UK Covid-19 Inquiry

Module 1: resilience and preparedness

Association of Directors of Public Health

WRITTEN CLOSING SUBMISSIONS

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1. ADPH's submissions are set out below under the headings:

A Factual background

Directors of Public Health

2. ADPH is the representative organisation of Directors of Public Health (DsPH) across the UK. The core purpose of a DPH is to act as an independent advocate for the health of the population they serve and provide system leadership for its improvement and protection. They are responsible within their defined populations for the delivery of:

- Measurable health improvement
- Health Protection, including emergency response
- Public health input to health and care service planning and commissioning
- Reduction of health inequalities

3. The DPH purpose and role is the same whatever the structures within which they sit across the four nations of the UK, although there are some differences between those public health systems. In England, DsPH and their functions were transferred to Upper Tier Local Authorities (LAs) in 2013 by virtue of the Health and Social Care Act 2012 (HSCA). DsPH in England are jointly appointment by their LA and the Secretary of State for Health and Social Care. Every LA with public health responsibilities in England must employ a specialist DPH. They retain the primary responsibility for the health of their communities and are accountable for the delivery of their authority's statutory public health duties. The DPH is a statutory chief officer of their LA and the principal adviser on all health matters to elected members and officers.

4. In Scotland and Wales, DsPH are employed by NHS Health Boards. In Northern Ireland the sole DPH is accountable to the Chief Medical Office. DsPH are also present in Crown Dependencies (Guernsey, Jersey, Isle of Man) and Overseas Territories, functioning as both DPH and the CMO for their respective jurisdictions.

5. There are 136 DsPH in England (all of whom are members of ADPH), 14 in Scotland, 6 in Wales and 1 in Northern Ireland (numbers correct as of 24 July 2023).

DPH role in England

6. In his oral evidence Professor McManus described the role of the DPH as follows [15/34/22]

"…in England directors of public health are placed in upper tier local authorities, that's county councils and unitary authorities, and they have a set of responsibilities including assessing the health needs of the population, advising the NHS and the local authority on commissioning functions, they have a series of commissioning responsibilities for services like sexual health, drugs and alcohol, and a variety of other things. There's about 142 individual things that they do. They also have functions in terms of health protection planning and assurance, and they have a duty to be assured and to assure the Secretary of State that the health protection system is working. They also have a duty to improve and protect and promote the health of the population which they serve."

7. More specifically the functions of DsPH (which derive from statute, guidance and custom and practice) require them to:

- Act as an independent advocate for the health of the population and provide leadership for its improvement and protection;

- Provide advice and expertise to elected members (in England) and other senior officers on a range of public health issues, from outbreaks of disease and emergency preparedness to improving local people's health and access to health services;

- Provide the public with expert, objective advice on health matters and to comment publicly in a professional capacity on matters pertinent to the health of the local population;

- Take responsibility for the public health grant and produce an independent, public annual report on the health and health needs of the population;

- Working with LA and NHS colleagues, take steps to improve population health by understanding the factors that determine health and ill health, and how to change behaviour and promote both health and wellbeing;

- Advise NHS commissioners and assist them in their work;

- Provide appropriate challenge to health protection arrangements and advocate for an emphasis on reducing health inequalities and improving access in underserved groups in the work of commissioners, providers and other key stakeholders;

- Work through Local Resilience Fora (LRFs) to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to its health;

- Work with local criminal justice partners and Police and Crime Commissioners to promote safer communities by developing a "Public Health Approach" to crime and disorder;

- Work with wider civil society to engage local partners in fostering improved health and wellbeing;

- Advise on and contribute to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and commission appropriate services accordingly;

- Advise and assist with their LA's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board;

- Contribute to the professional training and development of the public health workforce;

- Contribute to a strong public health academic and research function, supporting evidence-based decision making and evaluation.

National Public Health agencies across the UK

8. Whilst the core DPH role has commonalties across the UK, there are some differences between the UK public health systems in which they operate. In each nation DsPH have a range of statutory and non-statutory responsibilities:

8.1 In England, as of October 2021, there are two national public health agencies: The Office for Health Improvement and Disparities (OHID) is a division of the Department of Health and Social Care (DHSC) and is responsible for improving public health and reducing health inequalities. The UK Health Security Agency (UKHSA) is an Executive Agency, sponsored by DHSC and is responsible for health protection. The majority of UKHSA's functions relate only to England, with functions such as radiation planning and preparation being UK wide. Prior to this, from 2013, Public Health England (PHE) oversaw the totality of these functions.

8.2. In Northern Ireland, the Public Health Agency (PHA) was established in 2009 following reform of health structures. It is responsible for health protection, screening and improvement. There is one DPH for the population of Northern Ireland employed by the PHA, accountable to the Chief Medical Officer for Northern Ireland.

8.3 In Scotland, Public Health Scotland was established in 2020 with the remit to protect and improve health and wellbeing and is accountable to the Scottish government and the Convention of Scottish LAs. NHS Health Boards employ DsPH and their teams.

8.4 In Wales, Public Health Wales was established in 2009 with the remit to protect and improve health and wellbeing and reduce health inequalities. NHS Health Boards employ DsPH and their teams.

HSCA 2012

9. In England the HSCA 2012 transferred public health functions from the NHS to local government, effective from April 2013. Although DsPH in England were (and remain) convinced that the transfer resulted in many more

advantages than disadvantages and that they are best placed in local government, there were initially major challenges arising from the transfer:

9.1 There were significant differences between the structure and culture of LAs and the NHS. Notwithstanding the transfer, DsPH retained obligations towards the NHS (e.g. the duty to advise and assist NHS commissioners). Initially there was a lack of understanding in LAs about what DsPH did. Similarly, DsPH had to learn the importance of the role of elected members in the delivery of effective public health.

9.2 The transfer caused data flow difficulties as DsPH were processing data from a different environment. Some DsPH relied on legacy contracts to access NHS data. Over time data sharing agreements became more sophisticated but significant difficulties remained when the pandemic struck. There is an urgent need to address better data sharing between NHS trusts and LAs (see below).

9.3 The transfer gave rise to uncertainty about pay structures and funding responsibilities (e.g. HIV testing was funded by DsPH through the public health grant and HIV treatment was the responsibility of the NHS; yet NHS clinicians delivering HIV services often worked in premises paid for by DsPH).

9.4 Professor McManus gave evidence that the guidance published in 2013 was *"perhaps somewhat hastily written"* [15/52/7] when it addressed the health protection system, but the functions of DsPH have crystallised since the transfer. The most recent iteration of the guidance was published in June 2023. ADPH remains concerned that some health protection responsibilities still need greater articulation, and that a review of health protection legislation is needed. That is the place to deal with public health responsibilities in a pandemic (see below).

Finance (England)

10. The work of DsPH (in England) is funded by the public health grant, which is provided to LAs by the DHSC. The grant is then used by LAs to discharge their public health duties, principally through DsPH.

11. The grant is ring-fenced and the main and primary purpose of all spend from the grant must be public health. There are several 'prescribed functions' which LAs are mandated to deliver from the grant, including the LA role in health protection.

12. The public health grant has decreased over the last decade. A series of cuts starting in the financial year 2015/16 reduced the grant by between 26% and 33% in real terms. The Health Foundation estimates that the grant is down £1 billion since 2015/16, with some of the most deprived areas experiencing the largest reductions.

B Understanding of the DPH role and relationships with other agencies

DsPH

13. The Inquiry has evidence that the role of the DPH was and is well understood by DsPH themselves. When ADPH surveyed its members, over 90% stated that the DPH role was defined or clearly defined before the Covid-19 pandemic, and this view was shared across England, Scotland, Northern Ireland and Wales. Many English DsPH referred to the HSCA 2012 and how this outlined their roles within their LA.

14. ADPH provides training and guidance to DsPH through regular publications and face to face events. Its programmes facilitate the sharing of learning and good practice, and it provides professional development and practice improvement support to its members.

Local government (England)

15. In England, where the DPH is a statutory chief officer of their authority, they share the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their LA and deliver real improvements in the public's health, the DPH needs both an overview of the authority's activity and the necessary degree of influence over it. This may or may not mean that the DPH is a standing member of their LA's most senior corporate management team. That is determined locally, not least because the scope of the DPH role can also vary locally – for instance, where it is agreed that a DPH's role will extend beyond its core statutory responsibilities.

16. However, it does mean that there should be direct accountability between the DPH and LA chief executive (or other head of paid service) for the exercise of the LA's public health responsibilities, and direct access to elected members. DsPH should also have full access to the papers and other information that they need to inform and support their activity, and day to day responsibility for their LA's public health budget - although formal accountability rests with the LA's accounting officer (usually the chief executive).

17. When surveyed, DsPH in England said that their role was well understood by

local government, although there was some regional variation.

LRFs and Local Health Resilience Partnerships (LHRPs) (England)

18. LRFs act as an interface between central, local and regional bodies primarily by being the conduit for information, acting as a structure to communicate both up and down between levels of government. The survey of members showed that for some DsPH LRFs were their primary mechanism to meet with partners such as DLUHC, NHS or the Environment Agency. For DsPH these meetings act as an important channel to escalate concerns at a local level to the regional and national level.

19. LRFs also provided national and regional partners to communicate down to the local level through LRF meeting reps and information cascades. The role of the LRF is also one of assurance to the national/regional bodies that plans are being communicated and coordinated at the local level.

20. Not all DsPH were members of an LRF and those that were did not routinely attend meetings. Rather DsPH were at the disposal of LRFs if the incident under consideration called for their expertise. It is important to distinguish between health protection and other resilience incidents. Response to incidents which are not health protection incidents may be led by the LRF and it may appoint a Strategic Co-ordinating Group (e.g. for a flood). The advice and guidance of the DPH will be important here, but they may not lead. Health protection incidents, however, such as disease outbreaks, will be led by the DPH and local environmental health, in partnership with UKHSA.

21. In such cases the DPH will be responsible for advising and providing guidance on emergency planning and response matters relating to health protection and other public health issues. The resources of the LRF may be called on when the incident requires multi-agency co-ordination, response or resource. There are overlaps between health protection and major incidents requiring LRF response, but there are also important distinctions.

22. Prior to the pandemic, DsPH noted that the frequency of LRF/BRF (BRFs being the London equivalent, occurring at a Borough level) meetings generally ranged from monthly, quarterly or twice per year. However, during

the pandemic, the volume of these LRF/BRF meetings increased, with DsPH reporting that the forum would meet on a daily, weekly or monthly basis. Specific to the pandemic, DsPH provided regular updates to the LRF on the key issues, such as sharing high-level activity data including case rates, comparison with other areas as well as initiatives to deal with the pandemic.

23. In relation to LHRPs, (LHRPs were established under the HSCA 2012 to ensure that 'nothing falls through the cracks' in the public health system; they bring together local health organisations, regional representatives of the PHE, and subsequently UKHSA, and other agencies agreed locally) DsPH do sit on these and are by law expected to act as co-chair. Professor McManus explained in evidence [15/46/24] that confusion was caused between LRFs and LHRPs because sometimes LHRPs span multiple areas (such as in London), so there may be a single LHRP covering the area of several DsPH, but other LHRPs are geographically coterminous with the LA area covered by the DPH.

National governments and UK Government

24. DsPH felt their role was well understood by local government but there was less understanding in national government in England, such as in the Home Office and Department for Education which may have been less familiar with pre-existing pandemic plans. In Scotland, pandemic preparedness guidance was in place which could be used to define the DPH role. Similarly in Wales, the DPH role was clearly described as part of the Communicable Disease Outbreak Control Plan for Wales. National government in England needs to be clearer on the role of the DPH.

25. There were key national differences in DsPH responses. Both Scottish and Welsh DsPH felt their role was less well understood by the national and local governments in both countries respectively, a key difference compared to DsPH in England. However, DsPH in Northern Ireland felt the role was clearly defined, as a result of the DsPH sitting directly within the PHA.

26. ADPH returns to the relationship between central government and DsPH when the pandemic struck under “DsPH and the pandemic response” below.

Chief Medical Officers (CMOs)

27. Every nation has a CMO. The CMO acts as the professional head of all DsPH in each of their nations.

28. Across the four nations, interactions between DsPH and the CMOs occur on an individual basis and engagement occurs within a range of meetings and fora on specific issues. Prior to the Covid-19 pandemic, the majority of DsPH spoke to the CMO infrequently (61%).

29. Throughout the pandemic ADPH organised regular calls with Professor Sir Chris Whitty for all DsPH in England. Discussions in Scotland, Wales and Northern Ireland were also regular. Discussions usually included an update on epidemiology and dialogue about different aspects of the response and implications for DsPH and local communities. DsPH found these discussions extremely valuable and the meetings in England were seen as a "step-change" in engagement with DsPH by the CMO.

30. In England these meetings began after 21 January 2020, outside of the scope of Module 1. There may have been communication between individual DsPH and the CMO before these regular calls, but ADPH did not have oversight of these of these interactions, therefore is not well placed to comment. ADPH is not aware of any plan or structure designed to facilitate contact between DsPH and the CMO (or DHSC more widely), and as mentioned in opening it transpired that DHSC did not have a complete list of contact details for the DsPH when the pandemic struck.

31. In Scotland, Wales and Northern Ireland there were, and remain, lines of communication to ensure the DPH voice and views can be conveyed to the relevant CMO to help inform national planning and policy in relation to Covid-19 and other public health matters.

UKHSA

32. In England there is regular and ongoing liaison between DsPH and UKHSA and regional directors at OHID have direct lines of communication with DsPH. DsPH engage with UKHSA and OHID at regional group meetings. There are

similar links between DsPH and the public health authorities in the devolved nations.

Care sector

33. Health emergencies also impact on the adult social care sector. DsPH work with LAs in their provision of social care in England, Scotland and Wales and with Health and Social Care Trusts in Northern Ireland. They also work with private care providers in all four nations. They provide guidance, training and advice on infection control in care homes, and they have a legal duty to provide such advice to NHS commissioners. During the pandemic a number of DsPH provided trauma training for care workers. It is important to note that DsPH were responsible for assisting the care sector with the PPE shortfall in the first wave and there are numerous examples of them leading on infection and outbreak control. This saved lives.

C DsPH and the pandemic response

34. The view of ADPH is that the public health system was in many respects ill-prepared for the pandemic when it struck. Significant mistakes were made, and the system could have responded much better. When asked whether the system was prepared for a pandemic of the scale and severity that in fact ensued, Professor McManus replied [15/59/17]:

"I have to say partly yes and partly no, and the reason for partly no was partly because of funding. I think the national plan was unclear. We seemed to prepare for flu when a coronavirus, I would have thought, would have been a perfectly plausible scenario. A range of scenarios nationally were not explained. Some of the communication from national government was lacking. Participation in national exercises was unclear. And I don't believe we learned the lessons from the 2009 pandemic. I think the lack of resourcing was unhelpful. I think there was also a view that government would create parallel systems rather than working with the capabilities we already had. If I might make one final issue, this was seen as an NHS challenge, which meant -- which in some ways put a burden on the NHS…to be in charge of something that was a public health challenge, not an NHS capacity challenge. So the roles about -- from the beginning, were about the NHS."

35. ADPH expands upon these (and other) themes in the following paragraphs.

Relationship with central government

36. DsPH are local experts. They have extensive knowledge of their communities and the wider health and social care system. They have a critical contribution to make in developing approaches that work on the ground and in ensuring they reflect the diversity of communities and the range of needs that exist. Yet in the module 1 period, there was an insufficient understanding of the DPH role, capabilities and responsibilities at a national level and DsPH were largely ignored and omitted from systems, processes and plans as they were developed.

37. At the start of the pandemic, DsPH were learning about new policies and guidance at the same time as members of the public, when the televised 5

pm daily briefings were broadcast. ADPH recognises that, in the early days of the pandemic, decisions and announcements needed to be made at pace. However, the lack of coordination and foresight presented real challenges for DsPH. DsPH were often put on the back foot locally, leaving them with little time to plan and prepare ahead of policy announcements or new guidance. Particularly at the start of the pandemic, announcements were made – e.g. at the daily briefing – and DsPH were left to interpret and explain them as the structures and protocols for implementing them were not always in place.

38. There was a significant disconnect between how policy was formed nationally and how it was implemented on the ground. The top-down approach of government meant that DsPH were side lined in terms of the national decision making and centrally run programmes. There was an assumption that decisions could be made at a national level that would be suitable for all local areas. Data sharing was also limited (see below) and left DsPH in the dark about the presence and spread of Covid-19 in their communities.

39. Asked in evidence why it mattered that DsPH were *"left out of the loop"* Professor McManus said [15/57/11]:

"*Firstly, because we are trained and expert in some of these, such as contact tracing. Secondly, we have a range of services, such as sexual health, which are equally expert in contact tracing. Third, we know our local areas and our local communities. So if I may give an example…putting a vaccine centre in a golf club in a deprived area a mile and a half from the deprived area with no public transport is something we could help areas avoid. I think the fourth reason I would give is that we have capabilities that we could mould and shape rapidly, such as test and trace, and it was pretty obvious when local directors of public health and LAs took on test and trace additional work, that the improvement in test and trace was marked nationally in multiple reports.*"

40. When surveyed the majority of DsPH felt that initially, there were very limited routes available to them to engage with the national approach and that, during those initial stages of the pandemic, it is widely felt that the local voice was neither wanted nor heard.

41. As the pandemic progressed, there was increasing recognition of the value of local leadership as a vital component of an effective response to Covid-19. DsPH were brought in to provide a local perspective and inform the design of the system. For example, DsPH worked at pace to develop Local Outbreak Plans, which built on existing plans to manage outbreaks in specific settings and addressed the impact of Covid-19 on local communities.

42. In the view of ADPH, the reason DsPH were ignored in the module 1 period was that several aspects of the government's strategic response to the pandemic were wrong. The pandemic was a public health emergency yet early on the strategy focussed on the NHS. The main goal become to 'save the NHS' rather than a wider public health approach. Intensive care and mortality numbers were seen as the main measures of success or failure, rather than infection rates.

43. The focus was on dealing with the consequences of a serious pandemic emergency rather than trying to prevent such an emergency from taking hold. This, in ADPH's view, reflects the historic lack of understanding of the importance of public health and the role of DsPH in creating healthy populations and places, and also the belief that a healthy population is created by the NHS: it is not - a healthy population is one that does not smoke; not one that has been cured of lung cancer.

44. Policy and decision-making took place at a national level by default. This delayed local leadership and action that would have been more effective (e.g. National Test and Trace, rather than drawing on local contact tracing skill and experience). The principle of subsidiarity, one of the principles of effective EPRR planning under the CCA 2004 - that decisions should be taken at the lowest appropriate level with coordination from the highest level - was ignored. Whether this was a political or administrative decision is irrelevant, it was a mistake that delayed effective pandemic response.

45. The focus was on preparation for an influenza pandemic and the nature of the challenges provided by Covid-19 were not anticipated. One consequence of this was that lockdown was not foreseen as a reasonable worst-case scenario, so plans did not anticipate the difficulties to which lockdowns gave rise. It is the view of ADPH that there was inadequate learning from the 2009

and 2012 pandemics, and that a pandemic such as Covid-19 was predictable in the module 1 period and should have been planned for.

46. When surveyed DsPH considered the fact that (i) national guidance relating to pandemic preparation did not anticipate the nature of the challenges provided by Covid-19 and (ii) full lockdown was never anticipated and planned for as a reasonable worst-case scenario, to be two of the top five factors which most negatively impacted their organisation's state of readiness for the pandemic.

Exercises and planning

47. The involvement of DsPH in planning and exercises in the module 1 period varied depending on whether they were done at a local or national level. DsPH carried out their emergency planning functioning at both local and regional levels through existing coordination mechanisms. They worked closely with HPB, LRF, BRF, the NHS, other DsPH in the region and local partner agencies and contributed to the development, review and testing of multi-agency emergency plans.

48. As part of their role in preparing for a pandemic outbreak, DsPH worked with LRFs to develop, approve, and review a pandemic influenza plan, in accordance with government planning and guidance. In the survey DsPH reported that these plans were useful in their response to Covid as Influenza is also a respiratory virus, however once the scale of the pandemic unfolded, the plans were never developed to cater for the challenges it presented.

49. Many DsPH reported involvement in several exercises organised by PHE, LRF/BRFs and LAs. However, some also stated that there were not involved in any nation-wide exercises. Of those who were involved, the two most mentioned were Exercise Cygnus (2016) and Exercise Winter Willow (2007).

Data

50. DsPH identified that data sharing was a key challenge in the early stages of the pandemic. Adequate arrangements for data sharing between the NHS and LAs did not exist. Systems to monitor the virus and share information between key parts of the health protection system were inadequate, and

delayed appropriate action at an appropriate level e.g. person-level data on infections per local area were not always shared with DsPH.

51. The ability of DsPH to establish effective data sharing protocols varied significantly, both across England and in the devolved nations. Different organisations had markedly different interpretations of their data protection obligations. Legislative data protection requirements were, rightly or wrongly, thought to be an obstacle to data sharing:

"…the Civil Contingencies Act has a power for information sharing, but there is a view among some agencies that that is overridden by data privacy and data security. We do not have information and data governance right for an emergency in any part of the United Kingdom in the way it needs to be to save lives." (Professor McManus [15/62/23])

Health inequalities and vulnerable groups

52. Professor McManus gave evidence that national guidance and planning for emergencies needed to have done more to address health inequalities. This was because reports show that people who have the least access to health services and are the least well, are the least able to withstand the multiple impacts of a pandemic on physical and mental health and its economic consequences. They may also be more vulnerable to exposure to infection by virtue of their employment and therefore most in need of protective measures. When the pandemic struck pre-existing levels of health inequalities exposed disadvantaged communities to higher levels of illness and death from Covid-19. Proper planning for the vulnerable would have mitigated the effects of the virus on (e.g.) the elderly in care homes during the first wave.

53. DsPH have an important role in reducing health inequalities across their local populations. They work with partners in local government, the NHS and others to promote investment in, and policies to address, the social determinants of health. They approach the issue on the basis that to have an impact on health inequality rather than overall health outcomes, policies and programmes should be aimed specifically at addressing determinants of health inequalities, rather than at determinants of health. Policies and interventions should be 'universal' but developed to be more intensive where

need is higher to be proportionate to that need (this is known as the 'proportionate universal' approach").

54. Most DsPH reported in the survey that their local emergency plans and risk assessment did take into account vulnerable groups, usually meaning those people with protected characteristics under the Equality Act 2010 (or devolved equivalent). Some stated that their emergency plans took account of some but not all vulnerable groups, or did not specifically align to the groups featured in the 2010 Act. Frequently, DsPH highlighted that race, ethnicity, religious beliefs, gender reassignment or sexual orientation were not factored into their emergency plans. It should be noted that there was variation on which groups were featured depending on the local area the DPH was working in, so some plans did take these factors into account. Many DsPH drew attention to the fact that these plans were frequently reviewed or, because of the Covid-19 pandemic, are now being re-reviewed.

Workforce and training

55. It is the view of ADPH that low capacity levels of individuals with appropriate skill sets and experience in the public health sector generally in the module 1 period had a significant negative impact on the ability of LAs to prepare for and respond to the pandemic. DsPH considered inadequate capacity in the public health workforce to be one of the top five factors which most negatively impacted their organisation's state of readiness for the pandemic.

56. The King's Fund report stated that there is a shortage of public health consultants with the necessary training, skill and experience. Some health protection training is included in the requirements to become a consultant in public health or a registered specialist, but training beyond this minimum is vital in these roles. Training should be both continuous and continuously assessed.

Funding, Austerity and Brexit

57. The policy of public sector austerity commenced in 2010 cut the budgets for public health. Emergency planning and proactive health planning, which

were not considered as urgent needs and were easy to cut owing to limited perceived public impact, were prime targets.

58. According to the Health Foundation, there has been a 26% real-terms per person cut in the value of the public health grant between the initial allocations for 2015/16 and 2022/23. Whilst DsPH have sought to make efficiency savings, the scale of these spending reductions has led to cuts in staffing levels and services. (It is worth noting that the Health Foundation found that the reduction in spending through the public health grant on the LA role in respect of health protection is only 7% between 2015/16 and 2023/24, despite the grant being cut by 26% overall. This demonstrates the efforts of DsPH to protect health protection spending as much as possible despite significant budget reductions that have led to cuts in stop smoking services, sexual health services and obesity services to name but a few).

59. In respect of LAs, the LGA estimates that between 2010 and 2020, LAs faced a reduction to core funding from the Government of nearly £16 billion. That means that councils will have lost 60p out of every £1 the Government had provided to spend on local services.

60. It is firmly the view of ADPH that these cuts to public health funding had a significant negative effect on the readiness and response of the public health sector to the Covid-19 pandemic and an impact on the harm that Covid caused. DsPH considered inadequate funding to be one of the top five factors which most negatively impacted their organisation's state of readiness for the pandemic. It also had an effect on resilience: a healthier population would have resisted the virus better. Public health generally is an investment that benefits the whole of society.

61. ADPH has no specific submissions to make on the impact of Brexit, save to note the evidence of both Sir Chris Wormold and Clara Swinson that recommended public health measures from Exercise Cygnus were not completed due to Yellowhammer. Preparation for a no deal Brexit was prioritised over health protection and in particular emergency preparedness: meetings were cancelled and programmes of work stopped that would or might have made a difference when the pandemic struck.

E Reform

Structural reform

62. Independent reviews by The Kings Fund and PHE have concluded that in England LAs are the right place for DsPH to be situated. DsPH agree and ADPH is firmly against any fundamental restructuring of the system in which DsPH operate. Such a move would cause significant disruption and costs without tangible benefits. The LGA also agrees.

63. Although English DsPH sit within LAs and those in the other devolved nations and territories within health agencies, these structures work effectively in the different jurisdictions. The core DPH purpose and role remains the same regardless of the structure in which they operate, and the view of ADPH is that energy would be best directed at ensuring that DsPH are equipped with sufficient resources and that their responsibilities and capabilities are understood by the wider system. The focus should be on ensuring effective preparedness plans for future pandemics across systems, not restructuring DPH roles or locations.

Better understanding of the DPH role

64. In October 2016 (subsequently updated in June 2021), ADPH published a document titled 'What is a Director of Public Health?' This document, along with the Director of Public Health statutory requirements, forms a solid foundation for understanding the role of DsPH and is readily available online (and was in the module 1 period). Any professional working adjacently or directly with DPH should ensure they are familiar with at least these two documents in order to understand the role.

65. As mentioned above, the role was and is relatively well understood at a local government level, largely as a result of people in local government working with DsPH on a more regular basis. Central government knowledge of the role of DsPH could be improved through greater exposure to DsPH/ADPH such as meetings with representatives from ADPH or through a more explicit reference to DsPH in national documents concerning population health.

Better use of DsPH in pandemic planning

66. The overall view of ADPH is that the UK was inadequately prepared for a pandemic of the nature of Covid-19. At a local level, DsPH – working with partners and colleagues in LAs, NHS, the voluntary sector and other emergency responders – had plans in place for an influenza pandemic and adapted arrangements to meet the challenges presented by Covid-19. But national policy and guidance quickly fell behind the rate of transmission, and systems to communicate, engage with and share information with DsPH were poorly developed. DsPH should have been consulted - and engaged in policy and implementation challenges - earlier and more comprehensively by national bodies with responsibility for health protection.

67. In future, national and local plans will need to be more flexible to respond to different types of viruses. In terms of the planning, the risk assessment process and the assumptions which underpinned the national response, there needs to be greater flexibility and imagination to respond to the ranges of scenarios which might eventuate. Greater local involvement is needed in formulating national policy. This means bringing in bodies such as ADPH, LGA and the Associations of Directors of both Adult and Children's Social Services to collaborate and inform national decision making. Good policy making involves talking to those who will implement the policy and involving them in formulating it. Giving stakeholders ownership of policy makes it much more likely to operate effectively. It also binds stakeholders into the policy by giving them part-ownership.

Clarifying and codifying the role of state agencies during a pandemic

68. ADPH's evidence is that a lack of clarity has been evident in the aims, roles and functions of different actors during the pandemic. The overarching objectives of the governmental response was not always clear. ADPH conclude that it is important to codify the functions of a state during a pandemic and to ensure that these are well understood by all actors and by citizens. This enables citizens and actors to understand what the aim of response to a pandemic is, and to understand their role. ADPH identifies nine core functions for a state during and after a pandemic which can be used to assess plans and outcomes:

68.1 Prepare (with a comprehensive but adaptable plan) and harness the collective efforts of systems and society to prevent, mitigate and shorten the impacts and harms whether social, health, economic, ecological or otherwise.

68.2 Be clear on what each part of the system must do. This should be a plan to protect the whole population, not just deal with the aftermath.

68.3 Be clear on the aims and maintain trust with citizens.

68.4 Protect the vulnerable.

68.5 Care for those infected and unwell, especially those with enduring ill-health.

68.6 Ensure the dead are laid to rest with dignity.

68.7 Support the bereaved.

68.8 Vision, live and lead the way to recovery.

68.9 Rebuild, recover, remember what we learned and ready ourselves for the next time.

Clarifying and strengthening the role and responsibilities of DsPH

69. ADPH believes the role and responsibilities of DsPH need to be clarified and strengthened as important key local agents in pandemic preparedness, response and recovery. ADPH sets out below some of the key steps it believes need to be taken towards achieving this:

69.1 LRFs: Review the structures, roles and responsibilities of LRF/LHRP to ensure that they are well-understood and that there is a cohesive approach to emergency planning across all sectors and government departments at the national level. DsPH should be ex officio members of LRFs to ensure that their voice is heard.

69.2 Exercise planning: Formalised involvement of DsPH in exercise planning. There should be structures for regular tests of preparedness to better equip the workforce to respond to pandemics, more training opportunities for relevant staff in health protection and pandemic preparedness and a widening of the scope of emergency planning to be more inclusive of different emergencies and diseases.

69.3 Test and trace and surge capacity: Build an understanding in central government about the capacity and capability at a local level and across the public sector to contribute to test and trace initiatives, and ensure plans build on existing systems and expertise.

69.4 Communication: Specific national strategies should be developed for public communications and engagement in a public health emergency, including: harnessing behavioral science, improving transparency and timeliness of communications from national government, utilising the voices of local leaders and the voluntary sector (particularly in the promotion of public health messages and vaccination uptake), maintaining the relationships formed during the Covid-19 pandemic with internal and external partners and through LRFs and others, and better harnessing of voluntary and community sectors in emergency planning through clearer understanding of expertise and sufficient resourcing.

69.5 Data flow: Develop arrangements to enable data and intelligence to flow more freely from national agencies to local public health teams, organisations and authorities, to enable them to carry out their duties.

69.6 A new public health act: Legislation to address (i) creating a new legal framework to compel every government department to assess policies and investment based upon its health impacts (ii) consolidating existing public health legislation ensuring it is consistent and fit for the modern age and (iii) learning the lessons from Covid-19 including clarifying roles and responsibilities and any necessary new powers to support DsPH and local public health to protect public health (e.g. by closing premises and to ensure they are fully engaged in pandemic planning and response).

69.7 Workforce and training: Measures to (i) ensure sufficient health protection capacity and resourcing at all levels, including both standing and reserve capacity, to improve the preparedness and resilience of their organisation's work with relevant partners in the future; (ii) regularise the structure for continuous, and continually assessed, training of Public Health consultants along with DsPH.

69.8 Health inequalities and vulnerable groups: National guidance and planning for emergencies needs to do more to address the health inequalities that exist between groups and address these in emergency preparation and response.

69.9 Reform of the National Risk Register: Strengthen awareness of risks across national and local government, following up mitigations and actions and ensuring resources are sufficient for necessary planning and preparedness.

69.10 Funding: Increase local public health funding across the UK to ensure DsPH can fulfil their responsibilities in planning for future pandemics, ensure sufficient standing capacity and expertise is available, and to enhance local action to reduce health inequalities so we are healthier, fitter and more equal as a society ahead of the next pandemic.

E Final words

70. Although the nature and scale of the next pandemic cannot be predicted, that there will be one is not in doubt. The Covid-19 Public Inquiry provides a unique opportunity to turn the page on how we strengthen our resilience and preparedness for the future. It is within our gift to create a healthier, fitter and more equal society; to promote the roles and responsibilities of every profession and sector; to build on the systems and structures that exist to make them fit for purpose; to foster a culture of collaboration and trust between agencies and the public; and to resource properly the people, processes and organisations that we will once again call on in our hour of need.

71. The response to the Covid-19 pandemic showed a lack of preparedness, a top-down approach, a lack of understanding of the role of DsPH especially and local agencies generally and the determination to seek quick-fix parallel systems from private providers when existing local infrastructure was not understood, not used or simply bypassed. These cannot be the hallmarks of the next pandemic. With this in mind, ADPH has created some clear acid tests, which indicate whether or not we have learned from the failures and the successes of Covid-19 response. They are set out below.

72 In the view of ADPH, we should be able to answer these 'acid tests' positively – if we cannot, we have not learned the right lessons and will not have kept faith with those who we have lost loved ones and those living with grief or lifelong health consequences. We can decide to do better, and we must.

Acid tests of whether we have learned from Covid-19

1. **Do we have a well-funded, effective infrastructure of readiness and response?**

(a) Do we agree on the need to fund and share the bio-surveillance arrangements nationally and internationally to detect the emergence and dynamics of pathogens which could cause major international epidemics or global ones (pandemics?)

(b) Do we have the continued scientific research and modelling to determine and agree methods of preventing and slowing pandemic pathogens?

2. Do we have honesty and clarity about readiness and gaps?

(a) Will we deliver and act on honest and transparent assessments of national and local capability for prevention, response and exercising?

3. **Do we have honesty and clarity about what we want to achieve?**

(a) Do we have an agreed compact between national government, local agencies and the public about what "good looks like" in managing the next pandemic? Is it "save the NHS" with the devastating consequences that had on social care and much more, or is it "save lives and livelihoods"?

(b) Are we ready to do what it takes to genuinely be prepared rather than make up policy on the hoof?

(c) Do we have an honest understanding of what science can and cannot tell us at any stage of a pandemic?

4. Do we have the right systems with the right culture and behaviours?

(a) Do we have a culture of mutual appreciation and dialogue where national agencies have the humility needed to recognise they must understand, harness and work with local capacity and capability rather than bypass it or assume they know better?

(b) Are we ready to be clear that public health response and emergency planning response overlap but have significant differences?

5. Do we have a culture of collaboration and dialogue?

(a) Will we honestly agree that top-down command and control was counterproductive and that it needs to change?

(b) Do we have the clear understanding that every part of the system needs the other parts, and we must work together nationally and locally?

6. How are we keeping faith with the public as our greatest asset in a pandemic?

(a) Do we recognise that maintaining public trust is fundamental in managing any pandemic, and in having solidarity with each other to deliver recovery?

(b) Do we have the determination to engage the public clearly and transparently about what must be done, why and when?

(c) Will we put in place the culture, skills and moral compass to harness the public as the greatest force in preventing and slowing any pandemic?

7. Will we fund the infrastructure to deliver better public health?

(a) Are we prepared to fund the necessary national and regional public health infrastructure?

8. Will we seriously protect those most vulnerable in a pandemic before, during and after it?

(a) Will we fund and take seriously public health action and policy to reduce inequalities in health and life expectancy?

(b) Will we go into any pandemic without those bearing the worst burden of health and deprivation being predisposed to death and disease?

(c) Will we be clear on who is most vulnerable and undertake to protect them as much as we can?

(d) Will we set out a plan for exiting and recovering from the next pandemic which has recovery and reducing inequalities at its core?