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of Health

From Steve Brine MP
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Dr Sarah Wollaston MP
Chair
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For Dr Wollaston,

Thank you for your letter of 28 April to Jeremy Hunt MP seeking further information on some of the recommendations the Committee made in its report on the public health system post -2013. I have been asked to reply in my capacity as Minister for Public Health.

Funding

Will the Government commit to ensuring that funding for health protection work is maintained?

We continue to believe that local authorities are best placed to make funding decisions about the services need to meet the needs of their populations and many councils are re-tendering contracts and achieving better value for money than in the past. We are aware that many councils have redesigned services, taking a holistic place-based approach and are demonstrating real innovation – which we welcome.

We have to take tough decisions to ensure that public finances are sustainable, and that our economy can support the essential public services on which we all rely. Local authorities will still receive more than £16billion for public health over the current spending review period.

In addition to the public health grant to local authorities, a number of public health programmes are funded through the annual NHS public health functions agreement (made under Section 7A of the NHS Act 2006) and commissioned by NHS England. These include national immunisation programmes, national routine cancer and non-cancer screening programmes, and public health services for those in custody and other places of detention. In 2017/18 funding totalling £1.137billion is allocated for



the purpose of commissioning services under that agreement. The Government has no current plans to alter this arrangement for NHS-commissioned public health services.

Can you please provide an update on the progress the Government has made in its consultation work on changes to public health funding?

Can the Government please provide an update on the work that has been to date by the Department of Health in conjunction with Public Health England, the Department for Communities and Local Government, HM Treasury, the Local Government Association and Association of Directors of Public Health on the reforms to public health funding, with particular reference to how they intend to manage them as so not to further disadvantage areas with high deprivation and poor health outcomes?

The Government is committed to delivering the manifesto pledge to help local authorities to control more of the money they raise and will work closely with local government to agree the best way to achieve this.

Officials in the Department of Health (DH) will continue to work closely with the Department of Communities and Local Government (DCLG) on any proposed reforms and will ensure that all interested stakeholders are consulted on any changes to the system for funding local authority public health functions.

The Government remains committed to a Fair Funding Review as an important way to address concerns about the fairness of current local authority funding distributions. There have been widespread calls for a thorough, evidence-based review and this we plan to deliver. DCLG will therefore continue to make progress with the review, in collaboration with the Local Government Association and local authority officers.

It is important to get this right and we will continue to seek views on the approach and the target date for implementation.

Access to data

Can the Government please provide an update on why this perception exists among public health specialists and what has been done to redress it?

The Government published its response to the National Data Guardian for Health and Care's (NDG) review of Data Security, Consent and Opt-Outs and the Care Quality



Commission's review, 'Safe Data, Safe Care' on 12 July 2017. The response accepted all of the recommendations in both reviews. It highlighted the importance of sharing data in a safe, secure and legal way, which complements the Caldicott principles. The response noted the important role of NHS Digital in supporting the NDG's 10 data security standards and implementing the national opt-out. NHS Digital, as the statutory safe haven for the health and social care system, will anonymise personal information it holds and share it with those that are authorised to use it.

In doing so, NHS Digital and Public Health England (PHE) continue to work together to improve timely access to de-identified data and centralised record linkage services that local authority public health teams need to discharge their responsibilities. In the meantime, NHS Digital continues to make available access to a number of key public health data sets in an anonymised-in-context form to local authorities through its Data Access Request Service (DARS) process. PHE, meanwhile, is continuing to provide data analysis and health intelligence support to local authorities through its local knowledge and intelligence service and using information tools that are currently available, such as the Public Health Outcomes Framework online tool.

Can the Department of Health provide an update on the progress it has made implementing Personalised Health and Care 2020?

As previously mentioned, the Government's response to the NDG and CQC reviews 'Safe Data, Safe Care' on 12 July 2017 set out that, where possible, organisations should only use anonymised data. However, where it is necessary to use identifiable data, individuals will have the choice of how and for what purposes their data is used for purposes beyond their direct care as part of the national opt-out.

We recognise that it is important for organisations to have access to data they need to deliver high quality, integrated health and social care. They should be confident to share information where it is appropriate and ensure it is done safely, securely and legally. There is a need for ongoing dialogue with professionals, charities, researchers and the public about how health and care information is used and the benefits of data sharing to ensure a greater understanding of how information is essential to support excellent care, including protecting the public's health, and for a wide range of beneficial purposes, including research and innovation.

The Government response confirmed that strengthening data and cyber security, improving the response to data and cyber incidents and providing clarity on the handling of personal data remain an urgent priority. The 10 security standards will



help to ensure that organisations are prepared for, and resilient to, data and cyber security incidents, and are minimising the impact on essential frontline services when these occur. These standards are applicable to every health and care organisation that handles personal confidential information.

The CQC review set out the critical importance of senior leadership in any organisation's resilience to data and cyber security issues, and that successful data and cyber security demands engaged leadership and a culture of learning and sharing.

We recognise that there needs to be a collaborative approach across the health and care system focusing on ongoing engagement and communication which will be at the heart of successful implementation of any change.

Public health workforce

Please provide an update on the development of a public health workforce dataset.

Work on the Public Health National Minimum Dataset (PHMDS) is ongoing. Since late 2016, Health Education England (HEE) has overseen the project, in collaboration with the Department of Health, PHE, NHS Digital and others. This will provide information on numbers and trends across this key workforce group. The development phase is now complete, and work is now underway to pilot/test the PHMDS with selected local authorities and PHE, with the aim of introducing it across the system in 2018.

Prior to the introduction of the PHMDS, and to support effective workforce planning in 2017, HEE and PHE have conducted a one-off data collection exercise on workforce numbers, capacity and demographics of consultants and Directors of Public Health within local authorities. This collection closed in June, and achieved a 78 per cent response rate from local authorities. Results from the data collection will be available from the autumn, and the information obtained will be used to provide intelligence to the system to inform existing planning processes, alongside existing known information on PHE and NHS staff from the Electronic Staff Record.

Please provide an update on the Government's work to date with PHE and LGA to monitor the impact on the public health workforce of current barriers to workforce mobility and to look at how the mobility of public health professionals



can be supported to make sure that LAs and PHE have access to the skills they need.

The workforce mobility issues arise because of differences in the terms and conditions between the NHS, local authorities and PHE, which makes it difficult to recognise previous continuous service. This is an issue that goes beyond public health and has relevance across other parts of the public sector.

PHE monitors internal recruitment and retention to identify any areas of particular concern and the associated reasons, and we look to take mitigating actions on a case-by-case basis. PHE terms and conditions are reviewed regularly to ensure PHE is using flexibilities in the civil service system to best effect. There are also local initiatives to promote mobility in terms of developmental activities, such as secondment opportunities from the NHS.

PHE also continues to take advantage of a clinical ring-fence arrangement agreed with Cabinet Office at the time of transition from NHS to PHE terms and conditions. This allows PHE to appoint staff to posts within the ring-fence on terms analogous to NHS terms and conditions. This is a limited concession and each post needs to meet certain specified criteria agreed with the Cabinet Office, also the size of the ring fenced group may not exceed 17 per cent of the PHE workforce.

PHE continues to work with the Local Government Association and other stakeholder organisations in managing the issues, including guidance on promoting movement around the public health system within current governance frameworks.

Please provide an update on progress in deciding the level of professional regulation appropriate for public health specialist roles.

The Government is considering options on how to progress the reform and rationalisation of professional regulation and I will, of course, ensure you are updated once a decision has been made.



STEVE BRINE

Dr Sarah Wollaston, MP
Chair, Health Committee
House of Commons

07 September 2017

Dear Dr Wollaston,

I write in response to your letter dated 28 April 2017 requesting an update on recommendations made in the Health Committee report *Public Health Post-2013*.

The specific recommendations are as follows:

- **Recommendation 15:** work done by NHS Digital to ensure that public health specialists receive regular updates about developments in data access.
- **Recommendation 16:** work done by NHS Digital and Public Health England to maximise the access that public health specialists have to population data within the confines of existing laws and regulations.

You requested a progress report for when the Committee resumed business proper following the General Election, formation of a new Parliament and summer recess. To this end can I please extend my personal congratulations on your recent re-appointment and continued involvement.

Our substantive update is as follows:

Recommendation 15

NHS Digital and Public Health England (PHE) are working to ensure that the health and care system has access to the data and intelligence it needs to discharge its responsibilities.

In response to recommendations made by the Health Select Committee, NHS Digital and PHE undertook a number of initiatives to ensure public health specialists receive regular updates about developments in data access.

These include:

- Establishing workshops (jointly run between PHE and NHS Digital) for local authority public health colleagues to provide a better understanding of their data access requirements, and to explore the options for resolving them.

A series of workshops have been held across the country with over 120 attendees.

- Establishing an NHS Digital-led programme of webinars aimed specifically at Public Health Colleagues in local authorities to provide focused information and insight on the data available to them and how best to optimise its use.

This includes coverage of Hospital Episodes Statistics (HES) data, Primary Care Mortality Data (PCMD) and other data sets available to Local Authorities.

These webinars have also provided information on how access to the data, including the Hosted Remote Data Access Service (HDIS).

Invites have been extended to more than 4000 customers and, to date, nine webinars have been held, with 3 exclusively for local authority colleagues (a total of 262 attendees).

Feedback on these events has been overwhelmingly positive and the programme is continuing, with further sessions planned into the Autumn.

- NHS Digital has also established an ongoing programme of webinars open to all users covering the above topics and providing insight around areas such as consent, the impact of GDPR and patient opt outs.

Where topics impact specifically on local authorities, targeted webinars will be held.

- Running a number of one to one meetings with new models of care organisations (Vanguards) to establish ways of supporting their complex requirements within the constraints of the law.

Local Authorities have frequently been involved in these meetings with respect to providing joined up commissioning.

- Attending and presenting at a range of conferences, including the Local Government Authorities (LGA) conference between 4-6 July to provide information about the services that NHS Digital offers and workshops on how to access the data we hold.

Recommendation 16

NHS Digital is continuing to enable access to a number of key public health data sets in an anonymised-in-context form to local authorities through its Data Access Request Service (DARS) process.

In order to simplify and speed up access to the data, NHS Digital has created a template application for local authorities to use when requesting data for a common purpose. This has reduced the average time taken for an application to be approved (from submission) from over 60 days to 24 days.

In addition, circa 90 local authorities are currently receiving Hospital Episode Statistics (HES) extracts under live agreements and there are a number of applications currently in progress. Primary Care Mortality Data (PCMD) continues to flow. Currently, 105 local authorities are receiving PCMD data and several more are in the application stage.

As with HES, a standard template, which details why local authorities need access to PCMD, has been developed. Such detail meets the requirements for transparency and supports trust in the flow of data.

Feedback from the aforementioned data access workshops identified that whilst access to national data had improved, some local teams are struggling to secure the local data management resources needed to manage large volumes of record-level data.

NHS Digital has therefore made available to all local authorities access to the remote data access service (HDIS), which enables secure access to hospital activity data. Uptake was initially low, however, is now steadily increasing as a result of the targeted webinars and there are currently 35 live users.

All data releases meet the requirements of ICO Code of Anonymisation, and the data is considered anonymised in conformance with the ICO code. Patient objections are not upheld in relation to these data set requests.

NHS Digital is providing data to local authorities in line with agreed policy, and doing so in an open and transparent way, and upholding opt-outs appropriately.

Local Authorities are not charged for access to the data as described above. This represents a saving over £1.4 million to the Local Authorities as a whole.

Furthermore, NHS Digital also enables access for local authorities to the Personal Demographics Service.

Such access is given on the basis of the local authority making an application that complies with a standardised framework, and for use in supporting the delivery of direct care only.

Typically this involves tracing the demographic details (including NHS Number) of an individual receiving care to confirm or update the data in the local authority care record - hence facilitating communication with healthcare delivery partners who are also providing care to the individuals concerned.

The data thus provided is not used for public health or other local authority services such as education.

NHS Digital is also working with the Office for National Statistics (ONS) to simplify access to births and deaths data for all users, including local authorities. A position is expected to be reached and implemented regarding this by the Autumn.

Work is also under way to review how other data sets that NHS Digital controls, such as mental health and child and maternal health, might be made available to local authorities.

Thank you for your correspondence. I will close by stating that NHS Digital remains willing to engage on this matter, and will endeavour to fulfil any further requests where we have the ability to do so.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Rob Shaw'.

Rob Shaw,
Deputy CEO



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3 October 2017

Dear Sarah

Public Health England's (PHE) progress in implementing recommendations 16 and 20 of the House of Commons Select Committee Inquiry report Public Health Post 2013

Congratulations on being re-appointed as the Chair of the Health Committee. I am writing in response to your letter of 28 April regarding the progress PHE has made in implementing recommendations 16 and 20 of the Health Select Committee Inquiry report Public Health Post-2013.

Recommendation 16: Work done by NHS Digital and Public Health England to maximise the access that public health specialists have to population data within the confines of existing laws and regulations

PHE and NHS Digital have undertaken a number of joint regional workshops with local authorities to develop an improved understanding of the data and information that is available and what the barriers to access are.

Local authorities are now able to access anonymised Hospital Episode Statistics (HES) data and Primary Care Mortality Data (PCMD) directly from NHS Digital free of charge using standardised application forms produced by PHE and NHS Digital specifically for this purpose. As of August 2017, NHS Digital has provided 87 of the 152 unitary and county local authorities with access to HES and 103 with access to PCMD, and the PHE Local Knowledge and Intelligence Service is working with those local authorities not yet accessing these services to demonstrate their benefits.

NHS Digital has set up a regular meeting with representative Directors of Public Health to understand more about their requirements for the data and information services it provides. Similarly, the PHE Local Knowledge and Intelligence Service is continuing to provide direct support to local authority health intelligence leads to ensure that they are able to access the analysis they need to do their jobs effectively.

This work is fully aligned with the recommendations of the third report of Dame Fiona Caldicott and the recent Government response.



Public Health England

Recommendation 20: Health protection is a critical public health function, and more work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents. This work should begin with an audit of local arrangements, including a review of capacity in provider trusts, and the development of a national system to collate and disseminate lessons learned from incidents. We will review PHE's progress on this work in six months' time (Paragraph 135)

We agree that protecting the nation's health requires all parts of the system to work effectively together to provide a comprehensive response to the full range of threats. PHE convened a Steering Group for the Local Health Protection Audit including all parts of the local public health system with ten national organisations. These included: PHE, Local Government Association, Association of Directors of Public Health, Faculty of Public Health, NHS England, National Health Service (NHS) Clinical Commissioners, NHS Improvement, NHS Providers and the Department of Health. We have refreshed the overall approach, approved specific documents and secured support from the organisations represented.

The Steering Group has also designed a new and comprehensive assurance exercise which includes addressing the specific areas highlighted by the Committee.

They have commissioned an online questionnaire covering:

- The general approach to local health protection response (roles, responsibilities, agreements)
- Several scenarios to explore how these would actually be managed locally
- Perceived strengths and weaknesses of local systems
- Local improvement plans
- Whether any national actions would help resolve local concerns.

As you know, Local Health Resilience Partnerships (LHRPs) are the local fora tasked with emergency preparedness and planning and are co-chaired by local Directors of Public Health and a senior local NHS leader. The questionnaire was sent to LRHPs in June with responses due by mid-September and this is on track. We will send the Committee a copy of the results of the analysis and any follow-on actions when complete.

In addition, PHE, working with NHS England and the Department of Health, is leading on the development of an interactive nationwide and multi-agency database which collates and disseminates lessons identified from incidents and exercises involving lessons for local government, the NHS and PHE's local teams.

If there is any more information that you need, please only say.

With best wishes

Yours sincerely

Duncan Selbie
Chief Executive

cc: Professor Paul Cosford, Director of Health Protection and Medical Director, PHE
Clara Swinson, Director General – Global and Public Health, Department of Health



Public Health
England

Protecting and improving the nation's health

Local Health Protection Assurance Exercise

Report for the House of Commons Health and Social Care Committee

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Contents

About Public Health England	2
Background	4
Current arrangements for health protection	5
Assurance process	5
Assurance results	6
Actions taken	7
Appendix 1. The roles and responsibilities of the key bodies involved in delivering and supporting local health protection	9
Local partnership arrangements	9
Local organisations	10
National agencies	10
Appendix 2. Steering group membership	12
Appendix 3. Summary of areas covered by questionnaire	13

Background

1. The 2013 reorganisation of the NHS and public health system led to a new set of health emergency preparedness, resilience and response (EPRR) arrangements across England. These new arrangements initially focused on major issues, such as a flu pandemic, but because they also impact on local health protection arrangements, they are the most appropriate mechanism for enabling local agencies to collaborate on preparing and planning the response to local incidents and outbreaks of infectious disease.
2. In 2014 the key national organisations with a remit for the public's health conducted an assurance exercise to help local organisations such as local government and the local NHS work together on their response arrangements. While there was a reasonable degree of assurance, local organisations subsequently identified specific local areas where they needed to undertake further work to be better prepared. There was recognition from all national and local agencies that responding to an emergency was paramount for them and that administrative and financial issues should not be a barrier to meeting patient and public health need. A follow up exercise was planned for 2016-17.
3. On 1 September 2016 the House of Commons Health Select Committee published 'Public health post-2013', a report on the public health system post the 2013 reorganisations. The section on the local health protection system said:

"35. Health protection is a critical public health function, and more work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents. This work should begin with an audit of local arrangements, including a review of capacity in provider trusts, and the development of a national system to collate and disseminate lessons learned from incidents. We will review PHE's progress on this work in six months' time."
4. The Government's response (see www.gov.uk/government/uploads/system/uploads/attachment_data/file/573529/Gov_Reponse_Cm_9378_web.pdf) confirmed to the committee that PHE would establish a national group to plan and run an assurance exercise. This report describes how the recommendations have been taken forward, the findings of the assurance exercise and the actions to deal with the issues identified.

Current arrangements for health protection

5. Appendix 1 sets out the roles of the different bodies. It summarises the responsibilities of the relevant local agencies, the central role of local health resilience partnerships (LHRPs) in co-ordinating the local planning and preparedness for response, and the remit of the national bodies that provide support to local preparedness and response.

Assurance process

6. PHE set up a steering group (Appendix 2) with representatives of the key national statutory and membership bodies with a role in local health protection preparedness, planning and response. This group agreed that the committee's recommendation should be addressed through an exercise that combined assurance and local improvement (continuous service and sector led improvement) based on a questionnaire about arrangements in each LHRP area. The focus was on a range of incidents that required a multi-agency and clinical response to protect the public's health. This needed to be joined up and consistent with the arrangements in place for major incidents, especially an influenza pandemic. These are covered in the Cabinet Office led capability survey run by the Department of Health and Social Care (DHSC), NHS England and PHE.
7. The steering group developed an online questionnaire (Appendix 3) of LHRPs covering:
 - the general approach to local health protection response (roles, responsibilities, agreements)
 - scenarios to explore how these would actually be managed locally
 - what local and national actions would help resolve the issues
8. The questionnaire adopted a standard approach to assurance whereby LHRPs were asked to assess compliance (full, partial or none) against a wide range of capabilities covering generic arrangements and the specific scenarios. Respondents were also asked to describe what further developments were needed to achieve full compliance, whether these developments were local and/or national, and to provide any other comments they felt appropriate.
9. The questionnaire was tested with staff from local systems to ensure that the questions were well understood. To maximise the response rate, LHRPs were told

that responses would be treated in confidence and that the final report would be anonymised. This has been crucial in obtaining the excellent response rate and frank responses to the questions, and we are maintaining this confidentiality in working to support LHRPs in their improvement work.

Assurance results

10. All 36 LHRPs in England replied, with all responses authorised by LHRP co-chairs. Overall assurance levels were reported as fair. Since the results were initially fed back to LHRPs, PHE and NHS England teams have been in contact with LHRPs and all are making good progress with improving their assurance – more details can be found in paragraphs 17 to 19. Results are grouped under six areas shown below.
11. **Commissioning responsibilities.** While many capabilities were fully assured, there were concerns about some that related to finance, including a lack of local agreements about responsibility for commissioning and payment and no clear local mechanisms for rapidly resolving disagreements. Further work on commissioning responsibilities needs to be agreed between local authorities and NHS commissioners. The steering group asked LHRPs to ensure that they have clear agreements in place for a range of different scenarios and mechanisms for senior staff to agree responsibilities at all time. Some LHRPs have work to do on preparedness for specific scenarios.
12. **Primary care.** Clarity on the General Practice General Medical Services contract and what it covered in relation to response to incidents was raised, and LHRPs have been asked to seek clarification from local NHS England colleagues where this is a local issue. Other concerns were about primary care capacity for larger incidents.
13. **Learning lessons.** LHRPs identified the benefits from a national process on learning lessons, including clarity on where debrief reports, lessons, recommendations and actions are reviewed and where responsibility for resultant action lies. PHE has a well governed internal process for identifying and learning lessons from incident response and exercises. Since March 2018, these have been disseminated nationally to the EPRR community via the Cabinet Office Resilience Direct platform. Additionally PHE is working with NHS England and DHSC to develop an interactive nationwide database that captures lessons from the NHS, DHSC and PHE from incidents and exercises, to be disseminated through the national platform of Resilience Direct where appropriate. PHE and NHS England

are exploring whether learning from local authorities and LHRPs could also be shared through this route.

14. **Resources/capacity.** The scope to improve local out-of-hours co-ordination was recognised by some LHRPs and some localities are working to ensure that they have addressed issues on local environmental health input. Some LHRPs need to do further work on local capacity to undertake the range of local multi-agency planning and types of incidents. Local support from PHE and NHS England has been offered to all LHRPs.
15. **Standards.** Some respondents suggested that a set of national standards for LHRPs and their members on EPRR would help to create common expectations, especially given newer roles and responsibilities in the NHS including the impact of future changes such as sustainability and transformation partnerships and integrated care systems. The steering group is looking at proposals to create some common standards that all LHRPs can use and which would inform further assurance work.
16. **Others.** Specific issues raised by some respondents included clarifying the questions about radiological monitoring units and potassium iodide (KI) distribution, a suggestion that local authority social care should be more engaged with LHRPs, and requests for further national guidance on a range of issues including funding responsibilities. Some LHRPs appear to have resolved some of these locally.

Actions taken

17. Following an initial analysis, all LHRPs were sent an anonymised spreadsheet of the detailed results to allow them to compare their results with those from all other LHRPs. The steering group asked 19 of the 36 LHRPs to urgently address eight specific capabilities in the survey that were felt by the steering group to be of particular importance for local preparedness. Ongoing support to these LHRPs is being provided through local PHE and NHS England specialist teams. Update reports have demonstrated that the vast majority have made good progress.
18. After further analysis, a letter from PHE and NHS England was sent to all LHRPs in February 2018 to bring them up to date with where the assurance exercise had got to and to set out the next steps:

- for a few LHRPs who reported a high level of compliance, PHE and NHS England will have detailed conversations with to understand the details of how they have resolved issues that could be shared with other LHRPs
- for those LHRPs that reported partial compliance in some domains, NHS England and PHE emergency planning staff will continue to work closely with them via established mechanisms to develop improvement/action plans so that LHRPs will be able to give stronger assurance in future. This could include moving from verbal to written agreements. PHE and NHS England will collate and document the various issues that have been addressed in discussions between LHRPs and NHS England regional EPRR leads
- for those LHRPs who want to better understand what aspects of response are covered through the General Medical Services contract, NHS England local managers will be the first point of contact
- on radiation monitoring units formal guidance/a template plan is likely to be distributed in the near future. On stable iodine/KI distribution, we have clarified that not all LHRPs need such a capability. It is currently only needed for those few LHRPs that have an operational or recently shutdown (within 90 days) nuclear reactor which require planning for stable iodine
- as a number of LHRPs asked about whether there might be a set of standards for LHRPs to work to, we are asking LHRPs to be clearer on what they would like these to cover and how a 'sector-led improvement' approach could be used to progress this. Such standards could be part of updated guidance on LHRPs. This could include more on the leadership role of the director of public health, whether LHRPs have access to local suites of guidance and agreements and be clearer that LHRPs' responsibilities go beyond large scale/major incidents to cover the sorts of issues addressed by this assurance process

19. We also plan to repeat the assurance exercise in late 2018.

Appendix 1. The roles and responsibilities of the key bodies involved in delivering and supporting local health protection

Local partnership arrangements

Local resilience fora (LRFs)

These are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

LRFs are supported by organisations, known as Category 2 responders, such as the Highways Agency and public utility companies. They have a responsibility to co-operate with Category 1 organisations and to share relevant information with the LRF. The geographical area the forums cover is based on police areas.

(Adapted from Cabinet Office

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62277/The_role_of_Local_Resilience_Forums-_A_reference_document_v2_July_2013.pdf)

Local health resilience partnerships (LHRPs)

LHRPs are partnerships that provide a strategic forum for local organisations (including private and voluntary sector where appropriate) to facilitate health sector preparedness and planning for emergencies at LRF level. They facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning, are often coterminous with LRFs and have two co-chairs. One is a local director of public health and the other a local NHS England director. DHSC published guidance on LHRPs in 2012 (see

<https://www.gov.uk/government/publications/arrangements-for-health-emergency-preparedness-resilience-and-response-from-april-2013>).

Local organisations

Under the Civil Contingencies Act, local organisations are designated as Category 1 or 2 in relation to their responsibilities for planning and response to civil emergencies. Category 1 responders are those organisations at the core of emergency response (eg emergency services, local authorities, PHE, NHS providers). Category 1 responders are subject to the full set of civil protection duties.

Local authorities, through the directors of public health, provide leadership for the public health system within their local authority area. They have a mandated function to provide information and advice to relevant organisations to ensure that all parties discharge their roles effectively for the protection of the local population.

In May 2013, the Department of Health, PHE and the Local Government Association published 'Protecting the health of the local population: the new health protection duty of local authorities' (see

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf)

Category 2 responder organisations are 'co-operating bodies' that are placed under lesser obligations beneath the Civil Contingencies Act than Category 1 responders. Primarily their role is co-operating and sharing relevant information with Category 1 responders. They are engaged in discussions where they can add value, and must respond to reasonable requests. Clinical commissioning groups are Category 2 responders.

(Adapted from Health Emergency Preparedness, Resilience and Response from April 2013. Summary of the principal roles of health sector organisations, and 2014 Health Protection Assurance exercise (see

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216884/EPRR-Summary-of-the-principal-roles-of-health-sector-organisations.pdf)

National agencies

Public Health England

PHE is an executive agency of the Department of Health and Social Care. As a Category 1 responder, it delivers public health services including surveillance, intelligence gathering, risk assessment, scientific and technical advice, specialist health protection and public health microbiology services to emergency responders, government and the public during emergencies, at all levels.

PHE has its internal EPRR resources that deliver key planning, preparedness and response work in all PHE centres as well as nationally.

(Adapted from 'Health Emergency Preparedness, Resilience and Response from April 2013. Summary of the principal roles of health sector organisations' (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216884/EPRR-Summary-of-the-principal-roles-of-health-sector-organisations.pdf)

NHS England

NHS England leads the NHS in England and it directly commissions a range of public health services as set out in the annual public health functions agreement (section 7a), which includes vaccination services that are part of local health protection. NHS England is a Category 1 responder and has its own internal EPRR resources that support EPRR work across the NHS.

Local Government Association

The Local Government Association is a politically-led, cross-party membership organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government.

It is a key player in wider work on emergency planning and runs the sector-led Improvement work for local public health that supports local authorities in continuous improvement of their services.

Appendix 2. Steering group membership

Public Health England
Department of Health and Social Care
Local Government Association
Association of Directors of Public Health
Faculty of Public Health
NHS England
NHS Improvement
NHS Clinical Commissioners
NHS Providers
Chartered Institute of Environmental Health
Society of Local Authority Chief Executives (invited but did not attend)

Appendix 3. Summary of areas covered by questionnaire

Question number and topic
Questions 11-23. Generic planning for and response to outbreaks and incidents
Q 11 – A written protocol/plan is in place for the management and governance of local outbreaks and incidents
Q 14 – Arrangements are in place to collect samples (swabbing, blood and stool samples etc) if required
Q 17 – Arrangements are in place for environmental monitoring and sampling (food, water, premises etc)
Q 20 – Arrangements are in place for the delivery of clinical interventions (antivirals, antibiotics, vaccines etc)
Questions 24 -53. Specific scenarios
Q 24 – Arrangements are in place to establish a radiation monitoring unit
Q 27 – Arrangements are in place for the distribution of potassium iodide (KI) if required
Q 30 – Chemical Incident outside normal working hours
Q 34 – Integrated response to an outbreak of avian influenza in a poultry farm
Q 37 – Integrated response to a large and rapidly evolving outbreak of Legionnaires' disease
Q 40 – Integrated response to a TB outbreak in a school
Q 43 – Integrated response to a hepatitis A outbreak in a closed environment/setting
Q 46 – Integrated response to confirmed cases of seasonal flu in a care home
Q 49 – Integrated response to a confirmed case of hepatitis B in a tattooist with evidence of blood borne virus transmission to clients
Q 52 – Large fire with a plume out of hours