were considered as part of the regional Prevention and Response plans, required by the Welsh Government as a regional response to managing the pandemic. Plans included actions to tackle issues of inequities in groups such as lower socioeconomic groups and some ethnic minority communities. [Question 42]

Similarly, when discussing the extent these plans covered people with vulnerabilities eg survivors of domestic abuse, DsPH highlighted that the term 'vulnerable' is often used in the plans, with a requirement for them to be considered, but the specific group that impacts would be different depending on the exact situation. As with the previous question, it was stated that a register of vulnerable settings is maintained by each local authority so that these settings can be identified during an emergency.

One DPH said,

> 'There are many other definitions because vulnerability is dynamic and will be largely dependent on four factors: type of incident; nature of response; current circumstance of the individual; availability of support that individuals normally receive. There is no perfect solution. There will always be 'vulnerable' people who are not known to the authorities, and very often there will simply be insufficient time in a fast-moving emergency to implement systems. Therefore, a quick and flexible approach must be adopted to identify vulnerable people in an emergency.'

Again, flexibility needs to be considered when planning and issuing guidance.

Most DsPH stated that their plans did include 'vulnerable groups' however there was variation as to whether the groups listed above were included. This depended on the local area, for example in an area with no prisons, plans did not need to factor this specific group into account. Many DsPH considered vulnerable people to be somewhat or partially considered, or stated that in the hindsight of the pandemic, more detail was needed than that which was there in January 2020. [Question 43]

Many DsPH responded that they either were not aware of any guidance issued by central government to local emergency planners in respect to the groups above, or did not consider the guidance issued to cover this issue specifically. Of the DsPH who were aware of the guidance issued by central government, it was usually described as generic or limited or outdated.

That said, DsPH stated that it was a requirement to all local emergency response plans should give regard, consideration and clear and appropriate action plans in relation to the categories outlined in the previous questions.

Below is a list of the guidance documents that could be applied to/featured vulnerable groups created by UK central government that DsPH listed:

- Civil Contingencies Act 2004
- Identifying people who are vulnerable in a crisis: guidance for emergency planners and responders (2008)
- Equalities Act 2010
- In the Pandemic Strategy (2011)
- UK influenza Preparedness Strategy (2011)
- National Emergency Preparedness Guidance (2012)
- Communicable Disease Outbreak Management Operational Guidance (2014)
- Evacuation and Shelter Guidance (2014)

- Guidance on communicating with the public issued to LRFs
- Local Management Guidance on Risk Assessments

In Wales, guidance was provided from the Welsh Government to regional IMTs with regard to the expected content of regional Prevention and Response plans, as well as specific guidance depending on particular settings, vulnerable groups and circumstances. [Question 44]

As DsPH outlined their role in providing advice, challenge and advocacy to the guidance shared by central government, the key themes were scrutiny, leadership and oversight at a local level. Many DsPH referred back to their statutory responsibilities and the role of a DPH in LAs and multi-agency groups, and how health inequalities is a core consideration across all public health work.

DsPH saw their role as ensuring that various groups with relevant protected characteristics and vulnerabilities were included in plans and additional resources were secured to respond proportionally to needs of local population. The role was described as translational – considering the population and the unique context of the place to support planners. DsPH stated that they worked hard to meet specific needs of vulnerable groups and those considered under the 2010 Equalities Act.

One DPH stated,

> 'As the DPH I consider it my role to be constantly identifying areas of inconsistency that result in inequity or increasing inequalities or marginalisation of particular communities or individuals.'

Another key theme in responses was the DsPH had a role in the interconnectedness of plans, given the DsPH role in multi-agency groups such as HWBs, LRFs, LHRPs etc. DsPH ensured linkage of responses, being involved in plan writing, testing exercising and learning from lessons identified through these channels. DsPH are uniquely placed to provide insight and the application of technical and epidemiological intelligence to the plan.

It was stated that, although the role of a DPH involves representing the needs of all the local population, this did not always feel a significant part of emergency planning pre-pandemic and this is a key learning point for preparation for the future. [Question 45]

Most DsPH stated that robust planning exercises and updates were happening on a regular basis locally (via Council, LRFs/BRFs or LHRPs). These exercises would be either desk-top or live/operational exercises, or a combination of both. DsPH also stated that plans were tested and updated regularly both regionally and nationally.

There was varying frequency in which plans were described as being regularly updated, usually however DsPH stated this was as per best practice, which meant annually for local changes/contact changes/full review and then every three years with full multi-agency consultation.

Once DsPH ran an emergency exercise locally, this would be followed up with a debrief session where inadequacies or gaps were identified. Plans were then modified on the basis of these shortcomings and these became the most up to date plans and were ready to be operationalised should the need arise. This constant programme ensured plans remained current and effective over the course of time. All exercising of plans focusses on learning and the plan's continual development.

Many DsPH named local examples of planning exercises that had happened in their specific area and cited the details of these as examples of how updates to readiness were enforced. These were often specific to what health concerns a DPH may encounter, for example planning for a Nuclear Emergency if there was a Nuclear plant in that local area. Another key element that many DsPH highlighted is that plans were also rewritten if there was a change in legislation or guidance or following learning from a major event.

One DPH noted that despite plans being exercised regularly, in reality these exercises did not anticipate the full impact of Covid-19 and some of the associated risks eg supply chain pressures. Note that many DsPH highlighted following Covid-19 plans have now been updated in light of challenges faced during the pandemic. [Question 46]

Most DsPH received regular training, with a variety of levels of training shared in responses including updates and exercising from PHE, the Civil Protection Unit and Emergency Planning team; and through multi-agency exercises (as part of their LRF/LHRP). A key theme was that these often concentrated on training and testing Influenza pandemic plans, not always novel viruses. It was emphasised that this training was theoretical and although live exercises were a component these were not ever at the scale or duration of the Covid-19 pandemic.

Many DsPH stated that as part of their training in public health, they had undertaken specific Health Protection Training. Many DsPH stated that regular training was part of their continual professional development, examples given included: STAC training, LASC training, MAGIC training and Health Protection Training. A large number of DsPH highlighted that an important element of their training was on the job, such as the number of years experience they had in Public Health or previous emergency incidents which they could draw knowledge and experience from.

Generally, DsPH stated that the training provided has been thorough and adequate. Some stated more clarity around roles nationally and regionally at training beyond a more defined local area would have been beneficial. As when the actual pandemic occurred, it wasn't expected there would be so much reliance on local public health teams. One DPH highlighted that although training is very important it also needs to be backed up by resources so you can deliver the correct intervention such as testing, PPE etc. It was acknowledged that when Covid-19 began, although training had been thorough it did not match the scale of the emergency and could not have anticipated elements DsPH had to deal with eg PPE shortages.

In Wales, DsPH received Health Protection Training from PHW with regard to incident and outbreak

management. In Northern Ireland, as the Public Health Agency does run trainings, however the DsPH and their team are directly responsible for delivering these trainings. [Question 47]

Many DsPH were involved in several exercises organised by PHE, LRF/BRFs and LAs. However, many DsPH also stated that there were not involved in any nation-wide exercises. Of those who were involved the two most mentioned were Exercise Cygnus (2016) and Exercise Winter Willow (2007).

Exercise Cygnus was a cross-government exercise to test the UK's response to a serious influenza pandemic that took place over 3 days in October 2016 and involved more than 950 people. DHSC (known as the Department of Health at the time) and 12 other government departments, as well as NHS Wales, NHSE, PHE, local public services, several prisons, and staff from the Scottish, Welsh and Northern Ireland governments took part in the exercise. The aim was to test systems to the extreme, to identify strengths and weaknesses in the UK's response plans, which would then inform improvements in our resilience. Exercise Cygnus was not designed to consider other potential pandemics, or to identify what action could be taken to prevent widespread transmission.

Exercise Winter Willow was the largest of a number of exercises undertaken in the UK aimed at testing and strengthening planning for the response to an influenza pandemic. The Exercise built on exercises held in previous years, especially Exercise Shared Goal in June 2006 which tested response plans at WHO Pandemic Phases 4 and 5. Exercise Winter Willow thus focused on WHO Phase 6, covering the period from the first case inside the UK through the development of the epidemic.

Other DsPH highlighted their experience in previous pandemics such as the Swine Flu Pandemic 2009 and the Ebola Pandemic 2014.

Other named exercises some DPH participated in were Exercise Black Swan, Exercise Corvus, Exercise Samson, Exercise Cold Play, Exercise Mallard, Exercise Prometheus, Exercise Procursus, Exercise Albireo and Exercise Bluebird.

PHW ran several pandemic type scenario exercises over the years, with the last one being organised in a couple of years before Covid-19 pandemic. [Question 48]

In January 2020, there were well established systems and processes between Public Health England local laboratories and LAs (DsPH and LA teams including EHOs) to share information about notifiable diseases and outbreaks, through the NOIDS system. Most DsPH listed PHE as leading the response and communications on this matter. Regular surveillance reports across range of infectious and communicable diseases were produced by PHE and shared with DsPH. Communication was also happening via HPBs, LRFs, LHRPs, ADPH, and local discussions with health partners regionally and locally.

DsPH stated there were regular datasets provided and bulletins etc where there was a new/novel issue. There were also annual health protection update/learning sessions delivered by the local health protection team for DsPH and Public Health Consultants to attend and some other wider events annually, which

would give examples of outbreaks, incidents and response, surveillance data and general updates.

Many DsPH referred back to their previous responses to other questions such as those on LRFs and local surveillance. [Question 49]

Before Covid-19, PHE played a stronger role in surveillance. The local team took on a lot more during Covid-19 as they were supported with more data. COMF funding also increased their capacity and led to a temporary expansion of local teams.

DsPH played an assurance role in surveillance. They ensured that surveillance was in place, sufficiently robust with appropriate and proportionate action in place. They ensured that data was analysed and reviewed locally. They ensured local reporting arrangements were in place in response to local incidents. They also ensured up to date surveillance information, where relevant, should be shared with GPs, local team, schools, hostels, and partner organisations/ forums. DsPH also provided overview and oversight. They played a key role in monitoring the local situation and escalating concerns when needed. The interpretation element of data collection should not be underestimated as that is a key role for public health leads for any infectious disease outbreak.

Data enabled DsPH to identify epidemiological patterns, access the risks of spread, identify complex outbreaks, identify high-risk places and communities, and identify health inequalities. Data also enabled DsPH to understand the impact of interventions (eg testing and tracing, levels of vaccination uptake). This informed decision making on mitigating actions (eg whether to convene an outbreak control team) and supported all aspects of their pandemic response. They liaised with NHS (key primary and secondary care staff) and PHE colleagues and communicated directly with PHE/ UHKSA Regional Health Protection Team in the event of locally-significant issues.

Data sharing, analysis and risk assessment were carried out through different platforms such as the HPB, HWB, HPSG and regional networks which informed mitigating actions and fed into relevant elements of the LA, partner and wider LRF response. In London, the health intelligence team was part of the local surveillance in partnership with SEL and HPU. In England, information, updates, learning and best practice were routinely shared by a Health Protection Oversight Board (same footprint as the LHRP) which was chaired by a DPH and attended by both LAs, CCG, hospital and community trust and PHE with routine reporting. In Greater Manchester, situational monitoring was in place across the region supported via a GM-wide Contain Assessment that was produced on a weekly basis. In Wales, DsPH linked closely and had a good relationship with PHW colleagues and in particular the CCDC/CHP that covered their patch.

There were different sources of data. DsPH received and interpreted data such as weekly health protection reports from PHE (later, UKHSA). They participated in regional meetings with PHE (later UKHSA) and partner agencies. They keep up to date with the developing national and international evidence base about the epidemiology, inequalities and other trends for Covid-19. They also utilised local, on the ground reporting and intelligence (hospital data, capacity tracker, local contacts, etc.).

DsPH also produced multifactorial and multilevel surveillance data. Local Public Health Intelligence Teams

developed local dashboards and tools updated daily to meet the local surveillance needs. They provided a weekly data briefing for all partners. They also conducted local modelling with universities. An Annual Health Protection Report outlining key data and trends was presented in public to the HWBs.

North West (C&L) established an information system and a local case management system to support the management of outbreaks and to ensure accurate and timely data sharing and collection. North West (C&M) established CIPHA – a population health management platform with NHS, local government and university. London also reviewed the data via the Covid-19 Situational Analysis 'Power BI' system. They worked with the NHS to produce more real time data on immunisation uptake in general practice, schools and other community settings through the local population health management IT system, which gave real time and more accurate data on vaccinations, including with demographic background (such as ethnicity, age group, area of deprivation).

The availability of data affected the DsPH ability to exercise their role. DsPH said there was no access to local surveillance data for individual cases. Many DsPH said they had minimal and inconsistent access to data, making it difficult for them to act. Many DsPH also said it took time for them to have access to data. There was no direct sharing arrangement between the NHS and LAs. North West (GM) said they only had access to case data for their area but not across GM. Initially, they only received patient level positive test results instead of negative test results – this was a serious limitation because they could not stand down suspected cases and outbreaks. Nonetheless, some DsPH also pointed out that advances in information, data systems and data sharing agreements during Covid-19 led to more information being available to DsPH to help inform local action. [Question 50]

DsPH acted as trusted professional and public health expert voice on matters related to health protection. They adopted a data informed approach to local communications. They also approved communications issued to public.

Local communications were largely based around information received from NHS and PHE (later, UKHSA). Public engagement and trust were crucial. There was a need to ensure local communications were consistent with regional and national communications. There was also a need to decide when not to put out communications when national communications were appropriate and clear. Proactive and reactive communications varied according to the importance and urgency of the issue.

Joint communications protocols were established with PHE (later, UKHSA) for the media management of health protection issues. DsPH worked closely with PHE communications department. There was also a communication and cascade system in place which included PHE (SEL Health Protection Team), NHS and Council communications teams. Key VCS organisations are also networked into the communications cascade. In the event of outbreaks, jointly signed letters between PHE/UKHSA and DsPH were commonplace to show and reassure the public and professionals in the system there was close collaboration and to ensure there was no mixed messages. PHE also produced warn and inform templates to different audience such as parents/ carers.

At local level, DsPH took the lead and cooperated with local communications teams, public health teams

and EP teams. They contributed to the development of communications strategies/ approach to support the Local Outbreak Control Plan during Covid-19. Communications processes and systems were also detailed in council and public health emergency plans. Communication teams were responsible for handling communication requests and disseminate information for the public. Agreements were also made on who was the best person to communicate with the public depending on the nature of the incident. For some places, communications were made from the Health Protection Assurance Board and HPB. In London, local HPU Team and Regional London office had designated communication support that would link with local communication team to support public messaging, when needed.

At regional level, DsPH worked with other DsPH in the region as well as partner communication and engagement teams (including ADPH) to produce regional communications plans. They also played a key role at LRF and contributed to the development and testing of their communications strategy. There was a dedicated LRF communications team with senior staff that would filter media queries, support DsPH with preparing briefings and develop comms approaches and materials to assist with communicating and advising the public. LRF plans would see standing up of communications cell in an incident. Lead agency would depend on type of incident. It would have been PHE (UKHSA now) for a HP incident, and police or fire as lead in many other types of incident. Communications Cell would include local authority communications and DsPH would input through the cell as required by incident. During the pandemic DsPH chaired local authority tactical groups at which communications were present and through which communications actions were directed. Communications also represented at local authority Gold alongside DPH where more strategic discussions took place.

DsPH and local teams utilised different channels to directly communicate with and advise the local public, including statements, press release, mass emails, letters, newsletters, leaflets, posters, infographics, magazines, paid adverts, social media, websites, press conferences, TV, newspaper and radio interviews, zoom/ Teams information sessions, Q&As and webinars. They often produced weekly briefings for the public on the data. They provided media briefings for media and maintained good relationship with them. They also used different formats and languages to ensure all sectors of the community have access to information.

DsPH ensured local health and care professionals and leaders, including locally elected members, were sighted on relevant issues. They also engaged with community champions, businesses, VCS organisations, schools, housing and neighbourhoods teams and libraries to distribute information. There were also specific cascade and communications networks for defined groups (eg care settings, schools and business forums). Nonetheless, some DsPH found that communications and community engagement did not reach everyone, including at risk groups (eg people from ethnic minority backgrounds, 'shielded' community). The tackling inequalities subgroup of the health and wellbeing board in GM coined the phrase 'missing 20%'. Additional engagement and joint working between local authority community teams, communications team, public health team and VCS organisations were essential in reaching diverse communities who might not access mainstream media.

North West (C&M) said the nationally recruited volunteer network had limited impact, as they wrote to them asking for help to share any help and they did not receive any replies. [Question 51]

Factors affecting readiness for a pandemic

DsPH listed a variety of factors having positively impacted their organisations state of readiness for the Covid-19 pandemic, with the key themes being regulatory compliance, relationships with stakeholders and planning and response capabilities. Over three quarters of DsPH stated that a high level of compliance with the CCA 2004, good engagement /relationships/ protocols between LRF partners and overall effective corporate emergency planning and response capability positively impacted their state of readiness. [Question 52]

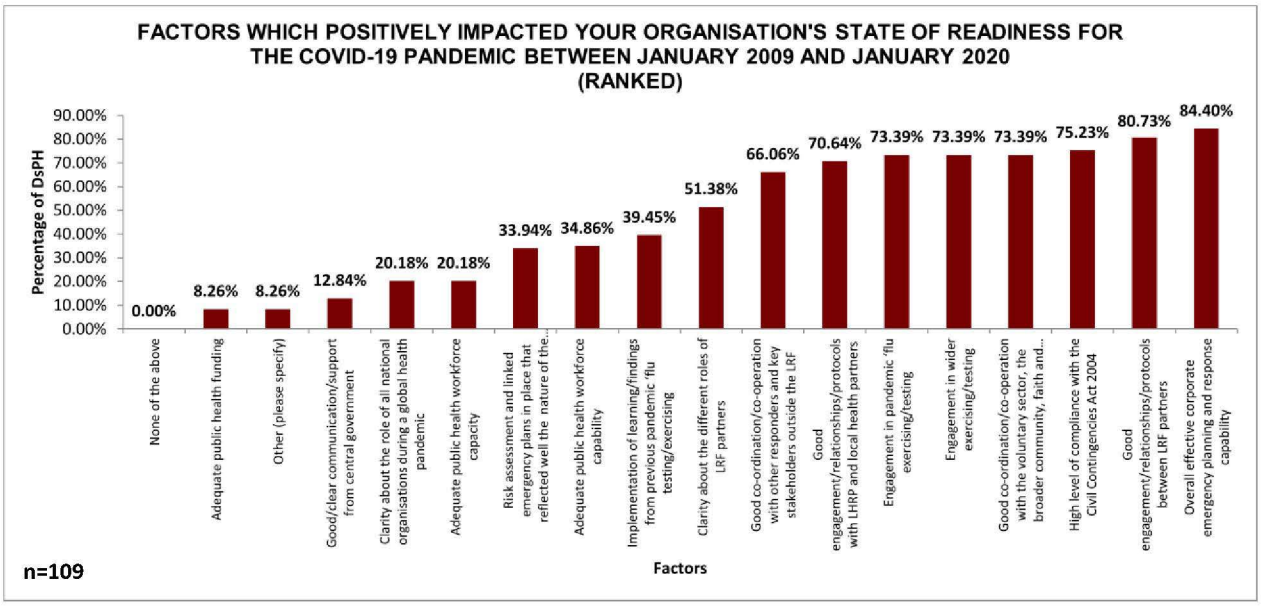

Figure 11: Factors which positively impacted DsPH state of readiness for the covid-19 pandemic between January 2009 – 2020 [Question 52]

When selecting the top five factors which most positively impacted their organisations state of readiness, DsPH selected **(1)** overall effective corporate emergency planning and response capability, **(2)** good engagement/relationships/protocols between LRF partners, **(3)** good engagement/relationships/protocols with LHRP and local health partners, **(4)** good co-ordination/co-operation with the voluntary sector, the broader community, faith and social enterprise sectors and **(5)** high level of compliance with the CCA 2004. Once again, these top five show the same key themes of regulatory compliance, relationships with stakeholders and planning and response capabilities [Question 53]

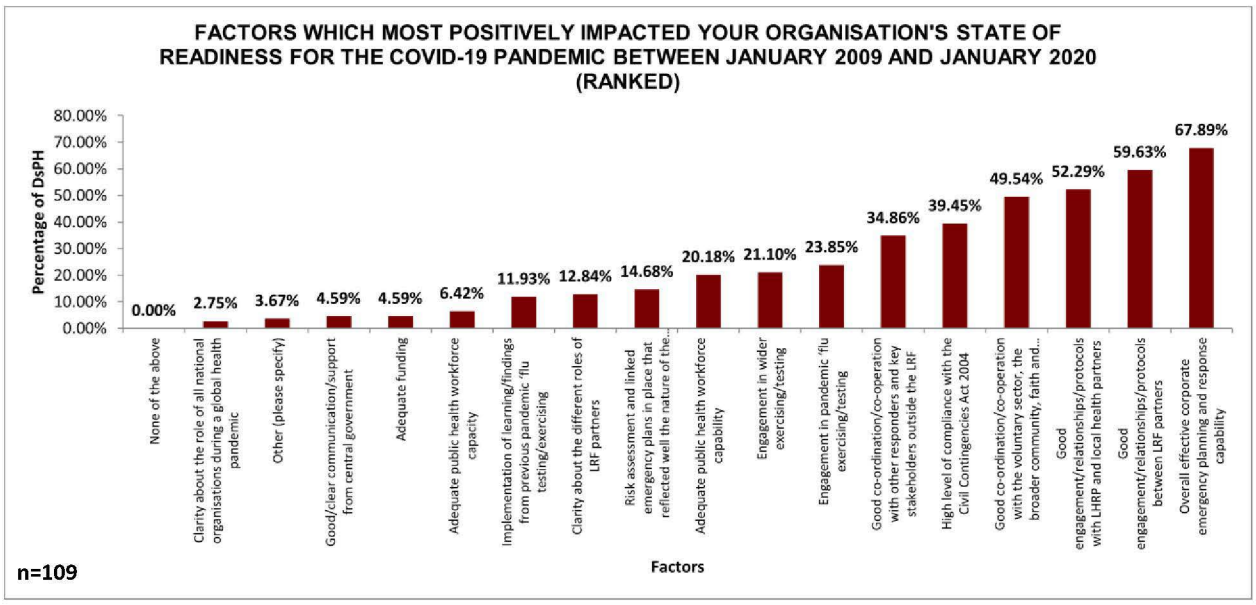

Figure 12: Factors which most positively impacted DsPH state of readiness for the covid-19 pandemic between January 2009 – 2020 [Question 53]

DsPH listed a variety of factors having negatively impacted their organisations state of readiness for the Covid-19 pandemic, with the key themes being poor communication and support from central government and inadequate planning for the worst-case scenario that unfolded with Covid-19. Over two thirds of DsPH stated that inadequate/unclear communication/support from central government, full lockdown never being anticipated as a reasonable worst-case scenario and national guidance relating to pandemic preparation did not anticipate the nature of challenges provided by Covid-19 negatively impacted their state of readiness. [Question 54]

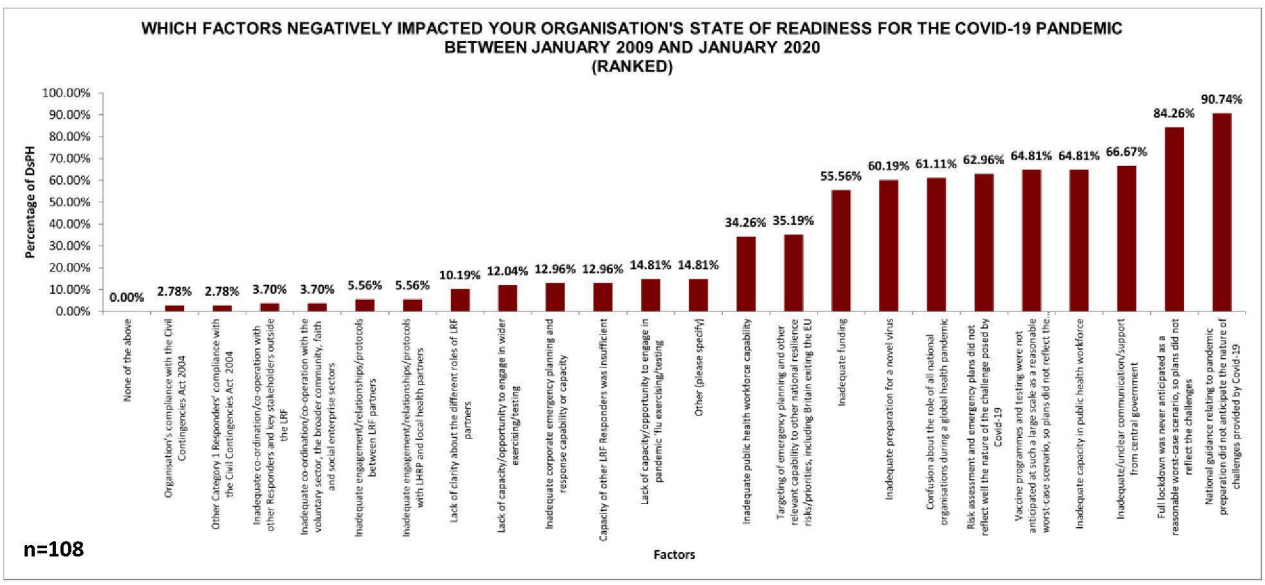

Figure 13: Factors which negatively impacted DsPH state of readiness for the covid-19 pandemic between January 2009 – 2020 [Question 54]

When selecting the top five factors which most negatively impacted their organisations state of readiness, DsPH selected **(1)** national guidance relating to pandemic preparation did not anticipate the nature of challenges provided by Covid-19, **(2)** full lockdown was never anticipated as a reasonable worst-case scenario, so plans did not reflect the challenges, **(3)** Inadequate/unclear communication/support from central government, **(4)** Inadequate capacity in public health workforce and **(5)** inadequate funding. Once again, these top five show the same key themes of poor communication and support from central government (specifically in regard to funding and workforce) and inadequate planning for the worst-case scenario that unfolded with Covid-19. [Question 55]

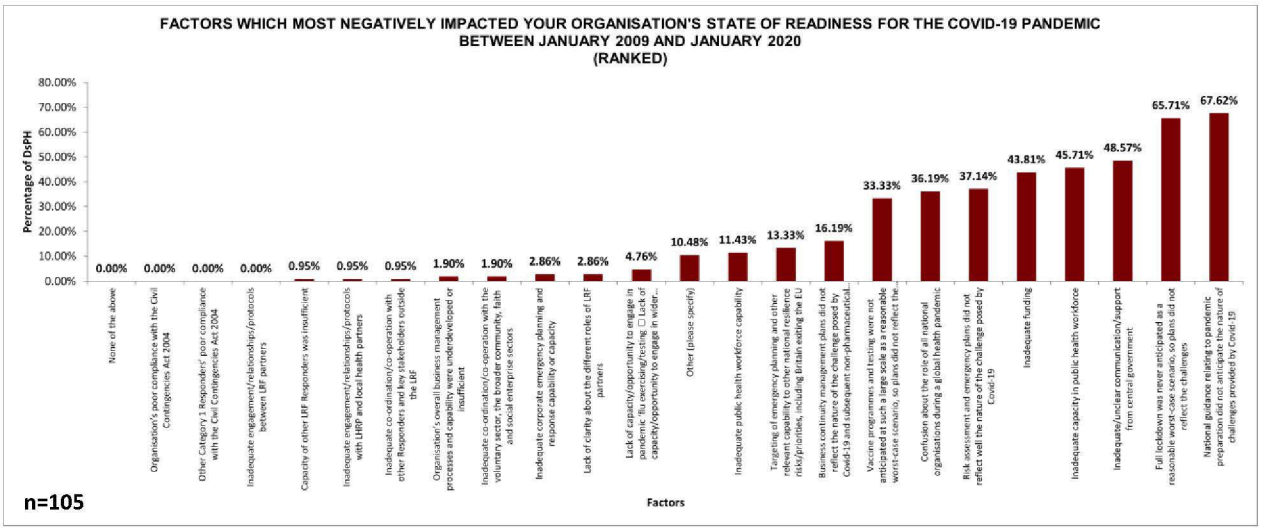

Figure 14: Factors which most negatively impacted DsPH state of readiness for the covid-19 pandemic between January 2009 – 2020 [Question 55]

The vast majority of DsPH (88.46%) stated that early on in the Covid-19 pandemic their ability to control local outbreaks was limited local and regional infrastructure capacity to take tests in the community. Other issues, not specified on the chart above are listed in themes below:

- Lack of guidance or conflicting guidance from PHE or National Government
- Top down approach meant lack of flexibility at a local level
- Failure to understand and appreciate the need for a locally mobilised response
- Lack of workforce and trained public health workforce to respond
- Outsourcing of testing and contract tracing
- Lack of resources eg PPE, hand sanitiser
- Discharging patients from hospitals to care homes
- The nature of Covid-19 eg asymptomatic transmission, a novel virus etc
- Early cessation of contact tracing because national plans followed outline for influenza pandemic
- Lack of understanding of diverse communities eg no multilingual information provided to share information with diverse communities

[Question 56]

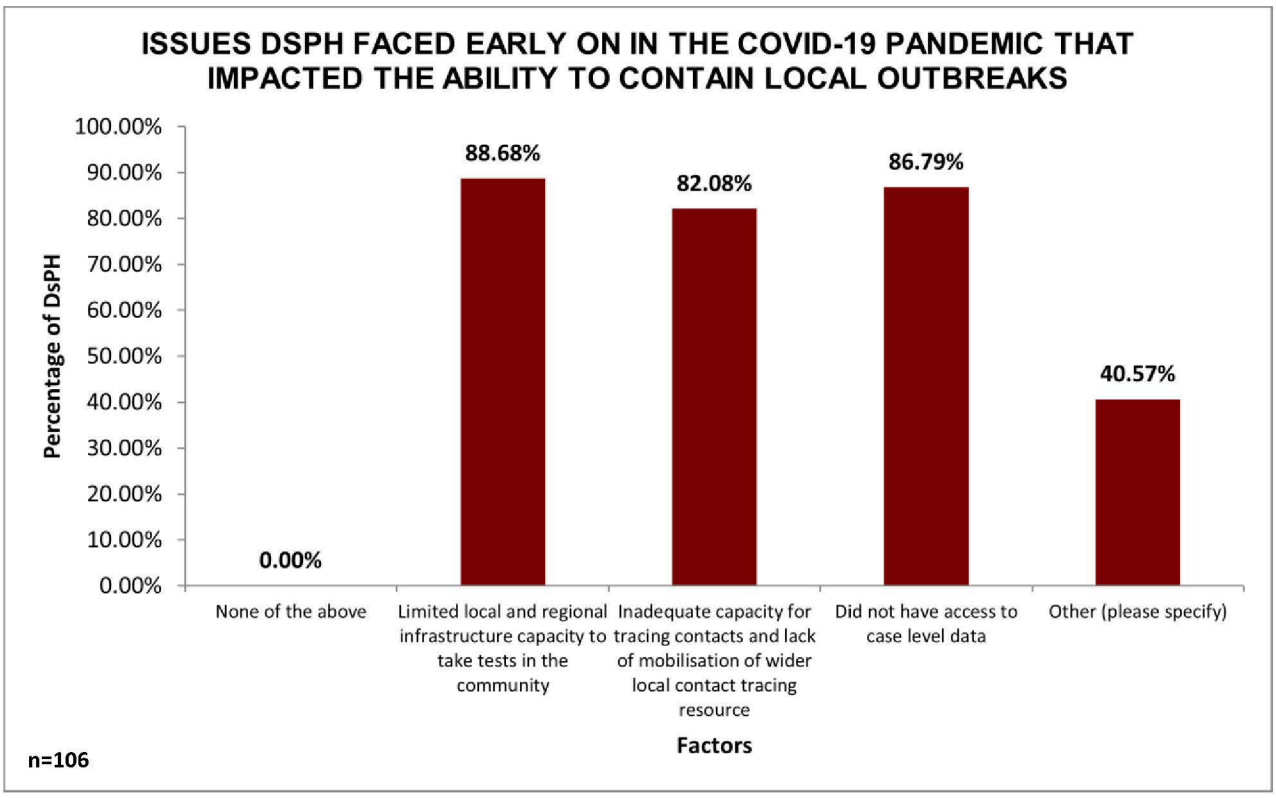

Figure 15: Issues DsPH faced early on in the Covid-19 pandemic that impacted the ability to contain local outbreaks [question 56]

Health Inequalities

Each local area had different challenges regarding health inequalities leading into the pandemic. There were distinct issues for rural communities, coastal communities, formerly industrial communities, urban communities, multicultural communities amongst others all listed by DsPH. Generally there are stark health inequalities between the most and least deprived areas in every local area and these are as result of an intersection of many individual factors. Many years of cuts to public services have eroded community and local service resilience, capacity and capability across the UK. Some DsPH felt that many of the inequalities in their area were not highlighted and discussed strategically prior to the pandemic which led to a poor response.

Examples of inequalities that affected communities going into the pandemic included:

Housing: housing density, poor quality housing and overcrowding; multigenerational households; temporary housing; lack of social housing; rough sleepers; travelling communities
Education: low levels of literacy; schools having to stay open for high amount of key worker and vulnerable children in certain areas; digital illiteracy
Employment: high unemployment and predominance of unsecure, low paid work; unpaid care workers; manual economy; tourism economy; retail economy; seasonal workforce
Health: mental health; multiple long-term conditions; poor diet; smoking rates; age; disability; obesity; older population; substance misuse
Wealth: high levels of poverty; high level of low income resulting in food insecurity; lack of financial support; child poverty; general affluence 'masking' poverty in an area
Mistrust: significant level of mistrust of statutory authorities, so no credibility in dissemination information about infection control or vaccination
Infrastructure: Low connectivity, poor access to services

The most prevalent theme that ran through a large proportion of DPH answers was the inequalities encountered by ethnic minority groups. These were specific to each local authority but individuals from these groups were disproportionately disadvantaged as a result of the intersection of many of the factors listed above. Poorer health outcomes and challenges around reaching these communities were highlighted by many DsPH, in conjunction with the factors listed above.

One DPH stated,

> 'The area that I serve is one of the most multicultural areas in the country which meant there was a challenge around language but more importantly challenge around culture and trust in relation to the work but was being carried out to combat Covid. There's clearly high levels of distrust of government and government organisations, and a feeling but the governments plans and policies were not constructed in a way that protected marginal or underserved groups. It was important that the messages that were being conveyed both centrally and and locally were adopted to local communities. This meant the blanket messages were not the solution for many of our communities and greater time, resource and effort where needed to ensure that health inequalities didn't increase.'

[Question 57]

DsPH are clear that health inequalities already existed prior to the Covid-19 pandemic but that the pandemic did make the inequalities more explicit. A strong majority of DsPH noted an exacerbation of life expectancies and healthy life expectancies because of the pandemic and response.

A predominant theme highlighted by an overwhelming majority of DsPH was a worsening of health inequalities in both mental health and children and young people because of the pandemic. Specifically, within children and young people the issue of educational inequalities steepening, and poorer development were both recurring themes. School absences have increasingly become an issue in children particularly those with special needs and those eligible for free school meals since the pandemic. Alongside poorer mental health outcomes, an uptake in substance misuse was also observed because of the pandemic.

Numerous DsPH emphasised the disproportionate impacts Covid-19 had on different communities. Specifically noting that deprived areas were hit both the hardest and longest by Covid-19. There was also recognition amongst DsPH of the disparities experienced by particular groups including traveller communities, black and ethnic minorities, people living with disabilities and rural communities. Although, of these types of inequalities those relating to poverty and socioeconomic deprivation were raised most frequently by DsPH. The most deprived areas suffered from higher mortality rates from Covid-19 due to factors such as vaccination uptakes, trust in services and access to health services.

Almost half of DsPH also acknowledged the impact of Covid-19 on employment, household incomes, economic issues (workforce, sickness absence) and its contribution to the cost of living crisis. DsPH also raised the impact Covid-19 had on the NHS, with it causing a substantial backlog in treatment and delays in the diagnoses of various conditions such as diabetes and cancer. [Question 58]

DsPH recommendations to improve preparedness and resilience included:

- putting in place data arrangements to enable data and intelligence to flow more freely from national organisations to local public health teams, organisations and authorities (note DsPH in the devolved nations did not have this as such a large concern, as they still sit within the NHS so can more easily access data compared to DsPH in England)
- improved transparency in communications from the national government
- the national government should consider developing a national strategy around communications during an emergency
- conducting regular tests of preparedness and to better equip the workforce to respond to pandemics by providing more training opportunities for relevant staff in health protection and pandemic preparedness
- widening the scope of emergency planning to be more inclusive of different emergencies and diseases and developing a national testing strategy early on
- maintaining the relationships they've formed during the Covid-19 pandemic with internal and external partners and through LRFs
- better harnessing of the VCS sector in emergency planning strategies going forward
- greater clarity around the role of DsPH and local authorities in pandemic preparedness and emergency planning
- greater certainty around the Public Health Grant and more funding for emergency planning/health protection

- expanding the public health workforce [Question 59]

Other Feedback

Key examples of good preparedness

A strong majority of DsPH noted the importance of local relationships, partnership arrangements and good links to the community sector (including faith groups) and social care sector as examples of good preparedness aiding their response to the Covid-19 pandemic. Some of the benefits of such relations expressed by DsPH was their ability to target tracing, testing and uptake of vaccinations in vulnerable populations by utilising their links to the community. Strong local relationships also allowed for enhanced data sharing and more transparent communications. Moreover, relationships to local authorities and Public Health England teams were also frequently described as invaluable by DsPH.

Additionally, many DsPH highlighted the usefulness of having a public health workforce that was experienced in EPPR, incidents control and or health protection. Noting that this substantially improved the capacity and capability of their teams. Existing emergency plans and exercises such as generic response plans, strong LRF structures and plans/exercises created for the influenza pandemic were deemed to be extremely useful tools to draw from in coordinating responses to Covid-19 by DsPH. Another useful tool that aided good preparedness were robust local outbreak management arrangements.

A few DsPH also expressed the utility of having a good ADPH network and noted the role ADPH played in mobilising support and responses to any queries that were raised. [Question 60]

Key examples of poor preparedness

A large majority of DsPH cited limited access to PPE particularly in care homes and settings as examples of where poor preparedness hindered their response to the Covid-19 pandemic. This was especially true during the early stages of the pandemic. Many DsPH also expressed that the influenza pandemic plans were not adequate and did not account for both the scale and wider impacts (such as on children and education) of the pandemic. Lockdowns, social distancing, mass vaccinations and testing on a large scale were not anticipated in the initial plans. DsPH often highlighted that the worst-case scenario in the original plans were not nearly as severe as the reality of the pandemic.

DsPH also felt as though their response to the pandemic was hindered by the lack of data sharing and the absence of warnings around national changes in policies and guidance. This in turn put pressure on local organisations to be more responsive to these changes. Furthermore, an issue highlighted by some DsPH was the inconsistency around advice provided by different Government departments. This inconsistency made it difficult to take and coordinate action locally. A few DsPH also noted that the protocol on discharging patients in hospitals to care homes was unclear and had grave implications.

Another key theme that was raised by most DsPH was the impact of the reductions in real terms made to the Public Health Grant over the years and the consequential impact this had on the capacity and capability of the public health workforce. These reductions limited the extent to which the public health workforce could invest in pandemic preparedness and health protection training. This caused specialists to be in high demand which made recruitment both competitive and expensive. DPH in Northern Ireland stated that planning for school closures was an element of the pandemic that was least prepared for, and the disruption to education that happened as a result of the waves of Covid-19. [Question 61]

Additional comments

One DPH stated,

> 'PHE was abolished, in part, due to its fitness as an organisation to respond to significant pandemic events. We are not assured currently that PHE's replacement, UKHSA, is a significantly different organisation to PHE, and therefore risks continue to exist around capacity and ability to respond in an appropriate and timely way to future pandemics. We remain unassured that our national direction of travel and decision making about discharge and admission to care homes. More focus needs to be given to vulnerable populations, including vulnerable older adults, such as testing strategies.
>
> LHRP should include social care as well as health organisations.
>
> Communications to local authorities was not timely – we found out a lot of national direction and guidance from watching the news.'

One DPH stated,

> 'One of the areas of significant learning was the need for an audit trail of guidance document changes, I understand PH Wales had records of changes and good processes for decisions based on current guidance. The guidance could have been more explicit so changes are easily identified and tracked.'

One DPH stated,

> 'Individual, setting and service risk assessments. Early identification of outbreaks based on suspected cases. Guidance for social care (preparedness) has to be included at the same time as for the NHS. Impact on primary care and pharmacies as part of the NHS preparedness took second place to NHS hospitals. Similarly for private health and care providers who are not considered along with NHS care.'

One DPH stated,

> '• The centralisation of lab and contact tracing capacity into PHE over the preceding decade, and then the reduction in capacity over that period contributed to the problem of scaling up testing and contact tracing and the sluggishness of the response.
>
> • This centralisation, along with cuts to public health budgets, contributed to a loss of health protection expertise in local authorities - who nevertheless were asked to pick up increasing parts of the operational response as PHE/UKHSA became overwhelmed.
>
> • In contrast the (belated) decision to ask general practice to lead the local delivery of the vaccine programme delegated the operational detail down to the lowest possible level (PCN groupings). This led to a response that scaled very rapidly.
>
> • The 'national knows best' attitude was clear early on - with little interest in sharing data with local public health teams or in involving them in planning the response - and persisted throughout the pandemic. Even where processes for engaging local expertise in national policy and guidance were developed, it was never clear that anyone was listening to what we said.'

One DPH stated,

'It is important in addressing the Module 1 topic of Resilience and Preparedness to consider how the preparations played out post 21st Jan 2020, as the proof of the planning is in the delivery. We all had pandemic flu plans, which were useful in managing the pandemic, but were not entirely sufficient. The gaps that emerged as plans were put into practice after Jan 2020 will be where there is the most to learn to support future Resilience and Preparedness and the Inquiry must ensure that this is covered.'

One DPH stated,

'Going forward we need to have a clearer understanding of the roles and responsibilities of both the public health team and Local Authority in relation to the health protection response and emergencies. Many PHE responsibilities were handed to LA teams with no discussion. Systems need to be in place to scale up and address the needs of the population within appropriate organisations rather than responsibilities being transferred to local authorities because national organisations become overwhelmed. If responsibilities are going to be transferred then we need to rethink the resource and capabilities of local teams and provide additional training, supervision and develop a robust governance arrangement to protect staff from working outside their competency.'

One DPH stated,

'There needs to be a greater emphasis on open information sharing with partners including national government, particularly around the impact on vulnerable people. Recognition that the transition to recovery will necessitate a local and potentially hyper local approach. National level testing capacity and arrangements to coordinate this must be maintained to enable swift local action. This is critical to getting ahead of the wave, as local decision makers only had hospital admission and death information available at the start of the pandemic, which lagged behind the actual infection rate by 1-2 weeks. The London SCG structure was replaced by a bespoke governance arrangement that better served the chronic nature of the incident. The Covid response structures put in place provided enormous resilience and depth to the response in London, providing key updates and strategic direction to authorities, coordination across key workstreams, real-time learning and best practice (e.g. surge testing), etc. These structures for chronic incidents should be formalised and embedded in response plans, training and exercising. We'd suggest a National review of supplies, including PPE, and a shared understanding of distribution mechanisms that can activate quickly during times of crisis. Helpful if the logging and evidence stream of work started at the point it was clear we were in a pandemic and could provide updates regionally.'

One DPH stated,

'The failure to have enough PPE was a huge failure of national planning, as was the early withdrawal of any attempt to undertake effective local contact tracing - these elements should have been included in the pandemic preparedness plans, as should the processes for sharing data with local DsPH. We were left having to sort all of this out and there was no understanding of the importance of the local response, it felt like the national systems thought they could do it without us. Surely the whole point of being a Cat 1 responder is because we are so obviously essential to effective delivery? We weren't treated as such and DsPH weren't even included in many of the NHS communications. Also PHE needed to be able to act more quickly without waiting for ministerial approval re guidance. and this should be in the plans. Finally, the money came through very late, and there were substantial skills gaps eg in PH specialist capacity and in PH intelligence - this remains a problem.'

One DPH stated,

> 'Government of [the Island] showed enormous flexibility to manage the pandemic which undoubtedly led to many lives being saved in the early stages.'

[Question 62]