Witness Name: Angela Leitch
Statement No.: 1
Exhibits: 6
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UK COVID-19 INQUIRY

DRAFT WITNESS STATEMENT OF ANGELA LEITCH

I, Angela Leitch, will say as follows: -

1. Professional background

1.1. I was appointed as the first Chief Executive of Public Health Scotland (PHS) in September 2019. I commenced in post in November 2019, four months before Public Health Scotland (PHS) became operational on 1st April 2020. I retired from PHS on 17th April 2023.

1.2. I worked for over 30 years in local government in Scotland before joining PHS. I have worked in senior roles in four local authorities, latterly as Chief Executive of, firstly, Clackmannanshire Council and then in East Lothian Council. I had eight years' experience as a Chief Executive prior to joining PHS.

1.3. The attraction of the PHS role was the emphasis on the prevention of poor health outcomes and how a different approach could enable people to live healthier for longer and reduce the de demand on health services. My experience was in line with the qualities that PHS set out in the recruitment documentation. In particular, I have held various leadership roles at a local level over several decades, worked in a political environment both locally and nationally and had a proven track record of delivering improved outcomes in conjunction with other partner organisations which would be a major feature of the PHS role. My national experience included being an Office Bearer with the Society of Local Authority Chief Executives in Scotland (SOLACE) for a number of years. I chaired SOLACE for 18 months and led, for several

years, the branch's work on both children and families and on leadership and development for senior managers across local authorities. This work involved considerable engagement with civil servants and politicians in the Scottish Government. I also held a non-executive role on the Board of the Improvement Service prior to starting with PHS.

1.4. I joined PHS with a firm understanding of the importance of public services such as education, early years, housing, good quality public spaces, a green environment, access to good quality food, jobs etc in improving outcomes for people and communities. I had developed strong relationships with partner organisations that operated in the local authority areas and I also worked extensively across regional boundaries to deliver improvements in my area. Throughout my career I have had a firm focus on improvement, performance, efficiency and effectiveness. I have successfully led large organisations, working constructively with a wide range of partners and stakeholders, ensuring resources were used to best effect and with a view to improving the quality of life of those who relied upon our services.

2. Contextual background

2.1. PHS was formed following a programme of Public Health Reform (PHR) in Scotland, which was led by the Scottish Government and the Convention of Scottish Local Authorities (COSLA). The Scottish Government and COSLA went on to become PHS's joint sponsors. In effect this means that PHS is accountable not only to national government but also to local government. This arrangement is unique amongst Health Boards in Scotland and reflects the combined responsibility of both sectors in addressing health inequalities.

2.2. Emerging from the public health reform programme was a vision for Scotland where everybody thrives. This vision was subsequently adopted by PHS as we developed our first strategic plan. The ambition of the reform programme was for Scotland to be a world leader in improving the public's health. Public health reform aimed to create a culture for health in Scotland that recognises the social and economic issues that affect health and creates environments that drive, enable and sustain healthy behaviours in our communities, supporting individuals to take responsibility for their own health and wellbeing wherever possible.

2.3. The first stage of the PHR programme was the development of Public Health Priorities (PHPs) for Scotland. The PHPs were to set a foundation for all parts of the public sector in Scotland to contribute towards sustainable public health outcomes and focus on those activities that have the greatest potential to make a significant improvement to health gains, inequalities and sustainable economic growth over the next 10 years.

2.4. The PHPs were developed over the course of a programme of stakeholder engagement and launched by the Scottish Government and COSLA in June 2018. The PHPs focussed on health improvement and I was aware before taking up post as Chief Executive of PHS that health protection stakeholders across Scotland, including colleagues in HPS, had noted that the priorities did not make reference to actions to protect the public from infectious disease and environmental hazards. In many ways this was to the credit of those working in health protection; the understanding was that Scotland already benefitted from a well-established infrastructure to protect the public's health, including ways of working between national and local partners, and clear statutory duties. The Scottish Government and COSLA recognised the established processes and systems that existed across those bodies responsible for health protection in Scotland. Health Protection Scotland, the then national agency responsible for infectious disease and environmental hazards would be further supported when it transferred to PHS by the combined functions, skills and resources that would form part of the new organisation.

3. Creation of Public Health Scotland

3.1. PHS brought together two legacy bodies. These were NHS Health Scotland (a national Health Board), and the two components of the Public Health and Intelligence Strategic Business Unit of NHS National Services Scotland (NSS): Health Protection Scotland (HPS) and Information Services Division (ISD).

3.2. When I reflect on the work that went into setting up PHS, I am struck by the extent of stakeholder engagement that took place, especially through the commissions, which covered aspects of how the new public health body would function. Stakeholders included:

- The wider public health community and workforce
- The NHS
- Local government (including COSLA and SOLACE)
- Community planning
- The third sector
- NGOs
- Health and Social Care Partnerships / Integrated Joint Boards
- Health improvement specialists

In addition to commissions covering the three domains of public health, there were commissions looking at key functions such as public health research and innovation and public health workforce development.

3.3. Examples of the commissions include:

- Improving Health: what do we need PHS to do to support the achievement of a step change in Scotland's health status and a reduction in health inequalities?
- Protecting Health: what do we need PHS to do to support an ongoing high quality, resilient and efficient health protection service for Scotland?
- Improving Services/Health Care Public Health (HCPH): what do we need PHS to do to support effective HCPH input to the design and delivery of care services across Scotland to maximise their population benefits and their contribution to reducing health inequalities.

The commissions were carefully governed by the PHR programme and were highly collaborative, with staff from NHS Health Scotland and Public Health and Intelligence working together with partners from across the system.

3.4. There was also extensive work undertaken on the practical elements that would help PHS deliver its functions, including governance and accountability and finance. It was clear that building on the strength of the legacy organisations we needed to undergo significant change to create an organisation equipped to be able to deliver on the PHPs and make a difference to population health and wellbeing in Scotland.

3.5. A Target Operating Model (TOM)[1] was developed that set out how the new organisation would transform in order to be able to deliver on the reform programme's ambition. The TOM described the contribution that PHS would make to the wider public health system and proposed the core responsibilities PHS would have in its executive management team.

3.6. The PHR programme intended for PHS to be more than the sum of its parts; to be more effective in meeting the challenges facing the people of Scotland than the legacy organisations before it. One initiative I undertook in preparation for the new organisation and the changes that would be necessary to form an organisation that was able to effectively address the PHPs was to run a series of staff events in the run up to the launch of PHS. This enabled me to explain to almost fifty percent of the new organisation some of the opportunities we would have as well as the need to 'do things differently, and do different things, to make a difference'. In the medium to longer term, this would involve refocussing the organisational activities that were less effective in improving health outcomes to free up resources for more impactful activities. These staff sessions which were well received set the tone and the context for the significant change that was to come.

3.7. I engaged extensively with senior colleagues in the Scottish Government and with my counterparts in other UK public health agencies in the run up to the launch of PHS. This included spending over a week with Public Health England (PHE) in January 2020, discussing their governance and operations with Duncan Selby, who was the Chief Executive at the time, and with the PHE senior team. I also met with colleagues such as Catherine Calderwood, the Chief Medical Officer at the time, and with the Chief Executive of NHS Scotland, Malcom Wright. This was useful at the time, and even more so when the pandemic hit because I was able to draw on the relationships I had in place.

3.8. PHS became a legal entity on 7th December 2019, when the Public Health Scotland Order 2019 (AL/2 - INQ000147858) came into force. This means that during the period covered by Module 1 of the UK Public Inquiry (11th June

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[1] Scottish Government / COSLA. Target Operating Model version 2.0. May 2019. (AL/1 - INQ000183552)

2009 to 21st January 2020), PHS was not operational. National leadership to protect the Scottish public from infectious diseases and environmental hazards at that time was the remit of HPS, which was part of NHS National Services Scotland (NSS).

4. November 2019 – March 2020: planning for PHS

4.1. When I joined PHS in November 2019 I was appraised of the work underway to create an Annual Operational Plan (AOP) for the first year of the organisation's operation. The plan was being taken forward by teams from across the legacy organisations and brought together the work programmes of Health Protection Scotland, Information Services Division and NHS Health Scotland.

4.2. The organisation's sponsors – the Scottish Government and COSLA – were engaged in the development of the plan and the approach being taken. The decision was made to use 'strategic areas' to bring together the work from across the legacy organisations. The strategic areas comprised the six Public Health Priorities (PHPs), which largely focussed on health improvement, together with work across the other domains of public health – health protection and healthcare public health – transformation work, and work on whole system approaches and maximising data and digital intelligence.

4.3. The Protecting Health strategic area contained seven specific pieces of work. Of particular note, regarding pandemic planning and resilience, was the intention to:

- Foster a collaborative approach to the surveillance of communicable diseases: this included plans to harmonise surveillance outputs to allow comparison across local areas, including adopting a case management system for use across Scotland.
- Support the Scottish Immunisation Programme (SIP) and local vaccine delivery system: as core members of the SIP, PHS was committed to playing a central role in the planning and delivery of routine and seasonal vaccination programmes and leading on a range of activities aimed at improving vaccine confidence and reducing vaccine hesitancy. Working with NHS Boards and other partners, PHS was committed to seeking to

identify and reduce variation in vaccine uptake, particularly for Scotland's most marginalised communities, and developing and executing a range of vaccine campaigns including the annual Flu and HPV campaigns.

- Strengthen our contribution to Public Health Microbiology and ensure increasing demand for virology is met: PHS was committed to providing consistent strategic and operational virological advice as required to address pandemic preparedness. This included specialist and reference virological laboratory commissioning and monitoring, advising on the health protection implications of new and emerging viral threats, and developing and modernising surveillance systems utilising advancing technology and techniques to ensure maximal epidemic intelligence gain.
- Strengthen the prevention contribution of health protection, including optimising the data linkage opportunities available to PHS, demonstrating the public health benefit of new vaccines for seasonal influenza, and providing strategic leadership for High Consequence Infectious Disease (HCID) preparedness in Scotland. This latter element included:
  - The development of HCID clinical pathways.
  - Public health guidance.
  - HCID web page on the PHS website
  - Working with partners to support delivery of the other recommendations within the HCID workplan.
  - Meeting legal obligations in relation to port health surveillance, preparedness and response.

4.4. These commitments were developed by the experts in the relevant areas. In the most part this was colleagues in HPS, with joint work across HPS and NHS Health Scotland in the case of the SIP. The development of the overall Protecting Health strategic priority area was led by Dr Jim McMenamin, the Interim Clinical Director and strategic lead for the Respiratory Viral team within HPS, with responsibility for responding to seasonal and pandemic influenza. Dr McMenamin worked with Kate Harley, the HPS Associate Director, and the Head of Marketing in NHS Health Scotland who brought particular expertise around vaccination campaigns. I was assured as a result of the expert involvement of these colleagues that in the context of pre-pandemic Scotland and the context of the strategic priority focus on the PHPs, that PHS was planning appropriately around pandemic preparedness

and resilience and factoring in lessons learned from past simulation exercises and near-pandemic events.

4.5. The AOP was submitted to the Scottish Government and COSLA on 24th February 2020, just weeks after the World Health Organization assigned COVID-19 its official name and days after the first death from COVID-19 in Europe. The plans put in place for the organisation over the years leading up to the launch of PHS, including the AOP and the organisation's Target Operating Model, had to be rapidly revised in the context of the pandemic. Providing a robust and effective contribution to Scotland's response to COVID became the organisation's over-riding priority, together with protecting staff wellbeing.

5. April 2020: the launch of PHS and pandemic response

5.1. PHS was launched on 1st April 2020, eight days into the first UK lockdown. The majority of staff were working from home, with the exception of staff required to attend the Incident Room in operation at our Meridian Court offices in Glasgow, and staff involved in the response who required access to systems that was not yet possible remotely.

5.2. Although the circumstances of the inception of PHS were perhaps the most challenging that any new national public health agency has had to face, the benefits of the creation of one unified public health agency were immediately apparent. The Senior Leadership Team (SLT) of PHS brought together experts in health protection, data and intelligence, health and wellbeing, and organisational governance. Prior to April 2020 and the launch of PHS, leadership for these areas was split between the legacy bodies. HPS would have led the national health protection response, working with colleagues in Information Services Division around the data infrastructure and reporting. It seems likely that NHS Health Scotland would not have had a significant role in the early stages of the pandemic, though would have offered evidence around inequalities as the pandemic progressed. But as a result of the creation of PHS, colleagues who joined the organisation from NHSHS were quickly mobilised into supporting the pandemic related work, in some cases moving into temporary work assignments in the Clinical and Protecting Health Directorate, in other cases lending their professional expertise in corporate services to the planning and coordination of the cross-organisational

response. This happened at speed and with minimal obstacles in terms of human resources processes by dint of everyone being part of one organisation. The agility, ability to flex, and mobilise people quickly to where they were needed is one of the cornerstones of the PHS response. I do not see that this would have been possible had all staff not been part of the one organisation under the unified leadership of the PHS SLT.

5.3. Although the benefits of the new unified national public health body were clear, PHS's opening budget and staffing levels were not sufficient for PHS to deliver the health protection response required by the pandemic. The Director of Population Health in the Scottish Government made it clear to me that additional funding would be provided and that concerns around resources should not be a hindrance to the effective delivery of the pandemic response. This funding materialised and enabled me to quickly step up the required staffing and infrastructure.

5.4. In my opinion it was quite appropriate that PHS did not initially have the necessary funds and staffing to respond to a global pandemic. It would not be good use of public funding or in line with Value for Money to stand ready at all times to respond to a global pandemic. What was important was the ability to respond quickly and stand-up the necessary staffing, systems, and surveillance mechanisms. This requires effective and shared leadership and an organisational culture with strong shared values, vision and mission.

5.5. A good example of having the necessary foundations in place is the EAVE project. Early on in the pandemic PHS was able to work with partners at Edinburgh University, with the support of the Scottish Government, to re-start the EAVE project with a focus on COVID-19. EAVE (Early Estimation of Vaccine and Anti-Viral Effectiveness) was a data reporting system originally created to support the 2009 swine flu pandemic response. The first EAVE study used health data from a group of 227,000 people from 40 general practices (GPs) across Scotland to assess the effectiveness of vaccines in Scotland. This was an important piece of work which contributed to the understanding of pandemics, and specifically the swine flu pandemic of 2009-2010. However, due to the time required to set it up, analyse data and publish results, the EAVE consortium was not able to deliver its findings until 2012. This was too late to have an impact on government policy because the pandemic was already over. Realising its potential for future use, the EAVE

consortium requested permission to place it into hibernation, so future responses could be faster. Dame Sally Davies, the Chief Medical Officer of England at the time, granted this permission together with the resources required. This meant, in the event of another pandemic, the study could be reactivated quickly.

5.6. When the COVID-19 pandemic broke, the EAVE consortium entered a bid to reactivate the platform. PHS indicated the intention to use the results to inform the national response and requested a significant scaling up of the project from a quarter of a million people to the whole population of Scotland. The platform was reactivated and EAVE-II (Early Pandemic Evaluation and Enhanced Surveillance of COVID-19) went on to generate vital intelligence and garner international attention when it published one of the first evaluations into the effectiveness of COVID-19 vaccinations. This was only possible because the foundations for EAVE-II were already in place.

5.7. Returning to the issue of funding, I worked with colleagues in PHS to establish the additional resources required to fund our pandemic response and submitted bids to the Scottish Government for additional funding. In 2020/21 this totalled £11.3 million, which covered costs including additional staff in health protection and data analytics, genomics, national contact tracing, surveillance and serology.

5.8. The funding required for PHS to continue its contribution to the pandemic response was included as part of the planning and budget setting process in 2021/22. The Scottish Government commissioned a financial plan that set out COVID-19 funding requirements. The funding made available to PHS was circa £24m.

5.9. The same process was followed in 2022-23, with the addition of conversations between the Scottish Government and PHS on what services should continue and what should stop. It was agreed in meetings and correspondence with the sponsorship team that PHS's work on the vaccination programme, genomics and respiratory surveillance should be continued, while contact tracing was to be stopped. £13m of COVID-19 funding was made available for PHS in 2022-23.

6. Future pandemic readiness

Funding

6.1. I commented earlier that in my opinion it was appropriate that PHS did not initially have the necessary funds and staffing to respond to a global pandemic and that what was important was the ability to respond quickly and stand-up the necessary staffing, systems, and surveillance mechanisms. This applies equally to future pandemic preparedness.

6.2. I believe strongly that a flexible funding model is crucial to an organisation like PHS's ability to respond effectively to different challenges, including pandemics. Much of PHS's budget comes from ring-fenced non-recurring sources in Scottish Government. I have sought to work with our funders to reduce the proportion of ring-fenced funding since April 2020. I spoke of this issue at our Annual Review with the Minister for Public Health and the COSLA health and social care spokesperson in March 2022, highlighting that 38% of PHS funding was non-recurring, short-term funding, ring-fenced for a specific issue, with little flexibility in PHS uses it. I also raised it with the Chief Executive of NHS Scotland, Caroline Lamb, when she visited PHS in July 2022, and with the new Permanent Secretary, John Paul Marks, when the Chair of PHS and I met with him on 8th August 2022.

6.3. This funding model meant that the pace of change was slower than initially planned. On the basis of evidence there was a need to redirect resources to areas that would make the biggest impact on the wellbeing of communities, including protecting their health from new and emerging threats. Ring-fenced funding offers poor value for public money and is a risk to the financial sustainability of Scotland's national public health body. Ring-fenced funding:

- Cannot be used elsewhere, reducing the incentives to do things more efficiently.
- Drives bureaucracy as each funding stream requires administration, and their owners want to monitor progress and performance of the work they fund with limited regard for other workstreams which may be complimentary.
- Is less flexible, impeding our responsiveness to Scotland's changing needs.
- Is unsustainable because it forces the organisation to pay for permanent resources using temporary funding.

6.4. There will always be a place for ring-fenced funding, but making more of our funding baselined and recurring, will improve efficiency and sustainability. It would allow PHS to be more flexible, use less resource securing, negotiating and administering funding streams, and reduce financial risk.

6.5. Despite the ongoing work by the PHS senior team, and the commitments made by the Scottish Government to revisit the situation, the PHS board noted with disappointment in March 2023 the very modest progress made on converting the ring-fenced funding to recurring funding.

Staffing structures

6.6. My intention on taking up post as Chief Executive of PHS was to put in place a staffing structure in relatively short order that would enable the organisation to deliver on its strategic ambitions. This involved NHS Scotland organisational change processes, working in formal partnership in line with the guidance associated with NHS Scotland's Staff Governance Standard.[2] The timescales of this were hampered by the necessity to focus efforts and resources on the pandemic response, and I was not able to move at the pace at which I had planned. Through ongoing organisational change PHS is able to ensure that staffing structures and our approach to recruitment stands us in the best possible stead for future pandemics.

6.7. An example around recruitment approaches is my vision goal to move to more generic job descriptions to enable agility and the ability to focus staffing resources where they were most needed to make a difference. This is linked to the ring-fenced funding issue referred to earlier. PHS inherited many small teams focussed on very specific issues, with funding and job descriptions tied to that issue. This limits our ability to flex and deploy resources where they are most needed and creates the need to use temporary work assignments as we did at the height of the pandemic. For instance, we received funding from the Scottish Government for statistics on cancer. We had a small, dedicated team that focussed entirely on cancer statistics. In contrast, now

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[2] NHS Scotland webpage. Definition of the Staff Governance Standard — NHS Scotland Staff Governance. Accessed March 2023. (AL/3 - INQ000183551)

we are bringing teams together that we will focus on a range of different activities and a range of different statistics. This will give the organisation greater resilience going forward.

6.8. One of the key changes to the staffing structures is the enhancement of our existing Emergency Preparedness, Resilience and Response (EPRR) structure to ensure we could plan, prepare and respond effectively to future public health incidents and emergencies that arise. The extended EPRR team has a number of responsibilities within the following high-level areas:

- Planning and preparation for public health incidents and emergencies, including risk assessment, assurance and contingency planning, development and review of emergency response plans, provision of specialist training and exercising, lessons learned programmes and inter-agency collaboration.
- Delivery of situational awareness, including supporting development and delivery to provide a structure to enhance strategic and tactical situational awareness at a Scotland, UK and global level.
- Provision of necessary and proportionate response arrangements through the provision of specialist skills and knowledge, including task manager, incident coordination arrangements, factual narrative, incident timeline and specialist advice.

6.9. An important issue facing all organisations that deliver population health related services is the relatively small pool of people with the right skill set in certain key areas including Health Protection Consultants and Data Analysts. This made recruitment a challenge even after the Scottish Government had confirmed the funding was available. We were creative in the approaches we took to respond to this, including recruiting in partnership with local boards because, as the national public health agency, we did not want to be a talent drain on the local areas and add to their pressure. We brought people in under different contracts to provide the services that we needed and used different methods to reach people including specifically targeting university-leavers.

Surveillance and response

6.10. The final update to the Scottish Government's Strategic Framework was published on 22nd February 2022 (AL/4 - INQ000147836). The framework

update included a commitment to work with PHS, Local Government and other partners to develop a plan for responding to future outbreaks. PHS worked constructively with partners to develop a plan for monitoring and responding to new variants and mutations; a core component of managing COVID-19 effectively and responding to future outbreaks. The Variants and Mutations (VAM) Plan[3] sets out how PHS will collaborate to identify SARS-CoV-2 variants and mutations as part of routine, national and international surveillance activities. Published alongside the VAM plan, Scotland's national respiratory surveillance plan[4] describes the essential activities of a modern national respiratory surveillance function in Scotland. It explains how national and local teams will collaborate to deliver an effective and efficient service.

6.11. Lengthy conversations took place with the Scottish Government on the funding for these plans. Along with the downward adjustments being required by the Scottish Government as a consequence of their funding capacity, the main issue was the inability of the government to commit to more than one year of funding. The budget available to the Scottish Government is under extreme pressure, not least in health where the pressure on the NHS is greater than ever before. However, the short-term nature of the funding commitment had implications for the employment of staff and I sought a letter of comfort from the government to underwrite the risk to the Board of recruiting permanently on a single year's funding commitment. In addition to the employment-related issues, the programmes are associated with significant development costs.

6.12. On 14th July 2022 I received confirmation from Christine McLaughlin, Co-Director Population Health in the Scottish Government and one of PHS's Scottish Government sponsors, that the government would provide PHS with £7.4 million of additional funding in 2023/24 to enable PHS to ensure the appropriate surveillance is undertaken across Scotland to identify public health threats (including, but not limited to, SARS-CoV-2). It was also confirmed that PHS would receive funding of up to £245,000 for 2022-23 for

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[3] PHS. Plan for monitoring and responding to new SARS-CoV-2 variants and mutations (VAMs). September 2022. (AL/5 - INQ000101048)
[4] PHS. Scotland's National Respiratory Surveillance Plan. September 2022. (AL/6 - INQ000147829)

costs associated with the field response element of the Variants and Mutations plan.

6.13. The Scottish Government asked for progress and expenditure to be reviewed on a monthly basis and for efficiencies to be identified, along with opportunities for PHS to absorb some of this expenditure in year. We were advised that the government would work towards December 2022 to agree funding to support these services beyond 2022-23. At the time of writing, this has not yet been agreed.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

5th May 2023

Dated: _____