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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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_Respone_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

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 (e.g., 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.


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.


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.

**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

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