UK Health Security Agency

The Association of Directors of Public Health

Health Protection Assurance Framework

Version 2.0 November 2024

Introduction

Health protection is "the protection of individuals, groups and populations through expert advice and effective collaboration to identify, prevent and mitigate the impacts of infectious diseases and environmental, chemical and radiological threats"[i].

Many organisations have statutory responsibilities for different elements of health protection and an effective, functioning health protection system requires strong collaborative working across all partners. See Appendix 1 for an outline of roles and responsibilities.

The Director of Public Health (DPH), with public health responsibilities and employed by upper tier Local Authorities, should be assured that the arrangements to protect the health of the communities they serve are robust, and implemented appropriately to meet local health needs. This includes seeking assurance that all organisations involved in health protection co-operate and work together; including agreeing funding, roles and responsibilities, and operational elements of response to incidents and outbreaks. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not being met. This may include reports to the Health Protection Board and/or the Health and Wellbeing Board (HWB). For further details see Health Protection in Local Authorities[ii] and DsPH in local government: roles, responsibilities and context[iii].

Purpose

The purpose of this framework is to enable DsPH to perform their statutory function to be assured that adequate local health protection functions are in place in their local system and being appropriately implemented and identify and agree mitigation measures with partners where elements may be perceived to be inadequate. In short, the framework is intended to be an internal tool for use by a DPH, and their team, and is not intended to be a tool to perform monitoring or evaluation.

Although DsPH are the primary audience, this framework will also support other system partners to collectively gain assurance on their health protection responsibilities.

It is recognised that health protection functions and governance arrangements will vary between the areas served by DsPH, although there will be some commonality, for example service delivery by UK Health Security Agency (UKHSA) and the establishment of Local Health Resilience Partnerships (LHRPs) and Health Protection Boards (or equivalent). The framework is therefore designed for DsPH to gather local evidence against the assurance standards and assess whether actions are required to strengthen local arrangements.

The framework is flexible, and the list of examples given under the 'suggested evidence' heading is not exhaustive. Assurance may be provided by 'hard' evidence such as documents and reports or via 'soft' evidence' such as details of working practices or relationships that exist.

The framework is intended to be a live document and as such, can be completed incrementally over on over a period of time.

What is assurance and how can it be applied to local health protection systems?

"Public health requires effective action by many different organisations and players. The balance of responsibility will vary from place to place, but the essential functions which must be assured in every locality remain constant. What is critical is that there is clarity with respect to each function as to who is accountable, who has responsibility for leading, and what contribution is required of different organisations and elements across the whole system"[iv].

The aim of assurance is to provide a positive declaration (intended to give confidence) that the areas of health protection are being commissioned and provided in a manner which meets the needs of the population or, if this is not the case, to identify gaps in the system so that measures can be taken to resolve these. It is not intended for the DPH to performance manage other partners in the health protection system, but it should support the DPH to secure confidence in the working practices of others and gain clarity on the threshold for flagging concerns.

The way in which DsPH will flag concerns will be determined locally, however best practice would suggest that escalation should go via the Health Protection Board, which feeds into the HWB. Other routes of resolution or escalation are to be determined by the DPH in conjunction with Lead Officers in other organisations. These may include the Health Scrutiny Committee, the Integrated Care Board (ICB), the ADPH, the RDPH or potentially the Secretary of State.

Scope

The following areas of health protection are included in Appendix 2 of this framework:

1. **Immunisations and vaccinations** – performance
2. **Communicable diseases** – case and outbreak response and management (including healthcare acquired infections (HCAI)/Infection Prevention and Control (IPC)/Antimicrobial Resistance (AMR)/Blood Borne Viruses (BBVs)/Sexually Transmitted Infections (STIs))
3. **Environmental hazards** (including adverse and extreme weather, contamination of water and land, noise and air pollution) - response and preparedness
4. **Local Authority Health Protection services** (e.g. environmental health, trading standards, licensing)
5. **Screening** – quality assurance and performance

Plus, the following **enablers** that cut across the areas above:

6. **Emergency Preparedness, Resilience and Response** (EPRR)
7. **Governance arrangements** – Terms of Reference, membership etc.

8. **Surveillance**
9. **Data sharing** and **notification processes** (incidents, outbreaks and exceedances)
10. **Workforce** - capacity and capability

The aim is for this framework to be as comprehensive as possible to cover all aspects of health protection functions. This means that there will be a range of metrics, with some more easily assured than others.

References

[i] Vivancos R, Leonardi G, Elliot A. Health Protection: Principles and practice. Health protection surveillance. Oxford University Press 2016; 21;216-227. doi: 10.1093/med/9780198745471.003.0021. Available online [Last accessed: September 2024].

[ii] Public Health England. Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities Regulations. 2013. Available online [Last accessed: September 2024].

[iii] Public Health England. Directors of public health in local government: roles, responsibilities and context. 2023. Available online [Last accessed: September 2024].

[iv] Faculty of Public Health. Functions and standards of a Public Health System. Systems and function: a framework for public health practice. Available online [Last accessed: September 2024].

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Appendices

1. Roles and Responsibilities
2. Assurance Standards

Acknowledgments

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APPENDIX 1 – Roles and Responsibilities (for more details, see local Memorandum(s) of Understanding or similar documents)

Local Authorities (LA)	UK Health Security Agency (UKHSA)	Integrated Care Boards (ICB) and NHS England (NHSE)
• Local health leadership, identify issues and provide advice to the NHS and LA, convene the Health and Wellbeing Board (HWB). • Lead LA's response to incidents. • Providing information and advice to relevant organisations and the public. • Assurance – the DPH has a statutory responsibility to be assured that adequate arrangements are in place to protect the health of the population. • Commissioning or delivery of sexual health services. • Seek assurance about Community Infection Prevention & Control (CIPC). • Lower tier/ Unitary LA environmental hazards, environmental health.	• Undertake the role of the Proper Officer of the Local Authority as detailed in the Public Health (Control of Disease) Act 1984 (as amended). • Specialist health protection response including responses to cases, outbreaks and incidents. • Specialist information, advice and guidance, respond to enquiries. • Supporting LA to understand and respond to potential threats. • Health protection leadership and stakeholder management. • Data collection, analysis and disease surveillance, epidemiology investigation • Research and development.	• Planning and securing health services response. • Mobilising NHS resource e.g. tuberculosis, prescribing of prophylaxis and administering treatment as appropriate. • Immunisation (ICB from April 2026, subject to delegation) and screening. • NHS incident response levels. *NB:* • NHSE is both accountable and responsible for people in custody. • NHSE are accountable for immunisations and screening but ICBs are preparing for a period of delegation to be responsible for delivery. • RDPH role/joint appointment with NHSE can tie into the NHSE/ICB regional assurance frameworks in place.

Roles and responsibilities of all partners:

- Preventing threats arising.
- Planning for and responding to incidents that present a threat to the population's health.
- Business continuity and emergency planning.
- Promoting health equity.
- Gathering and sharing lessons learned.

Local Resilience Forums (LRF) and Local Health Resilience Partnership (LHRP):

- Civil Contingencies Act duty, Category 1 responders – LRF on-call arrangements, planning, testing and exercising multi-agency plans.
- Arrangements for stockpiling of essential supplies and medicines as needed.
- Escalation protocols LHRP is co-chaired by DPH and ICB Accountable Officer.

APPENDIX 2 - Assurance Standards

1: Immunisations and Vaccinations

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	DPH to receive and have in place arrangements for the review of COVER data for nationally agreed programmes against WHO or other agreed targets on a regular basis at regional / LA / ICB / practice level and for vulnerable populations as necessary cut by IMD and ethnicity and those in the criminal justice system.	Data provided by lead commissioners and evidence of review at relevant meetings e.g. Health Protection Board, Vaccination and Immunisation Delivery Board. Data incorporated into the JSNA and used within Equity Audits as appropriate. Plans in place to manage new or changing programmes e.g. Chickenpox.	
2	Process in place to review performance for each immunisation and vaccination programme, and to agree actions to improve performance and reduce known inequalities.	Minutes, actions plans and data from relevant meetings e.g. Health Protection Board, Vaccination and Immunisation Delivery Board.	
3	Arrangements are in place to ensure local delivery of national targets on specific vaccine preventable diseases of concern e.g. M.pox, Measles.	Local delivery plan with clear organisational roles and responsibilities. Clear governance arrangements in place e.g. Health Protection Board, Vaccination and Immunisation Delivery Board.	

2: Communicable diseases

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Arrangements in place to confirm that UKHSA is receiving and reviewing notifications of communicable diseases and lab reported infections.	Routine and urgent notifications received by UKHSA Acute Response Centre (ARC) through notifications of infectious diseases (NOIDs), laboratory reporting, primary care or notification from community settings. Regular data / reports from UKHSA e.g. Weekly Epidemiological Bulletin from the Field Service. LA Public Health Team and other system partners advised when local health protection action is required and / or there are high profile cases being managed by UKHSA.	
2	Clear lines of communication with UKHSA Health Protection Team in relation to communicable diseases.	Regular contact with UKHSA County Team. Annual review of the process to ensure LAs and system partners are notified when local health protection action is required and / or there are high profile cases being managed by UKHSA.	

		Minutes from Health Protection Board showing UKHSA attendance.	
3	A 24/7 expert public health investigation and response is provided to cases and outbreaks and to call a multi-agency Outbreak Control Team (OCT) as required.	A named consultant within UKHSA to oversee the response within the patch and ensure that they, or a member of their team provide response advice and keep DPH informed as required. Details of the out of hours process. Periodic reports from UKHSA to Health Protection Board (verbal updates in meetings). Minutes of any OCTs in the last year where appropriate to share.	
4	Local arrangements in place to collect samples / take swabs, plus other activities that may be required, in a. timely manner as necessary.	Clear arrangements in place for swabbing / taking samples and that responsibilities are included in ICB contracts or agreements e.g. Memorandum of Understanding (MOU). Local outbreak plans.	
5	Plans in place or in development to tackle international / national / local priority issues e.g. Tuberculosis (TB), Blood Borne Viruses (BBVs) and Sexually Transmitted Infections (STIs).	Support provided by UKHSA in relation to local needs. Local plans in place where needed e.g. Measles Elimination Plan. Minutes and papers from relevant meetings e.g. Health Protection Board, Vaccine and Immunisations Board.	

6	Registered providers of healthcare and adult social care services demonstrate compliance with the 10 (IPC) criteria set out in the Code of Practice part 2 of the Health & Social Care Act 2008 (revised 2015).	Local IPC team / HP nurses to report periodically on the results of their assurance activities with registered providers - including reporting of where there may be gaps in assurance. Evidence of IPC assurance activities provided to the Health Protection Board. Evidence of training on IPC for relevant colleagues Clear process in place for the escalation of IPC concerns and seeking resolution.	
7	Local multi-agency plans in place to tackle Antimicrobial Resistance (AMR).	Clear actions for each organisation which are reported on through their own governance structures e.g. minutes from an ICB meeting referring to the action plan. Periodic report of actions against multi-agency plans provided to the Health Protection Board.	
8	Receive data on Healthcare Acquired Infections (HCAIs).	Minutes from relevant meetings e.g. Whole Health Economy meetings, where AMR and HCAI (healthcare associated infections) data is discussed. Evidence that actions to address any HCAIs are being delivered by the relevant organisation.	

3: Environmental Hazards

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Arrangements in place to confirm that UKHSA is receiving and reviewing notifications of environmental hazards.	LA Public Health Team advised when local health protection action is required and / or there are high profile cases being managed by UKHSA.	
2	Clear lines of communication with UKHSA Health Protection Team in relation to environmental hazards including the provision of appropriate public health advice.	Regular contact with UKHSA County Team. Minutes from Health Protection Board showing UKHSA attendance.	
3	A 24/7 expert public health investigation and response is provided to cases and outbreaks and to call a multi-agency Incident Management Team (IMT) as required.	A named consultant within UKHSA to oversee the response within the patch and ensure that they, or a member of their team provide response advice and keep DPH informed as required. Periodic reports from UKHSA to Health Protection Board. Minutes of any IMTs in the last year.	
4	Arrangements in place to collect samples, plus other activities that may be required,	Clear arrangements for environmental swabbing responsibilities (for samples such as such as food,	

	in a timely manner as necessary.	water and faecal) are included in contracts or agreements e.g. MOU.	
5	Identification of environmental risks.	Comments on Environmental Permit applications and planning applications where specific public health concerns are raised (note UKHSA does not review Standard Environment Agency permits or Local Authority Part B permit applications).	

4: Local Authority Health Protection services e.g. environmental health, trading standards, licensing

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Arrangements are in place for LA health protection services including port health where appropriate (in both Unitary and Two-Tier LAs) to report findings relevant to health protection as necessary and consult the DPH on actions as appropriate.	Minutes from relevant meetings, reports on key topics as required e.g. technical working groups / liaison groups for food / housing / environmental protection.	
2	Clear lines of communication with health protection services (which sit within Unitary LAs but with district / borough councils in Two-Tier LAs) including the	Minutes from Health Protection Board showing representative of local regulatory services relevant for animal health and some products safety matters.	

	provision of appropriate public health advice.	Feedback from relevant groups e.g. Food Liaison Group, Food Sampling Group.	
3	Engagement of health protection services in exercises and incidents which test the LAs response to various scenarios.	Minutes from relevant exercises / debriefs / inter-authority audits showing the role and involvement of Environmental Health officers and Trading Standards officers. Outbreak plans (food hygiene authorities only).	
4	Engagement with licensing colleagues as appropriate.	Minutes / reports from relevant meetings e.g. Health Protection Board.	

5: Screening

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	DPH to receive and have in place arrangements for the review of data for agreed programmes (see below) at an agreed frequency at regional / ICB level, which contains certain geographical level information (NB. LA and GP-practice level information is limited).	Appropriate governance arrangements in place. Minutes from relevant meetings e.g. Cancer Board, Local Maternity and Neonatal Services (LMNS) Board, Equity Board. Minutes and reports from Programme Boards (to evidence attendance from public health colleagues and their contribution).	

	See below a list of the national screening programmes: 1. Bowel Cancer screening 2. Breast Cancer screening 3. Cervical Cancer screening 4. Abdominal Aortic Aneurysm (AAA) screening 5. Diabetic Eye screening (DES) 6. Antenatal and new-born (ANNB) screening	Data incorporated into the Joint Strategic Needs Assessment (JSNA) and used within Equity Audits as appropriate.	
2	Process in place to review performance of each programme against standards and to agree actions to improve performance where necessary.	Minutes, performance reports and improvement plans from Programme Boards.	
3	Process in place to review quality information, and to agree actions as required.	Outcome summary reports. Minutes and reports from Health Protection Board meetings which show urgent recommendations (main quality concerns). Minutes and reports from Programme Boards which show Screening Quality Assurance Service (SQAS) visit recommendations. Reports from quality visits for all screening programmes.	

		Minutes from relevant meetings e.g. Performance and Governance Meeting, Programme Board.	
4	Process in place to report and review quality incidents and service failures, and to agree actions as required.	Regular assessments of the process. Minutes and reports from Programme Board and Health Protection Board. Programme Board risk register which shows local risks and how they are being monitored. Notifications from Screening Leads of any serious incidents. Details of screening incidents which have been presented to the Programme Board for closure.	

6: Emergency Preparedness, Resilience and Response (EPRR)

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Identification of key local, regional and national health protection risks.	Relevant risks identified in relevant local, regional and national plans e.g. National Risk Register, LRF Risk Register. Completed risk assessment template.	
2	Clear roles and responsibilities for all agencies which are consistent across all plans.	Up to date plans available on Resilience Direct e.g. UKHSA regional Outbreak Management Plan, Major Incident Checklist for DPH.	

		Clear arrangements (including payment) for swabbing / collecting samples responsibilities are included in contracts or agreements alongside details of how these contracts / arrangements are monitored. Out of hours arrangements in place. MOUs in place.	
3	Public health attendance and advice in place to support the command-and-control structure.	Minutes from exercises / debriefs showing public health attendance and advice. Action Cards.	
4	Opportunities to test various plans and scenarios and capture lessons learned.	Minutes / lesson learned from incidents / exercises showing attendees and their roles / responsibilities. Evidence that lessons learned and recommendations have been communicated to the relevant partners.	
5	Opportunities to access appropriate training.	Training plans aligned to National Occupational Standards e.g. • Multi-Agency Gold Incident Command (MAGIC). • Scientific and Technical Advice Cell (STAC). • Joint Emergency Service Interoperability Programme (JESIP).	

6	Appropriate engagement with the LHRP.	Minutes from meetings showing attendees and their roles / responsibilities and a summary of the discussions.	

7: Governance arrangements

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	A mechanism in place to exercise statutory assurance role e.g. Health Protection Board with membership from across the health protection system.	Health Protection Board Terms of Reference and meeting minutes.	
2	Appropriate reporting of health protection information and escalation of concerns to the Health Protection Board and where appropriate to the HWB and / or Integrated Care Partnership (ICP).	Minutes from Health Protection Board and HWB and / or ICP (or subgroup).	
3	Appropriate reporting of concerns about UKHSA via the Consultant / Regional Deputy Director.	Clear process for raising concerns and seeking 'solution focussed approaches' to ensure satisfactory resolutions. NB. As part of UKHSA's Future Health Protection System programme there is a conversation about the RDPH being a point of escalation where local	

		systems can't resolve a particular issue, in part because of the dual responsibilities of the role (DHSC/NHSE).	
4	Appropriate engagement from all members of the LHRP and LRF.	Minutes from meetings showing attendance and discussions.	

8: Surveillance

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	A system is in place for communicable diseases to be reported as necessary.	Diagnostic laboratories report causative agents to UKHSA in line with legislation and the LA Public Health Team is advised when local health protection action is required and / or there are high profile cases being managed by UKHSA. Routine and urgent notifications received by UKHSA ARC and regular data / reports from UKHSA e.g. Weekly Epidemiological Bulletin from the Field Service.	
2	A system is in place for notifiable diseases to be reported as necessary.	Registered medical practitioners report notifiable diseases to UKHSA in line with legislation and the LA Public Health Team is advised when local health	

		protection action is required and / or there are high profile cases being managed by UKHSA.	
3	A system is in place for exceedance and cluster detection (all laboratory reported organisms, key infectious diseases).	LA Public Health Team is advised when local health protection action is required and / or there are high profile cases being managed by UKHSA. An overview of epidemiologic reviews conducted by UKHSA, provided to the Health Protection Board or DPH as agreed locally.	
4	Access to appropriate data from UKHSA in line with the core offer.	UKHSA Field Service Surveillance outputs: • Weekly reporting of key infectious diseases via epidemiological bulletin. • Winter weekly reporting of acute respiratory infections, infectious intestinal diseases. • Quarterly reporting of vaccine preventable diseases, HCAI. • Annual reports of TB, hepatitis (B&C) and STIs/HIV.	

9: Data sharing and notification processes

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Health protection notifications (routine updates).	Regular surveillance data provided by UKHSA Field Service e.g.	

		• Weekly Epidemiological Bulletin. • ARI report weekly during winter. • IID report weekly during winter. UKHSA Briefing Notes and routine information cascade from UKHSA Regional Response Centre (RRC). Notification cascade for care home outbreaks. Regular verbal updates and routine liaison.	
2	Pathways in place for urgent escalation of health protection issues.	UKHSA notification of urgent issues to the DPH / LA Health Protection Lead.	

10: Workforce

			DPH to complete
	Assurance standard	**Suggested evidence**	**Comments e.g. gaps in assurance, mitigating actions, locally agreed standards**
1	Have sufficient (quality and quantity) staff to fulfil the LA's role in relation to supporting health protection incidents and outbreaks as required.	Minutes from exercises / debriefs showing public health attendance and advice. Job descriptions and evidence of Continuous Professional Development (CPD). Training opportunities for existing staff in other parts of the LA e.g. Environmental Health Officers and Trading Standards Officers, to enable them to be	

		proficient in health protection as and when required.	
2	Sufficient specialist capacity to adequately resource key health protection functions e.g. Public Health Consultants, Environmental Health Officers.	Information about capacity and details of any risks raised about the lack thereof to be taken to the Health Protection Board.	