Planning and Establishing Local Health Protection Areas in Response to Covid- 19

Findings from analysis of Strategic Leaders July 2020

C19 National Foresight Group

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EXECUTIVE SUMMARY

The main findings of recent presentations and discussions of the management of local health protected areas were themed and captured in this report. The challenges of planning for, establishing, and protecting the community health in these areas is explored. A series of suggested solutions are made within the main body of the report, and a summary set of recommendations are made at the end of the document.

The following outputs were used to inform this document on current findings related to the local management of Covid-19:

- Two presentations at LRF Chair's Call by experienced practitioners
- Plenary session of C19 National Foresight Group and invited participants
- Discussion of Local Area Management Plans within the Q&A of LRF Chair's Call
- Contributions from the military support who attended Leicester

CONNECTIVITY OF STRUCTURES

Data lag: Feedback from the LRF was that the data was slow to get to them and the quality of data shared was not adequate. This was attributed in part to the Local Engagement Board, the complexity of council and the political landscape being complicated because of the challenge in agreeing the boundary that had been put in place. Some of the aversion strategy tools put in place were unsuitable.

Exclusive, unannounced decision-making: The decision to define and declare a Health Protected Area was not inclusive. The perception of the local decision-makers was that they were in recovery and the statistical data from their cell was fairly stable. Then health bodies announced a major outbreak in the city, which the LRF was unaware of and that an Incident Management Team (IMT) was being set-up (IMT normally response to local situations, such as a serious outbreak of food poisoning).

New structures and systems arrived in the locality: Teams were sent from London to engage these included the Military, Cabinet Office Team and others. An Incident Management Team (NHS Midlands) was set up and whilst this was well meaning, it was unsuccessful in establishing a battle rhythm. IMT organised lengthy meetings at crucial points in the day (middle of the day) which took key health specialists who had been supporting the Tactical Coordinating Groups (TCG) and Strategic Coordinating Groups (SCG) away from activities they had been coordinating well. IMT did, however, do a good job of getting testing teams in and sorting a strategy.

Some questions from previous outbreaks are:

- How does the Public Health Incident Management Team meet the SCG?
- What structure or process is that through?
- Who (or which structure) is in ultimately in charge?

The learning from Leicester are that the IMT is effectively like a big Scientific Technical Advisory Cell (STAC) reporting into the SCG and the SCG is in charge.

These structures were new and arrived without first finding how they could align or ‘dock’ with the existing structures that had been operating with a tried and tested process for four months. The local partners had to provide capacity to coordinate between the IMT and the cells. The new structures arrived with cells and tried to join existing cells which was unsuccessful. Resulted in a disconnect with two structures trying to deal with the same situation.

Politicians: Where politicians sat in the Governance of Leicester’s experience was that the JBC Gold was chaired by the Health Secretary, and they make key decisions. Given the discussion about structures not docking and the reduced sharing of data, it becomes imperative that the JBC shares their intent, strategy and decision-making ahead of any action and works alongside and in collaboration with other organisations and partners (both national and local).

Communications of the management structure: This is very complex. Daily multiagency communications are required to facilitate the local to national information flow. Allowing and planning for the resource needed to fulfil this requirement should be planned for.

Comparable trigger/escalation *and de-escalation* points between sectors and structures: Establishing shared trigger points between structures and sectors is a priority to establish a shared understanding of when to activate and when to stand down. The stages before establishing a Health Protected Area should also be considered, so how can partners

and Public Health increase testing to understand the local risk picture, whilst all those involved know that that activity may lead to a Health Protected Area being established.

KNOWLEDGE AND INTELLIGENCE IS A PRIORITY

Understanding households within the community is key: Understanding the local area down to postcode or output area level and where the areas and activity of risk are is essential to being as prepared and knowledgeable. How areas are recognised by different groups and organisations will support the understanding of trends and associated predictors such as social deprivation, different community demographics and other relevant information (such as types of occupation.) This should inform the proportionality and appropriateness of NPIs when decision-makers are reviewing the most appropriate action.

The data to support decision-makers: The trends and detail of data is a balance, whilst decision-makers need trends and patterns to be demonstrated in the data, they also need to mitigate against the data protection issues of sharing. Data protection issues came up repeatedly across the discussions, this need resolving, and guidelines or data sharing expectations made clear between partners, particularly health.

The Multi Agency Information Cell: The MAIC is used to bring in intelligence to support and help with procedures, adding value to bring the response together. These were seen as an important asset to the response and ongoing management of Covid-19 over the coming months and years.

Multi-agency partnerships: The MAIC's input is significant and extends beyond the JESIP doctrine of raising situational awareness and sharing information. Ensuring that the LRF has access to a single version of the truth and that they can analyse intelligence information to produce foresight is essential.

The MAIC should be defined appropriately and backed by consistent frameworks in terms of knowledge, awareness, capability and expectations of its function. There is substantial evidence of the benefits of the MAIC during parallel response/recovery and through the create of foresight. Covid-19 has a long tail in terms of accumulation of adversity for individuals and communities. The MAIC is adding value from a hard data view and can deliver more in respect of mental health, education, employment and sentiment.

Field teams in the future from a military perspective: One size does not fit all, teams will be deployed depending on an LRFs capacity, capability, as well as the scale and impact of the outbreak. The Military Assistance Team (MAT) could work at LRF SCG level to look at what can be offered to enhance capacity to create value added teams. Agility is key and there is a potential of standing up additional teams to be deployed swiftly and provide assurance of support, noting however that the model for Leicester may not be appropriate for another health protected area.

THE RELATIONSHIP WITH THE COMMUNITY

Community perspective to 'lockdown' in Leicester: This is a challenging area in regard to information and messaging incoming from Central Government and internally (media and communications cell) as discussions took place in London, rather than Leicester. Messages

around sweatshop labour and other rhetoric such as not adhering to regulations around physical distancing should be avoided. Religious elements are also a big challenge as well as the public's relationship with the military. Particularly those who originate from countries with adverse experiences of the military or those in authority. All these aspects possibly played a part in resistance of testing. This is partly why a protective narrative rather than a restrictive narrative is so important. Changing language from 'lockdown' to 'protection'.

The media: The media were seeking 'stories' which distracted communication teams and disrupted the narrative of health protection. This was seen as confusing and distracting from the messages that partners wanted community dialogue about.

Demographic and place challenges: The rich demographic picture of some communities adds an extra layer of complexity to the resource envelope and detailed preparation work to ensure cultural awareness has been established and cultural competence tested within plans. So that the response is inclusive of a community, and not fully, or temporarily, exclusive. As well as the definition of place itself, where there are challenges when boundaries are defined within communities and where possible, these should not cut across streets.

Language barriers/issues: When a local health protected area is setup community relationships need to be prioritised and handed with diplomacy. Leafleting and door knocking (in addition to other messaging channels) extends messages into the community, with the assistance of interpreters. This is in addition to engaging with community and religious leaders to ensure that the message and duty of being tested, gets across to all members of the community. It is acknowledged that the voices of those who remain silent may be those of most need and it should be informed and led by the local/regional structures (such as MAIC, LRF, IMT). It should be an aim in a local health protected area that every resident in the area identified has received appropriate communication about the health protected area and the mitigation measures/plan.

The narrative created by local leaders: The narrative and lexicon used by local and national stakeholders is very important. Referring to a Health Protected Area instead of a 'lockdown' reframes the intent, the aims and the feeling around what is trying to be achieved and why. The communication and key messages need to be clear, accessible and understood by all within the community. A community may not engage in the desired way because they have misunderstood the key messages, so partners should understand how the messages are landing in at risk communities.

Providing the why as well as the how and what: Individuals are more likely to be compliant to be tested if they understand why they are being tested and are assured that they will not be asked other questions around their circumstances (e.g., immigration status/legality, filling in forms, showing of passports). As well as clear messaging on how to do that (where to go and what to do) and what behaviour is desired (completion of the test).

COMMUNITY ENGAGEMENT AND MESSAGING

Community engagement: Engagement and involvement of the voluntary sector in terms of engaging the community (i.e., door knocking, local insight to language issues) is vital in establishing and supporting a health protected area. The British Red Cross has focused on establishing relationships with LRFs and have been working with local emergency partnerships and Voluntary and Community Sector organisations to provide coordinated support. The next step would be for the Community and Voluntary Sector to be included at a

planning stage at a national level to bring these connections at a local level to effective use and build useful links.

Shielding perspective: The shielding programme has worked in conjunction with LAs, NHSE and Community and Voluntary Sector to establish links to those identified as vulnerable, facilitate workshops and sought local community support to resolve issues raised. These relationships will also inform future planning and some planning has already taken place since March-April (5 scenario planning situations reviewed) in terms of changing and adapting elements of the shielding package and supporting the cohort. Challenges and interdependencies are absolutely essential to be reviewed in terms of both a local and a national response. Those shielded also rely on the educational offer, furlough, employment and protection aspects and financial security. How this support is implemented once again in a health protected area should be considered as a high priority.

Concerns of individuals as well as a community: Worries about sickness pay, this was compounded as most of the transmission was mostly through households. This should be considered and addressed in the planning and actions when implementing a health protected area.

Communication methods to reach all the members of the public: Using digital channels such as Facebook through to postcodes, as comprehensive as possible to include door to door where required. The Police Chief's blog in Leicester was viewed 120,000 times and so it was translated in to five languages. Reducing file sizes also enables them to be shared and moved easily on WhatsApp. Advertising on lorries, community radio, use of trusted professionals to deliver the message and community advocates were all used in Leicester. They incorporated lots of images to demonstrate, role model and reinforce behaviour. They moved quickly and proactively to deal with fake news. They estimate that the scale of communications is roughly six times the normal level. However, by their indicators they moved from a public sentiment that was 95 per cent negative to 70 per cent positive.

Community advocates: Some of this was actioned through community advocates being on patrol with the police. Health colleagues went door to door and engaged with factories directly. This raised challenges as the aim was for testing to be completed, but there is also a desire from authorities to enforce measures against illicit activity, so that quickly became a complex partnership.

The technology: The testing requires QR codes and many people do not have phones that accommodate the app, or have a QR reader app. This should be included within plans so that this does not disrupt or interfere with the management of the outbreak in other areas.

Community cohesion: This is a priority and was a challenge in Leicester. The far right facilitated tensions on who to blame. Community cohesion should be a priority in plans for the implementation of both health protected areas, and NPIs. The additional strain on communities from these types of interventions are significant, with additional outside influences such as those referred to earlier in this paragraph, this creates more challenge for communities. Plans and exercising/testing of plans should include these aspects.

Clarity of message: Due to the fact that Leicester had two legal frameworks in place (the easing of national lockdown measures for the wider county, and the continuation of some measures for a geographically boundaried area) meant that a higher volume of briefing was required. The message that members of the public could not leave the Health Protected Area and stay overnight, or that only essential travel was not enforceable in law was difficult to negotiate.

IMPORTANT MESSAGES FOR THOSE MANAGING THE HEALTH PROTECTED AREA

Enforcement (future prevalence and legitimacy and scrutiny): How these statutory and legal instruments are applied or enforced in the future when establishing a health protected area, should be considered in the exercising and testing of plans; this is in the context of the police adopting a position of encouragement.

Put your own oxygen masks on first: Regarding those managing the health protected area, people get exhausted very quickly and the timescales are weeks or even months, consequently it is very absorbing. Advice from others who have been in the situation previously is to look after yourself. Leave needs to be taken, it therefore should be planned and accommodated for. As time goes on this will also apply to periods of typical leave such as non-term time, religious holidays and popular leave periods.

Resource/Budgets: These will reduce very quickly. There is also other business as usual (BAU) tasks to balance, this can become challenging when BAU spans two different contexts, inside the health protected area and other areas. For example, during the Leicester measures, a murder took place within the health protected area. This impacts on procedures and partners differently to the same event occurring outside the health protected area.

RECOMMENDATIONS

Alongside the specific recommendations embedded throughout the report, some recommendations have been developed from the information contained in this report.

RECOMMENDATION ONE: Invest in partners in 'peace time' before doing it in real time, if geographically possible. Relationships are primed and aware of a potential IMT beforehand. It was suggested that MHCLG do not always follow all of the standard regional structures, which have retracted over the years.

RECOMMENDATION TWO: Use standard structures from other types of emergency incident if possible as people are comfortable with what they know and how they have prepared for situations/emergencies.

RECOMMENDATION THREE: The national structures, like the JBC, are aware of the complexity of the local structures and vice versa. Make sure both parties know what to expect based on nuances of geographical areas when establishing a health protected area e.g. numbers of DPHs, structures of Local Authority.

RECOMMENDATION FOUR: To alleviate multiple teams arriving at a health protected area, it would be more practical and efficient/effective if a multi-skilled Government team was deployed, as opposed to representatives from many Government agencies arriving at the scene asking the same questions, to learn from the outbreak.

RECOMMENDATION FIVE: Provide the MAIC team in an area with a local outbreak with military intelligence personnel in the future, to assist them with procedures and data, as well as data sharing.

RECOMMENDATION SIX: Learning has shown that City and County Councils and other big decision makers are frustrated by the lack of data due to concerns about data protection (disclosure of personal health data about residents). Conversely, the military in attendance are often being thoroughly briefed and could see the previous local outbreaks emerging before others could. This data should be shared with MAICs. From other insights, it is clear that concerns over data protection varies according to geography. Some MAICs have benefitted in some areas, they have been entrusted with the data, trends and information in order to make decisions and plan, others have not.

RECOMMENDATION SEVEN: The experience of the LRFs, LAs, DPH around the country of managing a health protected area is commonly aligned to a food poisoning outbreak, or the management of the national lockdown measures. Therefore, advising the local partnerships to exercise and test their plans is a significant priority over the next few weeks to ensure their preparedness.

END.

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