Public Health England West Midlands response to Birmingham health and social care overview and scrutiny meeting 19th May2020

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Request

PHE West Midlands have been asked by the chair of the Birmingham health and social care overview and scrutiny committee to provide written evidence for the meeting on 19th May 2020 regarding 2 specific issues:

1. Can PHE help the committee understand better the Covid-19 data that is available to them locally
2. Can PHE WM provide clarity regarding the relationship between PHE WM as a national organisation with a local presence and Birmingham City Council's Director of Public Health

The purpose of providing this information is to enable the city to better plan and prepare for the ongoing impacts relating to Covid-19 for the population of Birmingham.

1. Data

Data describing the Covid-19 impacts continues to be collected by a number of different organisations both locally and nationally including the NHS, PHE and the coroners.

Data is usually only available at upper tier local authority level. This is because of concerns regarding confidentiality when small area statistics are published and the potential to identify individuals. Decisions regarding publication of small area statistics are made nationally. We appreciate that this causes colleagues frustrations especially for a city as large as Birmingham. The exception to this is the publication of ONS death data which is available at super output area.

Another reflection is that only some of the data is shared in the public domain because the data is classified as Official Sensitive. This data is shared with Strategic Coordinating Group partners with prior agreement by the Cabinet Office. The SCGs are statutory groups that are established under the Civil Contingency Act (2004) based upon Police Force Boundaries where key partners come together to coordinate the strategic response to incidents. Members of the SCG come from a range of organisations including PHE, Local Authorities, police, fire and ambulance services.

All of the data that has been gathered to date regarding Covid-19 is numerical. A call for research has been announced by the NIHR on 17th April 2020. We anticipate that this will include some qualitative research data and PHE WM have supported several local applications related to this with a specific focus on:

- Covid-19 and ethnicity
- Covid-19 virus transmission, risk factors, seroprevalence and priority groups

https://www.nihr.ac.uk/funding/covid-19-rapid-response-rolling-call/24650

As a public health community, we have previously reflected that we are 'data rich and intelligence poor'. This observation holds true for the amount of data that we are now able to access related to Covid-19. The fundamental description of surveillance is that it is 'information for action'. Hence, we

are fully supportive of this health and care overview and scrutiny committee seeking to understand the data better to help inform local actions.

The following section aims to give an overview of the variety of data sources that are publicly available. These have been categorised into the main heading of: numbers of cases, hospital, death, ethnicity, care home and PHE surveillance reports.

a) Numbers of Covid-19 cases

Currently detection of Covid-19 relies upon laboratory PCR testing. This test is where a nasal and throat swab is taken and analysed for viral particles. There is no reliable antibody test available at this time that is able to give us an indication of previous infection with Covid-19. Hence, we are unable to provide an accurate picture of the true numbers of cases of Covid-19 in the local community because we have not as a country under taken mass testing from the outset. Initially we were only testing: symptomatic returning travellers from affected areas and then those critically ill in hospitals and symptomatic residents in outbreaks in the care home setting. This has now further expanded to include testing of all key workers, care home residents and over 65s. The national testing strategy has evolved during the course of the pandemic. This has been nationally determined and further details can be obtained here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878121/coronavirus-covid-19-testing-strategy.pdf

We do have an indication of the spread of the disease through a number of different sources of data including: NHS hospital activity, laboratory test results and outbreaks in care homes that we will come onto describe in subsequent sections of this submission.

There is a national dashboard that reports the number of laboratory confirmed PCR tests and rates for Covid-19 at national, regional, upper and lower tier Local Authorities

https://coronavirus.data.gov.uk/?_ga=2.21896632.247002491.1588065248-1036432574.1588065248

A large-scale national study led by the Office for National Statistics has commenced that attempts to estimate the true numbers of Covid-19 in the community by recruiting 300,000 members of the public from across the country and undertaking statistics to estimate the spread of Covid-19. This will be very helpful in the future to aid our understanding of the spread of Covid-19 across the country.

https://www.ons.gov.uk/news/news/onsjointlyleadinggovernmentslargescalevirusinfectionandantibodyteststudy

b) Hospital data

The NHS has collected data on the patients who have been admitted to hospital wards and to critical care. This data has been reported through the SCGs on a daily basis by NHS Midlands providing hospital level data regarding bed occupancy, ventilated patients and deaths.

We understand that the NHS is also undertaking a national analysis of the healthcare workers who have died from Covid-19 specifically from the BAME community.

c) Death data

The reporting of deaths data is a complex area and we have been working with the lead coroner for the WM to help facilitate accurate reporting and recording of Covid-19 deaths.

Nationally, the ONS publish death data drawing upon the recording of Covid-19 cases on the death certificate. During the pandemic there has been a relaxation made to the legislation to enable more rapid reporting of deaths i.e. deaths can be reported as Covid-19 without the need to have a laboratory positive swab and the decision regarding the cause of death can be made based upon the balance of probabilities taking into account the clinical symptoms of the individual prior to death and contact with other known positive cases.

ONS publications include weekly report that describes the numbers of deaths by upper tier Local Authority areas and by setting:

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

The ONS have also developed a more local interactive map that gives deaths based upon postcode for super output areas:

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april#rural-and-urban-areas

The process for death certification can take a while hence the NHS established a 'real time' data dashboard for reporting suspected hospital deaths.

Daily NHS data of deaths reported up to 5pm each day in the hospital setting are published here:

https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/

There is also the national daily NHS hospital death dashboard. The reporting for this data changed on the 29th April where it moved from being only hospital deaths to include some community death data by linking the laboratory data of confirmed cases to deaths. This may result in an over estimate of cases where an individual has dies with and not from Covid-19. But it will also be an underestimate of community deaths because some individuals will not have had a swab and have died from Covid-19 that may or may not be reported on the death certificate hence the weekly ONS data dashboard will give a more accurate picture. This is the link to the national dashboard:

https://coronavirus.data.gov.uk/?_ga=2.21896632.247002491.1588065248-1036432574.1588065248

We are aware that some individual hospitals have reviewed their Covid-19 deaths and undertaken analysis of these to try and identify risk factors including ethnicity and pre-existing health conditions. We do not have access to this data in PHE but we understand your Director of Public Health does.

Based upon feedback that we have received from Care Homes we suspect that there has been an under reporting of Covid-19 on death certificates. We have been working with both the coronial community and through NHS Midlands to ensure that GPs are aware of the changes in guidance and aware of the need to report Covid-19 on death certificates.

A Midlands mortality cell established by NHS Midlands has been working with PHE colleagues to review the breadth of the mortality data. An excess death mortality dashboard has been developed as part of his work program and shared with all Directors of Public health.

d) Ethnicity data

PHE is taking reports that certain groups have been disproportionately affected by Covid-19 extremely seriously. PHE is therefore conducting a national review that will analyse how factors such as ethnicity, obesity and gender can affect people's vulnerability to coronavirus. https://www.gov.uk/government/news/review-into-factors-impacting-health-outcomes-from-covid-19

This study means that thousands of health records of people who have had Covid-19 will be examined to establish more robust data on what can have an impact on the number of cases and health outcomes for different groups within the population. The review aims to better understand how factors such as ethnicity, deprivation, age, gender and obesity could impact on how people are affected by coronavirus. This review aims to provide insight into emerging evidence the virus is having a disproportionate effect on different groups. The results are expected to be published by the end of the month.

A West Midlands Combined Authority Mayoral Roundtable is being organised with the aim of providing additional local insight into any disproportionate effects on different ethnic groups to inform the work of the national review and to further identify what health and social interventions can make a difference.

PHE's existing evidence and practice around vulnerable and inclusion health groups can also help to inform this future work including: children and young people, homeless, victims of modern slavery and vulnerable migrants, work on faith-based settings for health promotion building on the mosques work in the City, social prescribing, asset-based approaches, social marketing and a PHE project on language and interpretation.

e) Care home data

A Midlands Care Homes cell has been established that is jointly chaired between PHE and NHS Midlands with representation from the WM Directors of Public Health and WM Directors of Adult Social Care. This group has developed a dashboard to provide updates regarding numbers and percentage of care homes affected by Covid-19 that is shared with your Director of Public Health.

https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

f) PHE surveillance reports

Covid-19 is a statutory notifiable disease under the Public Health (Control of Disease) Act 1984/Health Protection (Notification) Regulations 2010 and registered medical practitioners have a statutory duty to notify the 'proper officer' of their Local Authority (who include PHE Consultants in Communicable Disease Control) or their PHE Health Protection Team of suspected cases. We collate this information through our HP zone database and then nationally PHE has analyses this data to produce weekly and daily surveillance reports at upper tier Local Authority level.

Until April 2020 PHE were not permitted to share the surveillance reports with local partners by the Cabinet Office. We now have permission to share these with our Directors of Public Health and SCG partners. These are marked as official sensitive and not in the public domain. They contain comparisons between absolute and cumulative laboratory confirmed cases, an age-sex breakdown,

rates by upper tier local authority level and syndromic surveillance in GP practices and Emergency Medicine departments of hospitals.

2. Relationship between PHE and Director of Public Health

PHE is the national expert public health body in England mandated under the Health and Social Care Act 2012 to protect and improve the public's health by: supporting and advising national and local government and the NHS; providing specialist public health services including specialist health protection services and public health intelligence; and by supporting the development of the public health workforce.

We are organised at national, and regional levels (Midlands and West Midlands). We have a key role to support local Directors of Public Health who are jointly appointed by Local Authorities and PHE on behalf of the Secretary of State for Health and Social Care and are the local professional public health leaders in their area. We do this in the West Midlands through ongoing professional relationships with each of our 14 DsPH and their teams; by working closely with ADsPH West Midlands; by undertaking bespoke public health work as agreed; and by contributing to a wide range of communities of practice and many regional and sub regional partnerships. We also provide public health advice and support to the West Midlands Combined Authority, and to NHS England for their public health duties including the regional commissioning of public health services, and most recently now fulfil the role of NHS Regional Director of Public Health (Midlands).

We are in the process of organisational change and moving to a larger Midlands footprint but the current pandemic has delayed this program. Currently, we operate on a West Midlands footprint covering 14 upper tier Local Authorities: Stoke, Staffordshire, Telford & Wrekin, Shropshire, Wolverhampton, Sandwell, Walsall, Dudley, Birmingham, Solihull, Coventry, Warwickshire, Worcestershire and Herefordshire.

https://www.gov.uk/government/organisations/public-health-england

Since 2013 we have worked closely with the WM Association of Directors of Public Health and their support organisation Learning for Public Health: https://www.lfphwm.org.uk/ including the current and previous Directors of Public Health for Birmingham City Council.

During the current pandemic we are operating locally within a nationally commanded incident and response structures. PHE is a category 1 responder in the context of Civil Contingencies Act 2004 https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others

In March 2020 COVID 19 was listed as a statutorily notifiable disease. All COVID 19 cases and outbreaks for example in care homes and other settings must be notified to PHE. Our role is to undertake a risk assessment of individual cases, outbreaks, ensuring symptomatic cases in care homes, prisons and other settings are tested, and we advise on appropriate control measures (isolation, infection prevention and control measures). In this role we work closely with DsPH and local authority teams as well as with local NHS teams to ensure that control measures are in place. We focus our efforts on the control of particularly complex and challenging situations and outbreaks.

In addition to PHE's significant role in responding to and supporting national and local management of the immediate crisis, we recognise that the pandemic provides us with an opportunity to further address health inequalities and health equity including what can be done differently and better in the future. For PHE "business as usual" is to protect and improve health and wellbeing in our places and for the most vulnerable. We have an ongoing work programme of work which is data driven and evidence led (both qualitative and quantitative) and reliant on effective partnership with system leaders including: 14 Local Authorities, a wide range of NHS partners, Violence Reduction Unit, WM Combined Authority, WM Association of Directors of Children's Services, WM Association of Directors of Adult Social Services and the voluntary sector to navigate the Covid-19 crisis and beyond.

As part of our wider contribution to the pandemic now and in the future, we have established a WMs Covid-19 Health Inequalities Cell which aligns the pandemic response to our business as usual priorities: health inequalities, inclusion health, lifestyles and behaviour change, access to services and wider determinants, wider partnerships, data, evidence, evaluation. For example in relation to asylum seekers: PHE contributed to the multiagency response to initial accommodation (IA) and asylum accommodation providers having to use contingency accommodation by advocating for a strengthened health response and recommending improvements to health related processes and service delivery including securing DPH and NHS involvement; risk mitigation and safeguarding considerations; making the case for sustainable funding; uptake of health assessments in IAs; developing wider care pathways and enabling primary care access. PHE also produced an evidence and practice resource on translation and interpretation provision across the WMs and recommendations impacted upon the PHE acute response centre delivery model which now includes dedicated translation support.

Across teams and partners, we are undertaking population level analysis to describe the direct and acute impacts of COVID-19 for groups and places and over time considering quality of life and interrelated social determinants including the economy, education, employment and the environment. A number of products will shortly be shared to support the local response including customised reports providing indicators for local populations most likely to suffer health inequalities during the outbreak; guidance developed by government and voluntary sectors for higher risk groups; possible impacts of COVID19 across groups along with actions that can be taken at a local level to mitigate these and an updated health inequalities assessment tool to support local prioritisation. It is too early to say precisely what lessons can be learned from the Covid-19 experience, but we are researching and evaluating our work in the short, medium and longer term including crisis management, adaptation and recovery.