Protecting our communities

Pulling together to achieve sustainable suppression of SARS-CoV-2 and limit adverse impacts

Guidance for Directors of Public Health

Foreword

SARS-CoV-2 has presented the world with the most significant public health challenge in a century. Directors of Public Health, and their teams and partners, have been working on the ground since February with a resolute focus on protecting the health, wellbeing, and livelihoods of the populations we serve.

During this time our communities have been asked to make sacrifices they could never have imagined. The early part of the UK's response to the pandemic was characterised by rainbows and clapping, a time when we came together to support and help each other in the fight against this virus.

Our communities and our colleagues are understandably tired but heading into the winter months we know we need to ask more of them, and of ourselves. We must engage across communities, businesses, and public services to explain that, whilst there are many unanswered questions, there are measures we can take which will limit the transmission of SARS-CoV-2.

The Scientific Advisory Group for Emergencies (SAGE) and several papers in pre-publication have concluded that the complete national lockdown earlier in the year was successful in slowing the spread. Whilst this was effective in the short term, we know such an approach is less acceptable in the longer term because it would have a devastating impact on our economy and further exacerbate inequalities.

Instead we must consider a range of other interventions with two objectives to balance: to achieve sustainable suppression of SARS-CoV-2 and limit the adverse impacts on health, wellbeing and the economy in the short, medium and long term.

We understand that every area will have a unique set of circumstances and so interventions will need to be considered within a place-based context. However, we also know there are some key principles of infection prevention and control which lead to potential options that can make a difference. The purpose of this guidance is to offer these, as well as the principles of engagement on which decisions should be made and communicated.

This is the first iteration of this document. Given the pace at which the epidemic is moving we explicitly acknowledge that it is being written at a time of much change and learning. Consequently, we recognise the importance of maintaining it as a live document. This means that we will regularly review, and update, it to reflect our growing understanding and the evolving evidence. We encourage Directors of Public Health, and their teams, to share their feedback and insight as this work develops.

Professor Jim McManus
Vice President, Association of Directors of Public Health

Introduction

Directors of Public Health are being asked to provide advice which balances the need for interventions to protect our communities from SARS-CoV-2 whilst minimising adverse impacts on economic and social life; and overall health and wellbeing. We do not have effective vaccines or prophylactic pharmaceuticals at the time of writing. Even if a vaccine is achieved, it will take time to roll it out. Therefore, Non-Pharmaceutical Interventions (NPIs) remain a core part of the set of tools available to reduce the spread of the virus. However, the success of NPIs depends on building, and maintaining, public confidence.

The purpose of this document is to support Directors of Public Health, local authorities, and partners in considering the range of NPIs that might be most appropriate.

In producing it, we have identified a range of strategies and measures that local areas can use to suppress the virus. There is no 'zero risk' scenario and, as such, local areas have tough decisions to make. This document sets out a menu of choices which have shown promise, whether in local places, nationally or internationally, in slowing the spread; as well as choices which have been pursued in previous outbreaks of communicable disease.

The document starts from a position of clear and transparent principles. Where evidence is provisional, developing, or silent we have set out a rationale. We have also sought to learn from what we already know.

Rationale

We are, at the time of writing, less than a year into the pandemic. During that time the science has developed rapidly. For example, over 900 papers on face coverings and face masks have been published and have led to face coverings being added to the list of NPIs available. The rapidly developing state of knowledge changes our understanding of "what works" in preventing and disrupting the transmission of the virus, and in caring for those who become unwell. We also know more about the transmission dynamics and mechanisms of the virus, and the multiple ways in which it can affect the body.

Against this background, there is considerable noise and disagreement, as well as ideologically driven debate, about strategies or tactics which should be adopted. This is all too often combined with simplistic analysis of which countries have done "well" or "badly", often with the conclusions reached misapplied to the UK situation. Claims of "certainty" about interventions are often also made prematurely or wrongly.

Detecting a consistent signal, against such a background of confusing and conflicting noise, which clearly shows what we can do with confidence to prevent and disrupt the transmission of the virus is difficult, and can be even more problematic when science is still developing or disputed.

But we are convinced that we must seek to do this. We consider there is clarity amidst the noise and confusion which point us to strategies we can adopt. We must articulate a rationale for which measures to choose, and why, which is explicit and transparent, and recognises what is known.

In this document we set down principles for how we should work as systems. But firstly, we articulate our rationale for choosing interventions. Our rationale is as follows:

1. While the science on SARS-CoV-2 itself is developing, we know enough to conclude that there is no single strategy which will disrupt the pandemic. Even if an effective vaccine becomes available, this in and of itself will not be enough. Given this, any single intervention will be inadequate.

2. There is enough scientific evidence and consensus to point clearly to a combination strategy – in which multiple different interventions, some well-known and evidenced, others formative, can disrupt and prevent transmission of the virus. This is often called "combination prevention".

3. Our view is that the consistent thread of science since the beginning of the pandemic has supported this approach.

4. The cumulative weight of evidence from previous major public health challenges including viral pandemics, HIV and other communicable diseases has also shown that combination prevention strategies are effective, and this evidence is salient and persuasive for the adoption of such strategies in the face of SARS-CoV-2 at the present time. A combination of interventions, each inadequate in and of themselves, can have and have had an additive and cumulative effect which is efficacious in preventing and disrupting the spread of the virus. This science is, and remains, as relevant now as it did then.

5. Combination prevention approaches by their nature rely on interventions at a range of levels from the biological (e.g. a vaccination when it is available) to the social (physical distancing, social norms) to the environmental (e.g. "COVID-secure" workplaces) to the legislative (policy and law).

6. We must avoid the temptation to over-rely without proper justification on one component only of a combination prevention strategy.

7. We have excluded those interventions for which there is currently evidence of harm, or no evidence of any kind.

8. While there is scientific evidence that "herd immunity" can be achieved for some infections, the rigorous science behind that is a far cry from some concepts often mis-used or mis-applied in the current debate. Such evidence as exists behind the efficacy of most currently mooted "herd immunity" strategies for SARS-CoV-2 is in our view far less clear than the evidence for combination approaches and carries far greater risk and many more ethical challenges than a combination prevention approach.

9. As the science changes and develops, so the tools used in a combination strategy will change and develop. This is to be welcomed and is part of the evolving nature of scientific endeavour.

10. Public health action to prevent and reduce transmission, not clinical evidence for treatment, is the salient context within which we are working. In this document we therefore make no comment on clinical treatment.

Evidence

We are working in an unprecedented situation where the evidence base is still emerging. In these circumstances we can draw on evidence and experience from the past, such as our understanding from previous outbreaks of other SARs like pathogens, or from the present, where evidence and experience from other countries of measures which have worked is available.

We can work on consensus, and iterate our approaches based on what we do know. For example, that the initial lockdown period significantly reduced rates of transmission in some places to almost zero, and that in areas where restrictions have been in place, they have managed to constrain the rate of increase or it has plateaued. We have learnt that a total lockdown works but at an economic cost, and that partial lockdown works partially with less economic impact.

As our detailed understanding of the evidence grows, we will keep this advice under review and further refine it to reflect improving knowledge, insight, and evidence.

In such circumstances, it is also paramount to operate from clear and transparent principles, designed to protect people, communities, and the economy.

Principles

Below we outline ten principles to support Directors of Public Health and inform policy, practice and decision making across all those systems, structures and sectors involved in the response to SARS-CoV-2:

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.

Hearts and minds

The confidence of the public, and all actors in the system, is crucial in any major health protection challenge. The psychological contract of trust, goodwill, and confidence between the public and system leaders is an important component of the response to a pandemic. When this is undermined, the public may disengage from the behaviours needed.

We state above that our rationale is explicitly based on combination prevention – the principle that no single measure is enough to defeat the pandemic, so we are reliant on a combination of strategies, tactics and behaviours.

Maintaining this contract requires clarity of what is to be done, by whom, and why. The principles we set out above are designed to help us foster and maintain that fundamental covenant of trust and confidence which is the primary tool in exiting the pandemic.

All actors in the system have an obligation to act in such a way that the psychological contract is protected and fostered, especially when the science is unclear, in the face of conspiracy theories and those who advocate solutions to SARS-CoV-2 driven by ideology.

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, and the open admission that precisely because our knowledge remains incomplete and developing, this way of working is paramount.

We offer three important ways of working for Directors of Public Health in the face of these challenges.

1. The greater, and consistent, use of psychological and behavioural sciences; we have included some of these in the menu of choices below.

2. The importance of clear and consistent local communications.

3. The value of a strong partnership between local elected members, communities and Directors of Public Health in navigating the course of the pandemic and its multiple impacts.

Many local areas have used psychology and behavioural sciences to develop strategies for prevention, for supporting staff, and for supporting local communities. For example, the ADPH, Public Health England, the Behavioural Science and Public Health Network and Local Government Association have worked together on tools ranging from collaboratives and training to podcasts and toolkits. Each of these ways of working are at their best where they are in the explicit service of building and maintaining trust and confidence with people.

It is in this context that enforcement must be part of a balanced strategy. It will be impossible simply to enforce our way out of the pandemic. A strategy which is devoid of enforcement measures is as self-limiting as a strategy which relies solely upon them. We should aim for a proportionate approach to enforcement, using it where necessary, and appropriate as part of the combination strategy as we have outlined above.

Choosing and using interventions

There are a range of interventions that can be deployed to help suppress the transmission of SARS-CoV-2. Some of the interventions should always be deployed and some will depend on the local context and the level of the virus circulating in the community. The following list is intended to outline key interventions for consideration - rather than being prescriptive, exhaustive or definitive - as part of an overall package of measures which together form an appropriate local combination prevention strategy. Each measure will need to be defined clearly within a place-based context. We will keep this menu under review.

Menu of interventions

This menu explicitly does not address treatment strategies for people with SARS-CoV-2. A range of guidance on therapeutic interventions already exists to which clinicians should have regard.

Group of Interventions	Intervention	At which levels of population infection would you use them? (All/Medium/High)
Understanding the importance of combination prevention		
Combination prevention	Ensuring that people understand no single strategy works, and combining measures is the best way to prevent transmission of the virus	All levels
Treating every encounter as a potential source of infection	Previous experience of major epidemics shows that people are better to consistently adopt measures when they consider everyone may be infected, including themselves	All levels
Embedding preventive behaviours	Making preventive behaviours "default" behaviours through use of psychology and behavioural science approaches	All levels
Wellbeing and Motivation		
Social trust and social norms	Culturally competent, relevant, and clear communications, using key channels and influencers including local elected members, community leaders and others	All levels
"I can, we can"	Promoting a sense that we can end the pandemic and the contribution of every single person and action is important and essential	All levels
Wellbeing and Public mental health	A range of different levels of wellbeing support, including 5 ways to wellbeing, resilience, trauma, bereavement and	All levels

	suicide and self-harm prevention	
Use of psychology and behavioural sciences	Use of psychologically informed approached to ensure people maintain resilience where possible	All levels
Testing		
Capacity	Adequate testing capacity relevant to local need	All levels
Access	Clear access routes into national and local testing	All levels
Prioritisation	Clear testing prioritisation criteria	All levels
Turnaround	Rapid turnaround time for test results	All levels
Advice	Clear instructions on next steps for people with positive test results	All levels
Asymptomatic	Asymptomatic testing for people in outbreak areas	Medium/High
The use of psychological science to support understanding of and uptake of testing	Crucial for people to understand testing	All levels
Contact Tracing		
National	Fit for purpose national contact tracing system	All levels
Local	Local contact tracing system established to compliment national offer, with knowledge of the local situation, communities, cultures and languages;	Medium/High
Operating systems	Compatible contact tracing operating systems	Medium/High
Backward contact tracing	Backwards contact tracing	Medium/High
The use of psychological science	Establishing trust, building rapport, winning engagement, helping people remember contacts and situations they may forget under the stress of a contact tracing call. Communicating clearly and	All levels

	explicitly the nature of contact tracing	
Supporting self-isolation		
Communication	Clear messages informed by psychological science on enabling and supporting self-isolation	All levels
Advice	Welfare advice and support	All levels
Financial support	Financial support for those on low incomes	All levels
Psychological approaches to reducing stigma in those self-isolating	Important to help underpin that self-isolation is an act of care for the common good and not a punishment	
Disrupting transmission		
Fomite transmission	Good Hand Hygiene	All levels
	Good Infection Control Measures	All levels
Droplets transmission	Social/physical distancing	All levels
Airborne transmission	Use of face coverings	All levels
	Good ventilation	All levels
	Minimising use of indoor space/venues	All levels
Physical distancing		
	Social distancing at 2m+	All levels
	Educate, engage, empower, enforce	All levels
	Restrictions on weddings, funerals, and civic ceremony restrictions	Medium/High
	No household mixing (private homes and gardens)	Medium / High
	Reduced capacity in hospitality venues (50%)	Medium
	No spectators at amateur and semi-professional sporting events	Medium
	Essential travel only	Medium
	No household mixing (all settings)	High
	Reduced capacity in hospitality venues (25%)	High
	Takeaway only in hospitality settings	High

	Alcohol sales restrictions	High
	Shielding for extremely vulnerable	High
	Cancellation of all sporting and cultural events	High
	Stopping of all social gatherings	High
	Travel restrictions apply	High
	Holiday restrictions apply	High
	Closure of businesses and workplaces for 2 weeks after an outbreak	High
	Closure of non-essential businesses	High
	Covid secure educational settings and moving through relevant tiers; from early years settings to further and Higher Education	All levels
Vulnerable Populations		
	Warn and inform advice to front line health and social care staff	Medium/High
	No care home visits except for exceptional circumstances	High
	Sequestration of care home staff	High
Other Supporting or Enabling Measures		
	Regional/sub-regional analytical capacity	All levels
	Regional comprehension and compliance campaigns	All levels
	Additional preventive and wellbeing activities	All levels
	Economic strategies to mitigate adverse impact	All levels

The role of the Director of Public Health in using this guidance

The ADPH, the Faculty of Public Health, the UK Chief Environmental Health Officers Group, Public Health England, the Local Government Association and Solace have previously outlined the legal framework for managing outbreaks of communicable disease within Guiding Principles for Effective Management of SARS-CoV-2 at a Local Level.

The ADPH and the wider public health community have also set out the important policy and legal context for Health Protection within What Good Looks Like for High Quality Local Protection Systems. Both documents are key documents to which local systems and national partners should have regard. They form the context and background within which this present guidance should be interpreted.

The intention of this guidance is to support Directors of Public Health in carrying out their duties and responsibilities in relation to SARS-CoV-2, including providing clear and consistent advice to local politicians and partners. The statutory guidance Directors of Public Health in Local Government: Roles, Responsibilities and Context was published under section 73A(7) of the NHS Act 2006 as guidance to which local authorities must have regard. This guidance makes clear that Directors of Public Health should:

- be an independent advocate for the health of the population and provide leadership for its improvement and protection;
- be the person who elected members and senior officers look to for expertise and advice on a range of public health issues, from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services;
- improve population health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that also reduce inequalities in health.

The same guidance refers in turn to the guidance produced by ADPH on the role of the Director of Public Health in which the ADPH reinforces the importance of Directors of Public being able to provide independent advocacy and objective advice to local systems and the public, as well as advocating on system issues such as the effectiveness of measures to protect public health.

The approaches and principles we have set out in this document are intended to help Directors of Public Health and system partners work together to the greatest effect in light of the current state of science, and the clear system leadership role of Directors of Public Health.