

Written evidence for the All-Party Parliamentary Group on Coronavirus, Tuesday 20th October 2020

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OVERVIEW

The ADPH has taken a clear view about the approach Directors of Public Health (DsPH) should take to COVID-19 and engaging with Government: *to be as constructive as possible and as challenging as necessary*. It is in that spirit which this submission is made.

The evidence outlined here is based on a combination of my own experience as a local Director of Public Health alongside five key documents which are particularly relevant to the points I am making:

1. The written evidence provided by the ADPH to the House of Lords Public Services Committee enquiry; 'Lessons from Coronavirus' on June 17th, 2020.
2. The Faculty of Public Health Statement on Covid-19. 19th June 2020.
3. The SAGE paper summarising the effectiveness and harms of different non-pharmaceutical interventions on September 21st, 2020.
4. The WHO report on Pandemic Fatigue – reinvigorating the public to prevent COVID-19.
5. The ADPH publication; 'Protecting our communities – pulling together to achieve sustainable suppression of SARS-CoV-2 and limit adverse impacts.

It is important to note that I am speaking on my own behalf rather than representing the views of either the FPH or the ADPH. This written briefing aims to summarise my views on key issues which the group may wish to consider.

INTRODUCTION

COVID-19 has presented the world with the greatest public health challenge in a century. Much amazing work has been done at international, national, regional and local levels to tackle the virus. However, there is learning from the past six months that could enhance and improve our ability to protect all our citizens as we head towards winter.

As we don't currently have effective vaccines or prophylactic treatments, we must focus our attention on implementation of Non-Pharmaceutical Interventions (NPIs) whilst also mitigating the negative social, economic, psychological and physical health harms associated with many of the protective measures.

CLARITY OF AIM

At the start of the pandemic the aim was clear; we needed national action to slow the spread with a focus on 'protecting lives and the NHS'. Evidence presented by SAGE has highlighted that the national 'lockdown' was a success with a rapid reduction in the reproductive value of the virus.

As we head towards winter, a time when respiratory infections are notoriously common, the current aims appear a little more ambiguous. What does success look like and how will we know when we get there?

To illustrate my point; when identifying which interventions are necessary to regain control of the virus what are we looking for?

- A slowdown in transmission of the virus across the whole population
 - To bring the R value below 1
 - To bring cases back down to 0
- Focused protection of those most clinically vulnerable (e.g. those aged over 60 or those with comorbidities)
- NHS capacity to manage the virus and sustain business as usual
- Protection of business and mitigation of economic damage
- Addressing the inequalities associated with how NPI's are experienced between regions and communities

Lack of clarity on aims is leading to some confusion which is played out in discussions that are taking place between local, regional and national partners. At times partners have come to the table with the intention of discussing possible solutions whilst looking at the issues through very different lens.

STRATEGY – COMBINATION PREVENTION

It is widely understood that, in order to effectively tackle this virus' a complex system of interventions and actions are required. No single measure is enough to tackle the pandemic on its own, so we require a combination of approaches, tactics and behaviours. The strategy required needs to be explicitly based on combination prevention.

Due to the complexity of the interventions required the response so far has been to break each component down into more manageable parts. To some extent this is operationally understandable. However, the unintended consequence is that this silo approach largely ignores the critical interdependence between components which is often exacerbated further by interventions being considered and developed at different geographical levels and by different organisations. There appears to be an expectation that each individual part will automatically add back up to the whole which, in combination, will succeed in tackling the virus. Unfortunately, this is not how it feels on the ground and, too often, local areas have needed to develop work arounds or sticking plasters for gaps or unintended consequences of actions and decisions taken at a national level.

A broad comprehensive strategy is needed which sets out:

- clarity about the principles on which it is based
- an understanding of how each part of the strategy connects with the others
- transparency of expectations from different players (national government, regional and local systems and communities)
- candour about how each player will be involved in coproduction and implementation
- explanations on when an intervention might be needed (based on the aims of what we are trying to achieve) and at which level an intervention has most value

The ADPH publication 'Protecting our Communities', sets out the principles which could be used as a starting point:

1. **Collaborative leadership.** *This is the time for people of all political persuasions to work together in the interests of public health and wellbeing. Decision makers should seek to put personal views and party politics aside.*
2. **With, not to.** *Action should be taken with, and through, local people with their local representatives being a key part of the solution, as well as national leaders. The system needs to work together: not national or local but national and local.*

3. **Partnership.** *A strong three-way contract between the people, local systems and national government is essential to creating a clear and consistent public narrative.*
4. **Communication.** *A commitment to explaining a rationale for decisions, timeframes for implementing measures, why measures are being selected and how they are being developed.*
5. **Subsidiarity.** *Consensus about subsidiarity should be sought i.e. the choice of which geographical footprint is best for interventions and actions.*
6. **Avoiding false choices.** *Promoting and protecting health and creating a vibrant economy is not a binary choice, both must be viewed as complimentary aspirations.*
7. **Sustainability.** *Agreeing timeframes and balancing the trade-offs between health, social and economic factors is a key consideration when implementing measures that could be in place for a short period of a few weeks, or for a much longer period of several months.*
8. **Consistency.** *It is important to provide enough time for the impact of measures to be observed and understood and realistic about how long interventions might take to reduce transmission rates whilst acknowledging certain circumstances will require rapid decision making.*
9. **Agility.** *There will remain a need for an agile response to the use of measures with local areas flexing their approaches to meet the changing circumstances as the pandemic progresses.*
10. **Evidence-informed.** *Application of measures should be informed by existing evidence where we have it but not limited to what is evidence-based now when there is a clear rationale for acting. We need to acknowledge that the evidence base is being developed through practice i.e. this will be iterative. Consequently, flexibility at all levels will be required to respond to the emerging data, epidemiology, evidence on effectiveness and outcomes and make the best possible decisions with the information available at the time.*

RELATIONSHIPS AND COMMUNICATION

Communication was highlighted as an issue in the ADPH submission to the House of Lords Public Services Committee back in June 2020. Whilst there have been improvements to some of the issues highlighted then, communication remains a challenge across all levels.

Timing – Too often decisions and announcements are still made without much, if any, notice. This often results in Local Authorities and DsPH being very much on the back foot, trying to respond to the understandable queries from residents but without the necessary detail. SAGE highlights the importance in building and maintaining community trust and this is undermined if local leaders can't explain what is going on.

An example of this was the change to regulations for the seven local authorities in the north of the North East. Amendments were announced in Parliament on Monday 28th September without clarity at a local level of what this might include. The regulations were not published until 11pm on September 29th even though they came into force at one-minute past midnight just an hour later. The impact of this was that we were unable to provide our local communities with clear guidance about what we were asking them to do which resulted in a loss of community trust in our guidance.

Local by default – DsPH, working in Local Authorities, have extensive knowledge of both their communities and the local place-based systems in which they work. As such it was acknowledged that they have a critical contribution to the development of approaches that work on the ground.

During August a commitment was made for the work to be **'local by default'** and co-produced with local partners. However, whilst there have been some attempts to engage local partners, the overall programme continues to feel 'top down' and co-production doesn't appear to be influencing some of the fundamental changes which are felt as necessary at a local level. Partners need to come to the table constructively and in the spirit of openness and honesty. There must be a willingness to hear and understand the issues that are being experienced by people on the ground so we can create a shared understanding of the 'problem we are trying to solve'.

An example of this is the work that is being developed on a model for contact tracing. Much evidence has been provided to demonstrate the significant impact that local contact tracing has had on improving the reach and impact in local communities. Despite wide recognition of this evidence, and an expressed desire to build the local model, there remains a vast imbalance in the resources available to implement this between national and local partners.

INEQUALITY

COVID-19 has shone a further spotlight on the unacceptable inequalities experienced by some of our poorest communities across the Country. Inequalities are evident in both the impact of the virus, in terms of risk of infection and outcomes, as well as the experience of the restrictions. Inequalities are divisive and countries with a steep social gradient are characterised by lower levels of civic participation and cooperation. The success of many NPI's are predicated on the level and extent of community support and engagement. The sense that we were **'all in it together'** has been widely documented as a critical factor in the success of the first national lockdown.

In February 2020 Professor Sir Michael Marmot published a review of his 2010 report. This report highlighted an increase in the inequalities experienced between individuals and communities across England. Poverty and social inequality are sources of enormous stress for local families. We know that when parents are overwhelmed by stress, they can struggle to meet the basic needs of their children and this can result in life-long implications for their physical, emotional and social development.

Evidence shows that NPIs, to reduce the spread of the virus, implemented in the same way across the country have different impacts on different people and communities. The SAGE paper produced on September 21st states:

All these interventions (NPI'S) have associated costs in terms of health and wellbeing and many interventions will affect the poorest members of society to a greater extent. Measures will be needed urgently to mitigate these effects and to achieve social justice

We also know that people in our most deprived communities are more likely to work in low paid, front-line occupations where there is a greater risk of exposure to COVID-19. Furthermore, people from the poorest backgrounds are most likely to be working in the sectors that will bear the brunt of local restrictions. Current packages of support do not sufficiently take account of the different way that restrictions will be felt between regions and across communities. SAGE highlights:

'Planning should start now to refine measures to minimise the harms and mitigate the impact on vulnerable groups, to achieve equity and social justice'.

'If measures result in those with the lowest incomes losing money, having less access to shops, having fewer social or educational interests, or being without vital social support

networks, they will need financial and other support. **Without this, health, adherence and trust could be harmed**.

HEARTS AND MINDS

We cannot 'enforce' our way out of this.

The evidence of success in the first wave of the pandemic was built on a shared understanding and commitment to tackle this at a societal level, together.

The ADPH publication 'Protecting our communities', sets out the critical importance of the psychological contract of trust, goodwill and confidence between system leaders and the public. When this psychological contract is undermined the public may disengage from the behaviours that are required. The publication outlines:

The health of the people is the highest good. It is served not by ideology or jumping to single solutions but by:

- *an open, constant and transparent review of the evidence as it emerges,*
- *the clear articulation of the best rationale for what action should be taken, a*
- *open admission that, because our knowledge remains incomplete and is developing, this way of working is paramount.*

Pandemic fatigue

The World Health Organisation published a document, '*Pandemic Fatigue: Reinvigorating the Public to prevent COVID-10*' (2020), which highlighted pandemic fatigue as a natural response to an extended public health crisis. This document sets out the rationale for a multifactorial approach which seeks to maintain and reinvigorate public support for protective behaviours, by:

- understanding people – including the barriers faced by people,
- engaging people and communities in solutions
- allowing people to live their lives whilst reducing risks
- acknowledging and addressing the hardship people experience

This approach needs to be more central to the work at national, regional and local levels. Information on protective behaviours is no longer enough. We need to openly acknowledge the differential impact of interventions on different communities and seek to address this, so it is equitable. If the perceived costs of the response outweigh the perceived risks of the virus people will naturally be less likely to comply with protective behaviours. We need to reach a compromise, with our communities, that we're prepared to live with in the longer term.

The ADPH suggest three important ways for a DPH to work in the face of these challenges which I have adapted to reflect the broader situation and the way we need to operate at all levels.

1. The greater, and consistent, use of psychological and behavioural sciences
2. The importance of clear and consistent local communications
3. The value of a strong partnership between national leaders, local elected members, communities and local place leaders (including Directors of Public Health) in navigating the course of the pandemic and its multiple impacts