Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF THE ASSOCIATION OF THE DIRECTORS OF PUBLIC HEALTH

Annex A

Overview of ADPH

Origin and development of ADPH

1. As the membership body for Directors of Public Health (DsPH), ADPH is a collaborative organisation, working in partnership with others to strengthen the voice of public health and has a heritage which dates back over 160 years.

2. We also work closely with a range of Government departments, including the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID) as well as the four Chief Medical Officers (CMOs), NHS, devolved administrations, local authorities and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

3. We improve and protect the health of the population by:
    a. Representing the views of DsPH on public health policy
    b. Advising on public health policy and legislation at a local, regional, national and international level. In respect of the Covid-19 pandemic, ADPH collated and presented the views of DsPH to help inform the UK government's response across a range of programmes and guidance
    c. Providing a support network for DsPH to share ideas and good practice
    d. Identifying and providing professional development opportunities for DsPH

4. Every Director of Public Health within the British Isles and British Overseas Territories has the right to be a member of the Association. Deputy directors and consultants in public health can become Associate Members while former DsPH can sign up as Alumni. This means ADPH is a unique repository of information, knowledge and evidence about the role and contribution of DsPH.

5. ADPH is a Company Limited by Guarantee, registered in England and Wales (#08448934) and a Registered Charity (No.1164513).

6. We are funded by annual corporate subscriptions from our members' employing organisations. We also receive funding and seek sponsorship for specific projects. However, it is vital that we maintain our independence and do not allow external partnerships to bring the name of ADPH into disrepute.

7. To ensure that we maintain this independence, we have an ethical collaboration and sponsorship policy which has been devised to ensure clarity and openness to all our stakeholders. It is designed to address sponsorship and cause-related marketing and we welcome comments, criticism and suggestions as to how these goals can be met.

8. We work to a three-year strategic business plan, produce annual reports and are led by an elected Board, which includes the President and Vice President. Our policy is

guided by an elected Council which consists of honorary officers and member representatives.

Composition of ADPH

There are four membership types:

Full and Affiliate Members

9. All directors of public health (or equivalent) within the British Isles and British Overseas Territories automatically become an Ordinary Member of the Association on taking up their position. There are two categories of Ordinary Member:
10. Full membership, which is extended to DsPH whose organisation has subscribed, comes with full voting rights and members can stand for national elected positions.
11. Affiliate membership, which is extended to DsPH whose organisation has not subscribed, does not come with voting rights and members may not stand for, or hold, national elected positions.

12. All Full Members are encouraged to get involved in our policy work, have access to a wide range of support programmes, our annual conference and policy workshops and receive our weekly newsletter. They must comply with our Governance Framework.

Associate Members

13. Directors of Public Health (DsPH) are able to put forward exceptional Deputy DsPH and Consultants in Public Health to join as Associate Members. Associate Members, who have many of the same benefits as Full Members, with others at discounted prices are often on a trajectory to become a DPH in the future.

14. An unlimited number of Associate memberships are available to each subscribing organisation at no extra cost.

15. Associate members must agree to comply with our Governance Framework

Alumni Members

16. Former DsPH who would like to remain connected and further support our work are encouraged to become Alumni members.

17. Alumni membership offers the opportunity to:
    Reconnect with colleagues
    Become a mentor
    Stay informed on the latest ADPH activity and PH news
    Help shape public health policy

18. Alumni members are not able to vote or hold elected posts on our Council or Board.

Honorary Members

19. Honorary membership is awarded to individuals whose work or service has been particularly significant. Honorary members are not able to vote or hold elected posts on our Council or Board and are usually given complimentary membership for a term of five years.

20. We ask our Honorary members to:
    Continue to contribute their professional expertise and support our policy work
    Adhere to the high levels of ethical, professional and personal standards as defined by the Nolan principles
    Not seek or accept preferential rates or benefits in kind for private transactions carried out with any bodies or individuals with which they have had, or may have, official dealings with or on behalf of ADPH
    Register any material interest – personal, professional, financial or otherwise, which may have a bearing on their membership

21. Following the completion of an initial term of five years, the Board may renew Honorary membership for one further five-year term.

    Membership figures

22. It total, there are 384 ADPH members as of 13 January 2023. A breakdown of the number of members by membership type:
    Full Member (148)
    Associate (182)
    Affiliate (19)
    Alumni (30)
    Honorary (5)

23. A breakdown of the number of members in each UK nation is available below:
    England (350)
    Northern Ireland (1)
    Scotland (15)
    Wales (11)

24. Note there are 7 remaining members in Republic of Ireland.

Overview of the work carried out by ADPH

25. A list of the partners that ADPH works with is available on our website. Where possible, we work through a number of formal alliances to advance causes e.g. reducing health inequalities, to improve public health practice or in relation to specific issues on an ad hoc basis e.g. public health funding with organisations with whom we can find common cause. We also work in partnership with others on one-off projects.

26. ADPH policy is guided by an elected Council, made up of representatives from our nine regions, the devolved administrations and our associate members. A Faculty of Public Health observer also sits on the Council.

27. As well as leading our Policy Advisory Groups, which inform ADPH policy and shape our consultation responses, Council members work to ensure good two-way communication between their regional network and ADPH.

28. Our policy work is collaborative, based on our members' priorities (our understanding of these is shaped by formal surveys, discussions at ADPH Council and contact from individual DsPH or regions) and is always evidence led. During the Covid-19 pandemic, DsPH would ask ADPH to engage with the UK government on aspects of the response they felt could be improved e.g. access to vaccination or data sharing. We undertake both reactive and proactive activities including, but not limited to, development of policy position statements, consultation responses, representation at meetings and joint work as part of coalitions.

29. ADPH works in a way that is as constructive as possible and as challenging as necessary by providing a collective DPH view, achieved through consensus, building on key public health issues through meetings, consultation responses, engagement with Ministers and other politicians, collaborating with partners and media activity in line with our charitable objectives.

30. We are committed to supporting the professional development of our members which we do through using our strong network of specialists and national public health organisations who can share knowledge, problem-solve and build on the expertise of one another.

31. Each year, we offer a range of virtual and face-to-face events and programmes to strengthen links between DsPH and improve practice including:
    ADPH Annual Conference
    ADPH DPH Workshop
    ADPH Associate Workshop
    ADPH New DsPH Workshop
    ADPH/LGA Conference
    A range of masterclasses and webinars

32. In addition, we offer:
    Mentoring
    Peer support
    Exchange visits
    Thematic support networks
    DPH Annual report celebration

33. Practice improvement is the approach to improvement in local authorities, which we work in partnership with the LGA to promote. It aims to provide assurance to both internal and external stakeholders and the public, as well as demonstrate continuous improvement to Public Health Practice.

34. Practice improvement is based on the underlying principles that councils are:

Responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people
Accountable to local communities through elections
Collectively responsible for the performance of the sector as a whole

35. By bringing thematic and regional networks together, we are able to facilitate the sharing of learning and good practice and support the development and implementation of national SLI tools.

36. Every year, we run an Annual Report Celebration and in 2022, held our inaugural ADPH Awards to recognise and share good practice among our members.

37. National leadership and governance is provided through the ADPH Sector-Led Improvement (SLI) Programme Board, which:
provides quality assurance, challenge and feedback
celebrates and disseminates successes
ensures stakeholders understand the role and importance of SLI

38. ADPH also hosts three national networks for local authority commissioners:
The English Healthy Weight Commissioners' Group
The English HIV and Sexual Health Commissioners' Group
The English Substance Use Commissioners' Group

39. Through sharing and identifying good practice, we have supported the development of a range of toolkits to support the public health workforce, including:
    a. A suite of publications, called What Good Looks Like setting out the guiding principles of what good quality looks like for population health programmes in local systems
    b. The Toolkit for Implementing Quality in Public Health: A Shared Responsibility to map individual quality improvement resources to the overall Quality in Public Health document and facilitate local use

40. We also would like to note the publication of other documents to support DsPH during significant public health events in particular, namely Guidance for DsPH in a Major Incident and a Major Incidents Checklist for Directors of Public Health.

ADPH's interactions with national government, local government and governments of the devolved nations in the context of the Covid-19 pandemic

41. There is no record of an ADPH representative attending any meetings with the UK Government specifically to discuss Covid-19 prior to 21st January 2020. Likewise, there is no record of an ADPH representative writing correspondence to the UK Government specifically on Covid-19 prior to 21st January 2020. Individual DsPH may have interacted with the UK government and had discussions on a regional basis, but ADPH would not have knowledge of this.

42. There is no record of an ADPH representative attending any meetings with other local government civil contingency actors to discuss Covid-19 specifically prior to 21st January.

43. ADPH does not represent local resilience forums. Perhaps not surprisingly given they are a collective of different statutory agencies and other partners, there is no representative body for LRFs. ADPH does not routinely engage with LRFs collectively, although individual DsPH do so locally, within the scope of their role.

44. ADPH engaged with partners in relation to the production of relevant materials in the years before the pandemic. Most notably, Public Health England. ADPH and PHE co-produced a series of 'What Good Looks Like' (WGLL) publications that set out the guiding principles of 'what good quality looks like' for population health programmes in local systems. This includes 'What Good Looks Like for High Quality Local Health Protection Systems.'

45. There is no record of an ADPH representative attending any meetings with the devolved nations specifically to discuss Covid-19 prior to 21st January 2020.

46. ADPH would have welcomed, and been responsive to, engagement from the UK government at an earlier stage in the pandemic as that is where knowledge and responsibility sat. The need for discussion and consultation with relevant bodies, sectors and professions early and regularly is a key lesson from the pandemic.

Overview of Directors of Public Health

Background to Directors of Public Health (DsPH)

Brief overview of the origin of DsPH and their historical role and functions

47. The core purpose of the DPH is as independent advocate for the health of the population and system leadership for its improvement and protection. As such it should be a high-level statutory role bridging local authorities, the NHS and other appropriate sectors and agencies with responsibilities for health and well-being for a defined population.

48. It is important to note that the DPH purpose and core role is the same whatever the structures within which they sit across the UK. This has not only been true historically (since William Duncan's appointment as the first Medical Officer of Health in Liverpool in 1847) but is currently relevant across the UK. A DPH should be an individual trained, accredited, and registered in specialist public health.

49. A Director of Public Health will be responsible within their defined population 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 heath inequalities

Statutory functions and responsibilities of DsPH

In England

50. Several of the DPH's specific responsibilities and duties arise directly from Acts of Parliament, mainly the NHS Act 2006, the Health and Social Care Act 2012, and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered. This section summarises and explains the main legal provisions in effect from April 2013.
51. In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population: the DPH has a duty to write a report, whereas the authority's duty is to publish it (under section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report may be decided locally.

52. Section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for:
    a. all of their local authority's duties to take steps to improve the health of the people in its area;

b. any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations. These include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act;
c. exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to the public's health;
d. their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders; and
e. such other public health functions as the Secretary of State specifies in regulations, including services prescribed under Section 6C of the 2006 Act and under dental public health powers under in 111 of the 2006 Act, as amended by the 2012 Act.

53. As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:
    a. through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department has confirmed that DsPH are responsible for their local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);
    b. if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended); and
    c. DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

Professional qualifications and skill sets of DsPH

All DsPH should:

54. be an independent advocate for the health of the population and provide leadership for its improvement and protection.
55. be the person who elected members and senior officers look to for expertise and advice on a range of public health issues, from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services;
56. improve population health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that also reduce inequalities in health;
57. provide the public with expert, objective advice on health matters;
58. be able to promote action across the life course, working together with local authority colleagues such as the director of children's services and the director of adult social services, and with NHS colleagues;
59. contribute to and influence the work of NHS commissioners, helping to lead a whole system approach to public health across the public sector. For screening and

immunisation programmes (e.g. Covid-19 vaccination), DsPH are expected to provide appropriate challenge to arrangements and also to advocate for an emphasis on reducing health inequalities and improving access in underserved groups in the work of commissioners, providers and other key stakeholders.

60. work through Local Resilience Fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to its health;
61. work with local criminal justice partners and Police and Crime Commissioners (PCCs) to promote safer communities. There are a range of natural areas for collaboration between DsPH and PCCs. These areas include but are not limited to the commissioning of drugs and alcohol services, mental health, adverse childhood experiences, illicit tobacco, and developing a "Public Health Approach" to crime and disorder. Directors of Public Health are well placed not only to work with police and crime commissioners on addressing the crime and offending aspects of drugs and alcohol, but to address wider determinants (public environment through licensing) and other health issues (blood borne virus treatment).
62. work with wider civil society to engage local partners in fostering improved health and wellbeing.

63. Within their local authority (if in England), and working with statutory partners, DsPH also need to be able to:
    a. be a leading member of the health and wellbeing board, advising on and contributing to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and commission appropriate services accordingly;
    b. contribute to and influence the work of NHS commissioners, helping to lead a whole system approach to the public's health across the public sector.
    c. take responsibility for the oversight of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money;
    d. play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board;

The DPH appointment process (as it was between January 2009 and January 2020)

In England

64. The Secretary of State for Health has two general duties that are particularly relevant to the joint appointment process: to promote the comprehensive health service (section 1 of the NHS Act 2006, as amended by section 1 of the 2012 Act); and to promote local autonomy so far as that is compatible with the interests of the comprehensive health service (section 1D of the 2006 Act, inserted by section 5 of the 2012 Act).

65. Local authorities undertaking public health duties conferred on them by the 2012 Act are part of the comprehensive health service. This means that the Secretary of State may not normally intervene in decisions about matters such as the role or position within local authorities of DsPH, but must intervene - and ultimately may refuse to agree a joint appointment - if the Secretary of State has reason to believe that an authority's proposals

for the appointment of a DPH would be detrimental to the interests of the local health service.

66. Local authorities recruiting a DPH should:
design a job description that includes specialist public health leadership and an appropriate span of responsibility for improving and protecting health, advising on health services and ensuring that the impact on health is considered in the development and implementation of all policies;
make every effort to agree the job description with the FPH and the PHE regional director (now OHID), ensuring in particular that it covers all the necessary areas of professional and technical competence; and
manage the recruitment and selection process and set up an advisory appointments committee to make recommendations on the appointment to the leader of the local authority.

67. The advisory appointments committee should be chaired by a lay member, such as an elected member of the local authority (the cabinet member of the health and wellbeing board, for example). It should also normally include:
    a. an external professional assessor, appointed after consultation with the FPH;
    b. the chief executive or other head of paid service of the appointing local authority (or their nominated deputy);
    c. senior local NHS representation;
    d. the PHE regional director, or another senior professionally qualified member of PHE acting on his or her behalf; and
    e. in the case of appointments to posts which have teaching or research commitments, a professional member nominated after consultation with the relevant university.

68. The relationship of the Secretary of State and the local authority in the joint appointment process is one of equals. The role of the Secretary of State is to provide additional assurance of the DPH's competency. This means that PHE, acting on behalf of the Secretary of State, should be involved in all stages of the process. PHE will advise the Secretary of State on whether:
    a. the recruitment and selection processes were robust; and
    b. the local authority's preferred candidate has the necessary technical, professional and strategic leadership skills and experience to perform the role - proven by their specialist competence, qualifications and professional registration.

69. In order to provide this assurance for the Secretary of State, PHE will:
    a. agree with the local authority and the FPH a job description that fits with the responsibilities of the DPH and sets out the necessary technical and professional skills required;
    b. offer advice in relation to the recruitment and selection process, including the appointment of FPH assessors;
    c. participate in the local advisory appointment committee;
    d. confirm to the local authority the Secretary of State's agreement to the appointment;

e. ensure the interests of the Secretary of State are taken into account in circumstances where the designated DsPH responsibilities are carried out by an officer with other broad responsibilities

70. PHE regional directors (now OHID) will work with local authorities in any area where there is a DPH vacancy to ensure a robust and transparent appointment process is established and a timescale for recruitment and appointment agreed. This should be completed within three months of a post becoming vacant.

71. If the regional director has concerns about the process or their involvement in it, they will seek to resolve these concerns through negotiation with the local authority. They will be able to draw upon advice and dispute resolution support if it is required. It is important that the interaction between the regional director and the local authority is based on dialogue, collaboration and agreement.

72. The local authority has the primary role in recruiting people who will be under contract to it. However, there are clear joint considerations in processes for appointing a DPH. If, at the end of this procedure, the Secretary of State is not satisfied that an appropriate recruitment process has taken place and that the local authority preferred candidate has the necessary skills for the role, s/he will write to the lead member and chief executive of the council setting out in full the reasons for not agreeing the appointment and proposing steps to resolve the situation.

73. Under section 73A of the 2006 Act, inserted by section 30 of the 2012 Act:
    a. The Secretary of State can direct a local authority to review the DPH's performance, to consider taking particular steps, and to report back if the local authority believes that a DPH is not properly carrying out any Secretary of State function that has been delegated to the local authority. This power does not extend to the DPH's performance of the local authority's own health
    b. improvement duties; and
    c. a local authority must consult the Secretary of State before dismissing its DPH. The authority may still suspend its DPH from duty (following its standard rules and procedures) and the Secretary of State cannot veto its final decision on dismissal. An authority proposing dismissal for any reason should contact PHE for advice on how to proceed with the consultation. PHE will normally provide the Secretary of State's formal response within a maximum of 28 days.

DsPH accountability

Corporate accountability

74. In England, the DPH is a chief officer of their local authority and shares the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their authority 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.

75. This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be 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.

76. However, it does mean that there should be direct accountability between the DPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members.

77. 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 authority's public health budget - although formal accountability will rest with the authority's accounting officer (usually the chief executive).

Professional accountability

78. Medical and dental public health consultants are registered with - and regulated by - the General Medical Council (GMC) or the General Dental Council (GDC). They, and other public health consultants, can also register with the voluntary UK Public Health Register (UKPHR), accredited by the Professional Standards Agency. An applicant for a DPH post will not be considered as suitable unless s/he has the appropriate registration with the GMC, the GDC or the UKPHR.

79. To assure themselves of the continuing competence of their DPH, employers should ensure that s/he:
    a. undertakes a continuing professional development (CPD) programme that meets the requirements of the Faculty of Public Health (FPH) or other equivalent professional body;
    b. maintains a programme of personal professional development to ensure competence in professional delivery. This programme should include all training and development needs identified by both management and professional appraisal processes; and
    c. undertakes appropriate annual professional appraisal in order to ensure revalidation and fitness to practise.

Revalidation

80. Revalidation is the process by which all registered specialists in public health, including DsPH, are required to demonstrate to the relevant specialist register that their skills are up to date and that they are fit to practise in order to retain their license to practise. The requirements for revalidation for the GMC and UKPHR vary but are broadly equivalent. The GMC and UKPHR publishes guidance on the revalidation process.

81. GMC registrants require a designated body and responsible officer for the purposes of revalidation. Following organisational reforms to the public health system in

England in 2021, UKHSA, OHID/ DHSC and NHSE are the designated bodies for registrants they employ directly.

82. It is expected that OHID/ DHSC will become the designated body for local government employed registrants.

83. The UKPHR directly revalidates its registrants (i.e., no designated body is needed). GDC registrants, not otherwise registered with UKPHR, must meet strengthened CPD requirements to maintain GDC registration.

The role of responsible officers

84. Responsible officers help to evaluate doctors' fitness and monitor their conduct and performance in the context of fitness to practise. The role of the responsible officer is to support doctors in maintaining and improving the quality of service they deliver, and to protect patients and citizens in those cases where doctors fall below the high standards set for them. Responsible officers are licensed doctors themselves, and as such must have their own responsible officer.

85. The Responsible Officer Regulations came into force on 1 January 2011 and apply to medically qualified DsPH. The regulations designate those bodies that are required to nominate or appoint a responsible officer for the purposes of medical revalidation – this includes local authorities that employ medically qualified staff.

86. The responsible officer:
makes recommendations to the GMC about the fitness to practise of doctors;
assures the quality of professional appraisers;
ensures that recommendations are informed by clinical governance information provided by the employing organisation, and other key stakeholders, where appropriate; and
provides support and advice to employers and appraisers where performance concerns have been identified, in liaison with GMC, GDC and UKPHR when appropriate.

Professional appraisal and continuing professional development

87. An employer should reassure themselves that all public health professionals are in a position to participate in professional appraisal and that those with suitable experience and training are enabled to appraise others in the public health system.

88. CPD is an essential feature of the revalidation process for public health consultants and specialists. The overall aim of CPD is to ensure that those who work in the field develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving and protecting the health of the population. Employers should consider how to support their DPH to meet these aims.

89. CPD is a professional obligation for all public health professionals and protected time for CPD is a contractual entitlement for directors in local government on medical and dental contracts. In order to comply with the FPH minimum standards for CPD all

Faculty members must either submit a satisfactory CPD return annually or have been formally exempted by the FPH from this requirement.

90. The UKPHR expects all its registrants to participate in CPD, preferably as part of a formal scheme operated by a professional body.

91. Personal development plans should include recommendations made as a result of both management and professional appraisal. This ensures that CPD activities are suitably aligned to the needs of the employing body, and the professional development requirements of the individual.

The relationship of DsPH to the Chief Medical Officer (CMO)

92. In England, there a several bodies that are part of the public health system following the reforms in 2013. DsPH sit within Local Authorities and are overseen by the Department for Levelling Up, Housing and Communities and Local Government.

93. The Chief Medical Officer is employed by the Department of Health and Social Care and is the professional head of all of directors of public health in local government.

How the DsPH role differs across the devolved nations

94. 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.

95. **In England,** as of October 2021, there are two national public health agencies: the Office for Health Improvement and Disparities (OHID) and the UK Health Security Agency (UKHSA). OHID is responsible for improving public health and reducing health inequalities, whilst UKHSA is responsible for health protection. Prior to this, from 2013, Public Health England oversaw the totality of these functions. In England, Directors of Public Health and their functions were transferred to Upper Tier Local Authorities in 2013 by virtue of the Health and Social Care Act 2012. DsPH in England are jointly appointment by their local authority and the Secretary of State for Health and Social Care.
96. **In Northern Ireland,** the Public Health Agency 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 NI.
97. **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 Local Authorities. NHS Health Boards employ DsPH and their teams.
98. **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.
99. Directors of Public Health are also present in the administrations of Crown Dependencies and Overseas Territories where they also act as Chief Medical Officer.

How the DPH role 'as an independent advocate for the health of the population and system leadership for its improvement and protection' translates in practice

100. How this translates in practice is best illustrated by on the work conducted throughout the Covid-19 pandemic. DsPH played a crucial systems leadership role – of which there have been five main tasks:

Preparation

101. DsPH are trained for outbreaks and teams have tried and tested processes in place to both monitor the local situation (surveillance) and provide place-based leadership. DsPH provided local guidance and information for local authorities, elected politicians and the wider community e.g. the NHS, social care sector, education settings, businesses and faith groups. ADPH produced guidance on local outbreak management with partners and on local outbreak management plans.

Prevention

102. DsPH worked with the local media and community groups to promote clear messages and advice. This included developing resources and campaigns on issues like public mental health. Many DsPH, working within their system, took a proactive approach to sourcing personal protective equipment (PPE) and hand sanitiser, in partnership with universities and manufacturers.

Prioritisation

103. DsPH ensured services were adapted so resources could be redeployed to the Covid-19 response e.g. sexual health and drug treatment services enhanced their online offer. Focus on other services increased e.g. as evidence grew that smokers are more at high risk of severe Covid-19 symptoms stop smoking support expanded in many areas.

Collaboration

104. DsPH worked closely with other key parts of the local response e.g. social care colleagues on PPE and external partners e.g. national and regional public health colleagues in relation to monitoring and responding to outbreaks. They often acted as a local system leader, for example ensuring appropriate testing and tracing and other support was available for arrivals in the UK.

Advice

105. DsPH become the 'go-to' source of knowledge and information for numerous agencies on planning and providing local analysis on Covid-19; supporting local public services and businesses.

106. Below are illustrative examples of the role of DsPH in respect of two critical components of the response to Covid-19: test and trace and vaccination.

Understanding the DPH Role: Test and Trace

107. During the early phase of the NHS Test and Trace Service, performance was hampered by centralisation – a more human, local approach that worked with people and communities delivered higher levels of engagement and compliance. Data demonstrated that local Test and Trace systems helped increase the uptake of test and trace.

108. Locally supported contact tracing of more straightforward cases, that a national call centre operation could not reach, was an initiative DsPH and their teams were well placed to undertake. With adequate resourcing, local public health teams were effective in locating and engaging with many of these cases. Local teams were also able to provide a 'wrap-around' service, directing people to local self-isolation payment systems and other support, such as food bank provision and voluntary sector support. The local voice, knowledge and links to reach and support people from diverse and disadvantaged backgrounds added huge value. Accessing a test, engaging with the contact tracing process and self-isolation should be made as straightforward as possible during a pandemic.

109. Lessons should focus on understanding the end-to-end journey of a person requiring a test and trace type intervention, the various behavioural responses and how barriers can be removed to make the process simple. DsPH and their teams proved effective in developing local models that delivered accessible and effective testing and tracing models suitable for the local population. At the time of writing the National Audit Office has produced an interim report on national Test and Trace which highlights the importance of information transfer to local authorities.

Understanding the DPH Role: Vaccination

110. Successful mass campaigns are partnerships between communities and health systems and rely on trust and access to all communities. DsPH and their teams – if resourced properly – can significantly enhance local delivery and build on strong partnership in localities working closely with acute, primary care and community services. DsPH understand the factors that promote effective interventions at scale including using local leaders to build trust, engaging with communities, and aligning national data with local systems. Highly effective emergency planning and health protection functions have delivered locally-led approaches rooted in local public health, third sector and community support systems linked to the full range of partners such as education, faith and business.

111. DsPH were at the core of the Covid-19 response and, given their extensive experience of vaccination programmes, were well placed to provide system leadership. Given the scale of the Covid-19 mass vaccination programme, there were inevitably challenges eg access and equity. The consequences of these challenges were felt locally. Strong alignment of national work and communications with local community engagement and interventions as the programme developed was critical to maximising uptake eg tailored communications to diverse groups and the identification of appropriate venues for all. Oversight and engagement from DsPH is a vital lesson for future vaccination efforts and pandemics.

112. On 11th January 2021, ADPH published Explainer: Covid-19 Vaccination which provides more details about the challenges of the programme at that point, the DPH role and what improvement could be made.

The key roles and functions of DsPH leading up to the start of the pandemic

Understanding and responding to the health risks in their designated areas

113. DsPH are important members of 'local resilience forums', which are aligned to the boundaries of 42 police areas across England and Wales (Cabinet Office 2013) in the context of the Civil Contingencies Act 2004. Note that multiple DsPH will be members of each LRF, with the exact number depending on the footprint of the LRF. These forums are partnerships of representatives from several statutory services, including NHS, local authority and emergency services (for a full list, see Cabinet Office undated). Local resilience forums plan and prepare for a range of civil emergency situations, including flooding, terrorism and infectious disease outbreaks. For example, since 2012 they have held a specific influenza pandemic plan as an influenza pandemic was identified in the past decade as a particularly high risk to the United Kingdom (Cabinet Office 2013). Local resilience forums have the function of leading the local public service response to civil emergencies, which includes the police (indeed the police often lead the forums), and of leading more focused 'local health resilience partnerships' with NHS England and NHS Improvement, Public Health England (and following transition, expected to be the UK Health Security Agency in the future) and ambulance services.

114. When an incident occurs, the local resilience forum's 'strategic co-ordinating group' is activated to provide strategic leadership and co-ordinate the response across local agencies. It acts as a 'gold command', with a hierarchy of silver (tactical) and bronze (operational) groups and issue-specific subgroups (focused on aspects such as intelligence, communications and scientific and technical advice). Smith et al (2017) set out the relationships between these agencies. In particular, as they say, local health resilience partnerships were established to ensure that 'nothing falls through the cracks' in the new system. NHS England and DsPH were made co-chairs of these partnerships in 2013.

Emergency preparedness, resilience and response (EPRR)

115. For many DsPH, late January or February 2020 marked the starting point of the most intense period of their careers to date. From that point, many DsPH were asked to give briefings to their colleagues in local authorities, to partners in the local VCS and to local media. Emergency planning structures (such as area strategic co-ordinating groups) were 'stood up' across England. Directors' involvement in emergency structures both within and beyond their local area varied within our sample, in that some had formally established links to strategic co-ordinating groups and others had not. Either way, DsPH found themselves in high demand to represent public health on key decision-making committees, in some instances as the chair.

116. The Covid-19 pandemic meant that public health teams had to move quickly to distribute personal protective equipment (PPE) to local health and care services, charities and other public services. In several places, this was expedited by local authorities or local resilience forums establishing central 'hubs' from which to request PPE and with the support of other council services or the military to deliver it. Local public health teams also relayed the national guidance for the appropriate use of PPE in different settings and from July 2020 this extended to encouraging the use of face coverings too (Hancock 2020a). Public health teams have also been responsible for drafting local guidance for and giving advice about Covid-19 safety measures, such as social distancing, hand hygiene and managing outbreaks in workplaces, schools, universities and so on.

117. As well as directly supporting local communities, local public health teams have played a key role in co-ordinating or mobilising the efforts of other local authority departments or VCS organisations. From the early stages of the pandemic, public health teams have been involved in commissioning and/or setting up interventions to support local people. For example, most DsPH in our sample noted the likely economic impact on local people of becoming unemployed and this could therefore lead to (or exacerbate) food insecurity. Many teams have been involved in mapping need and increasing the capacity to meet demand through foodbanks or co-ordinating the delivery of food parcels and the collection and delivery of medical prescriptions alongside partners in the VCS and volunteers.

Reducing health inequalities across their local population

118. DsPH have an important role in reducing health inequalities locally. They undertake this task in two respects. They work with partners, such as colleagues in local government and the NHS, to promote investment in, and policies to address, the social determinants of health. They also ensure the public health services they commission adopt a 'proportionate universalism' approach. This means that action should be universal, but 'with a scale and intensity that is proportionate to the level of disadvantage'. 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. Universal action to improve health can widen health inequality due to the decreased likelihood of vulnerable groups engaging with services.

Surveillance of population and interpretation of needs

119. Public health teams have been involved in offering a wide range of support to local communities, specifically to schools, care homes and workplaces but also to different local groups. In terms of schools, public health teams have been involved in providing reassurance and responding to the concerns of school staff and parents, or delegating support for schools to a local authority director of education. DsPH have highlighted the impact on children of school closures as an equality issue in terms of access to laptops for home schooling and the reliance among many families on free meals at school. Also, as part of their statutory responsibilities, public health teams

have been supporting care homes with access to PPE and advice on safety for staff, residents and visitors.

120. At various points over the course of the pandemic, some DsPH (along with directors of adult social care services) have had to make difficult decisions about stopping and restarting care home visiting, balancing the risks of Covid-19 infections among residents against their need to have personal contact with visitors for their sense of wellbeing. Public health teams have also provided specific support to different community groups over the course of the pandemic, for example local Chinese communities and travellers.

Deciding and advising where local public health resources should be delivered

121. DsPH have a key role in protecting the health and wellbeing of local populations and have varying degrees of influence in their local system. In some areas, DsPH strategically support the effectiveness of spending the whole local authority budget for health, while in others, there is a more specific focus on the DsPH managing the public health grant. In others, they have been influential in changing the way that the local authority thinks about its role in improving health and delivering care through maximising assets in communities.

Bridging local authorities, the NHS and other sectors and agencies with responsibilities for health and well-being for their defined population

122. Prior to the upheaval in business as usual that Covid-19 brought with it, the DsPH in England were in different positions within their local authorities' organisational structures. For some, their role and statutory responsibilities were placed alongside those of senior colleagues in the executive management teams and they had a seat on central management teams. In other areas, DsPH were less able to influence decision-making and resource allocation at the highest level. During the pandemic many DsPH reported having a higher profile and more influence due to their expertise and it is hoped that a greater understanding of their role will be a lasting legacy.

How DsPH understand and assess local health risks

Joint Strategic Needs Assessments ("JSNAs");

123. DsPH in England are leading members of the health and wellbeing board, advising on and contributing to the development of Joint Strategic Needs Assessments.

Joint Health and Wellbeing strategies ("JHWS");

124. DsPH in England are leading members of the health and wellbeing board, advising on and contributing to the development of Joint Health and Wellbeing Strategies. In addition, they contribute to the creation and oversight of Integrated Care Strategies and related action plan for Integrated Care Systems.

The role of DsPH in ensuring that local authorities and local partners support preventative services

Developing plans and capacity to monitor and control outbreaks of infectious disease

125. DsPH are trained in containing infectious diseases, both understanding and interpreting data, recognising risk factors, understanding the evidence base and what motivates behaviour change, and helping develop policy interventions. Contact tracing is also a tried and tested public health intervention.

126. DsPH had a clear role to play in ensuring an effective, early response to Covid-19 across the UK, and their knowledge and skills could have been drawn upon by national government at an earlier stage. They:

a. Produced local guidance and information to advise public services, elected politicians and the wider community
b. Adapted local services to ensure they were fit for the context eg sexual health and drug treatment services enhanced their online offer
c. Acted as the 'go-to' source of knowledge in relation to planning and provided local analysis for public and private bodies
d. Developed Local Outbreak Plans – working with colleagues in local government, the NHS and other local and national bodies - to deliver a coordinated place-based approach

Developing local initiatives to raise awareness of risks of infectious diseases

127. DsPH and their teams 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 solutions are tailored to the diversity of communities and the range of needs that exist (from language to inequalities). DsPH have played a key role in stitching together the different elements of the pandemic response - whether it be on PPE, volunteering, or testing - to ensure that the system is joined up.

128. DsPH demonstrated their role in developing local initiatives to raise awareness of risks of diseases with Covid-19 by:
Producing local guidance and information to advise public services, elected politicians and the wider community
Working closely with local media and community groups to promote clear public health messages and advice

129. These activities were undertaken based on the role and responsibilities of DsPH; informed by relevant national policy and guidance and in consultation with local and regional partners.

DsPH as influential system leaders

130. As an influential system leader, a high performing DPH requires the following qualities:

high energy and passion to motivate others and use their energy;
vision, bravery to ‘dare to dream’ and work towards long term aspirations;
resilience, doggedness and the ability to persist where there may be difficulties;
celebrates success but has the humility to give away credit to enable strong partnerships;
the ability to ‘think on one’s feet’, to improvise to get the best out of any situation;
technically competent across all domains of public health practice
system leader with highly tuned and effective communication skills
willingness and pragmatism to move on from traditional roles in order to achieve more
Prepared to show initiative and take the lead

Other factors that influence the effectiveness of DsPH in their role

131. A DPH cannot work in isolation: they require adequately-resourced and professional Public Health teams providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base. At the start of the pandemic there was no mechanism by which information on new cases could be shared with DsPH in real time, which prevented a complete local picture being developed, delayed local action, hampered support for individuals and communication with the community. They also require political support at both national and local level to enable them to discharge their duties effectively.

Public Health Services

132. The purpose of the requests in this section is for the Inquiry to understand the structure of public health bodies at the local government level, their development during the proposed date range and their readiness and preparation in practice, as at 21 January 2020. As outlined in the Provisional Outline of Scope, the Inquiry is interested in public health capacity, resources, levels of funding, any impact from the UK's departure from the European Union, and the way in which relevant bodies monitored and communicated about emerging disease.

Structure of Public Health Services

Overview of the structure of the public health system in England and the changes brought about by the Health and Social Care Act 2012

Transfer of public health functions from the NHS to local government

133. The Health and Social Care Act 2012 transferred most public health functions to local government from the NHS across England. The move to local government was a major change to public health policy and its delivery. As not all functions were transferred from the NHS to local government, this resulted in smaller budgets and, therefore, smaller teams. Being described by the LGA as "one of the most significant extensions of local government powers and duties in decades". In practice, this meant the comprehensive movement of public health responsibilities and funding for a variety of services from the NHS to councils in April 2013.

134. The move received support from a wide range of organisations and individuals working across health and wellbeing, as well as cross party support. The main reason for supporting the transfer from the NHS to local government was that local government are best placed to embed and extend public health in local communities as they have the knowledge of the community and its needs and already maintain existing community projects.

135. One of the biggest challenges during the first 12 months of moving into local authorities was the shared attitude that movement of public health could and should result in an evolution of the services for the 21st century. DsPH, councils and the NHS recognised that the structural move represented an opportunity for serious change.

Transfer of DsPHs from primary care trusts in the NHS to local authorities

136. Every local authority with public health responsibilities must employ a specialist Director of Public Health (DPH) as a Chief Officer, jointly appointed with the Secretary of State of the DHSC, to support a local government-led approach to better public health.

137. DsPH felt strongly that to reflect their senior, cross-council role, they should report directly to the chief executive and the lead member for health and wellbeing

and should be part of senior management teams (see our member surveys for views).

138. In the first LGA reports following the transfer, DsPH described the benefits of their move to local government, a trend that has continued in the ten years following. Public health was closer to local communities and DsPH valued the democratic system in which councillors represented citizens' views.

139. Challenges in the transfer included cultural and organisational differences between the NHS and local government, such as decision making protocol. An initial difficulty experienced by many DsPH was a lack of understanding of what public health meant and what it could do, coupled with a high bar of what it was capable to achieve. Accessibility to data flows (chiefly those from Central Government) was an issue and this was a problem that persisted during the pandemic.

140. As outlined previously, DsPH came to local government with a clear goal of integrated health and wellbeing across the organisations, encouraging everyone to consider the importance of the public's health and inequalities. The desire with the transition was to create a public health council which could strategically leverage the connections within local authorities for the benefit of public health and the local population.

141. Once DsPH became embedded in their local authority the main challenge was the national cuts to the public health grant, which limited existing activity, exacerbated by the inaccessibility of data flows, and curtailed new initiatives, such as pump-priming pilot studies or partnership initiatives. These stringent cuts, against the background of wider local government budget constraints, have had a significant impact on what public health can achieve. However, people who were directors in both NHS and local government point out that the NHS public health budget was the first to be "raided" by local NHS leaders to meet funding deficits in acute services. While budgets were even tighter in local government, there was some opportunity to discuss how resources could be allocated, and savings made, on a cross-council basis, but this varied.

Transfer of a ring-fenced budget to commission public health services transferred to local government

142. The public health grant is paid to local authorities from DHSC. It is used to provide preventative services that help to support health such smoking cessation, drug and alcohol services, children's health services and sexual health services, as well as broader public health support across local authorities and the NHS.

143. While DHSC spend on NHS England has increased in real terms since public health was transferred from the NHS to local authorities in England in 2013, there has been a 20% real-terms per person cut in the value of the grant between the initial allocations for 2015/16 and 2019/2020.

144. The public health grant allocation was announced on March 17 for the 2019/20 financial year, beginning April 1. On top of the large real-terms reductions in the grant, the lack of certainty this creates can make it difficult for local authorities to effectively plan and implement services for the longer term.

145. In addition to the public health grant being reduced at a national level, cuts to the grant have been greater in more deprived areas. Research conducted by the Health Foundation shows that per person reductions in the public health grant tend to be largest in more deprived areas. This means that DsPH and local authorities who work with the most vulnerable populations face the biggest challenges in public health improvement and improving quality of life.

Public Health England (PHE)

146. The Health and Social Care Act 2012 and its reorganisation of the NHS in England meant the creation of Public Health England (PHE) in April 2013. PHE was an executive agency of the Department of Health and Social Care, with the main remit to protect and improve health and wellbeing and reduce health inequalities. DsPH welcomed the consolidation of public health in one body, and regional teams. Crucially, when considering its structure, PHE was a distinct delivery organisation with operational autonomy. Duncan Selbie was the chief executive of PHE from when it was set up in April 2013 until 2020.

147. PHE was accountable to the Secretary of State for Health and took over public health activity from DHSC and from the regional strategic health authorities. The Secretary of State set the total budget for public health, and determined how it was allocated between PHE and local authorities. PHE also took over all activities of the Health Protection Agency, the National Treatment Agency for Substance Misuse, the Public Health Observatories, the cancer registries, the National Cancer Intelligence Network, and the UK National Screening Committee together with its screening programmes.

148. PHE had the following public-facing divisions:
Health protection (immunisation, major incident response, field epidemiology etc)
Health improvement (screening programmes, reducing health inequalities etc)
Knowledge and Information (disease registration, research and development)
Operations (Microbiology, regional units etc)

Why DsPH in England were moved into local government

149. Local government is considered the best place for public health for a variety of reasons, including that councils are well placed to address the economic, social and environmental factors (often referred to as the social determinants of health) which shape up to 90% of our overall health and wellbeing.

150. The NHS has a vital role in healthcare, but councils are public health organisations that can utilise all their functions, community relationships and

extensive partnerships to promote health. This means in practice that prevention and public health an integrated into wider public services and that the interconnectedness local governments have can be leveraged by DsPH for the needs of the local population.

151. Having public health as part of local government means that public health and councils influence each other, learn from each other and grow together.

152. Over the ten years since the move from the NHS into local government, health has become an important part of council functions, like planning and leisure, and has extended to wider partnerships such as those responsible for work, training, economic development and the environment. Councils and partners are delivering an extensive and comprehensive range of health and wellbeing measures to meet local priorities.

The extent to which DsPH in England have responsibility for carrying out statutory duties relating to public health

On behalf of local authorities

153. The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a frontline leadership role spanning all three domains of public health - health improvement, health protection and healthcare public health. They have a vital leadership role for system-wide efforts to secure better public health.

154. Within their local authority, and working with statutory partners, DsPH need to be able to:

a. be a leading member of the health and wellbeing board, advising on and contributing to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and commission appropriate services accordingly
b. contribute to and influence the work of NHS commissioners, helping to lead a whole system approach to the public's health across the public sector
c. take responsibility for the oversight of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money
d. play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board

On behalf of the Secretary of State

155. A number of the DPH's specific responsibilities and duties arise directly from Acts of Parliament, mainly the NHS Act 2006, the Health and Social Care Act 2012, and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered.

156. In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population: the DPH has a duty to write a report, whereas the authority's duty is to publish it (under section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report may be decided locally.

157. 3.3 Section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for:

a. all of their local authority's duties to take steps to improve the health of the people in its area
b. any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations. These include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act
c. exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to the public's health
d. their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders; and
e. such other public health functions as the Secretary of State specifies in regulations, including services prescribed under Section 6C of the 2006 Act and under dental public health powers under in 111 of the 2006 Act, as amended by the 2012 Act

158. As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:

a. through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department has confirmed that DsPH are responsible for their local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);
b. if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended); and
c. DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

DsPH in England and their management of their local authority's public health services

159. The fundamental aspects of the DPH role, are as an influential system leader with oversight and expertise across all determinants of health within local authorities, the NHS and other sectors and agencies, working across organisational boundaries, in a complex system with a wide range of stakeholders, to influence and facilitate

systemwide change and to secure the improving health of their population.

160. The DPH is a chief officer of their local authority and shares the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their authority 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.

161. This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be 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.

162. However, it does mean that there should be direct accountability between the DPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members.

163. 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 authority's public health budget - although formal accountability will rest with the authority's accounting officer (usually the chief executive).

Overview of the organisation and governance of public health services in the devolved nations of Scotland, Northern Ireland and Wales

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

165. 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 Local Authorities. NHS Health Boards employ DsPH and their teams.

166. In Wales, Public Health Wales was established in 2009 with the remit to protect and improve health and wellbeing and reduce health inequalities. Public Health Wales also has responsibility for Health Protection in Wales. As of 2022, NHS Health Boards employ DsPH and their teams, before this time they were employed by Public Health Wales.

167. Directors of Public Health are also present in the administrations of Crown Dependencies and Overseas Territories where they have dual responsibilities as DPH and CMO.

How the DPH role is affected by structural constraints

168. The DPH role has key features and responsibilities to undertake whatever structure a postholder falls within. It is the responsibility of a DPH to work within the context in which they find themselves, regardless of financial, structural or capacity constraints, and the role of ADPH to provide support in assisting them to do so through various support programmes and policy advocacy. The DPH role in England is especially affected by lack of access to NHS (including primary care) data and lack of ability to deploy health professionals locally.

The shared elements of the role of DsPH across the UK

169. Regardless of where DsPH sit (within local authorities or within the NHS) there are common aspects of the role which they are expected to carry out.

170. A Director of Public Health should be an individual trained, accredited, and registered in specialist public health.

171. A Director of Public Health will be responsible within their defined population 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 heath inequalities

172. They are likely to have further responsibilities as senior leaders within their organisation including management of services and corporate roles. The following principal functions describe the ways a DPH will deliver the required outcomes:

a. **Advocacy** – for the health and well-being of the population both within and outwith their organisation
b. **Leadership** – pulling the agenda together, maintaining an overview across the three public health domains and working with other system leaders across the place
c. **Population perspective** – putting the ‘denominator’ on the table and ensuring the needs of the population are considered alongside those of individuals
d. **Translation and interpretation** – translating different approaches (from differing organisational/sectoral cultures and backgrounds) and interpreting views to produce ‘actionable insight’ – a distillation that enables decisions to be taken
e. **Real understanding of their population** – advising and taking decisions based on deep knowledge of the local population and their health and well-being needs
f. **Expertise** – provided through the high-level education and training in public health competencies and the wide-ranging experience gained as Consultant or Specialist in Public Health

g. **Programme Director** – managing services impacting on health and well-being (as required locally) using evidence base to provide efficient and effective services

173. The DPH role does not depend on structural form although its effectiveness may be compromised by some structural constraints. Given the appropriate resource and authority (see requirements below) a DPH would be accountable to the following with related responsibilities:

Accountability	Responsibilities
Their population	**Independent advocacy** – visible leadership; media work; communication with and objective advice to the public; DPH Annual Report **Advice** – influencing leaders and programmes within NHS, local government, third sector, business and commerce and integrating action **Leadership across agencies** – leading health partnerships and facilitating collaboration across organisations and sectors
Secretary of State / CMO	**Health Protection** – including surveillance; programme quality assurance; emergency response **Improvement of health and well-being** **Oversight of service planning and commissioning** **Reduction of health inequalities across their population** **Working with partners and civil society to foster improved health and well-being**
Their employing organisation(s)	**Executive/Corporate/Strategic Director** – Board level responsibilities; high-level performance and influence over the whole budget and agenda; innovation and challenge **Principal adviser to the Health Partnerships (e.g. Health and Wellbeing Boards, Public Service Boards)** – surveillance of population and interpretation of needs **Service Director** – leadership of public health and other services (locally agreed), financial accountability and co-design of evidence-based solutions
PH system	**Capacity building** – ensuring population perspective and public health skills are

widely understood across professionals and the wider workforce **Public health development** – clinical audit, professional innovation and input to national initiatives **Developing public health workforce** – taking responsibility for their own professional development and creating a learning environment to support specialist and practitioner education, training and development and contributing to the wider development of the public health workforce

174. Directors of Public Health are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning.

175. A Director of Public Health must be empowered to have oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other sectors and agencies in order to secure the improving health of their population.

176. A Director of Public Health will need clearly defined responsibilities and powers which can be summarised as follows:

a. The professional status and enablement to express an independent view in order to provide advocacy for the health of the population.
b. A requirement to produce an independent, public annual report on the health and health needs of the population; and authority to comment publicly in a professional capacity on matters pertinent to the health of the local population.
c. The authority to influence all the levers that impact on health and well-being and to act as a statutory and principal advisor (across the three public health domains).
d. The authority to decide where to use resource to deliver health gains and reduce inequalities.
e. Executive/Corporate/Strategic Director status – the ability to act at corporate/strategic level (as a full executive member of the corporate leadership team and reporting or accountable to a CEO or equivalent), with direct access to decision makers (such as local authority Cabinet and councillors; Health Board Independent Members etc); have credibility to engage externally; influence across all organisational functions and tiers; to work alongside other Directors; develop and promote corporate policy; and contribute to whole organisational decisions.
f. Information and intelligence – a strong public health information and intelligence system supporting the DPH in providing relevant and timely intelligence and evidence reviews to enable prioritisation of resource and understanding of population health.

g. Contribution to the professional training of the public health workforce.
h. Contribution to a strong public health academic and research function – supporting evidence based decision making and evaluation.

177. A Director of Public Health cannot work in isolation: they require adequately-resourced and professional Public Health teams providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.

Public health capacity, resources and funding

An overview across the UK of public health capacity, resources, and funding that was specifically allocated to the pandemic preparedness of local public health services –

178. It is for the UK government and devolved administrations to determine the public health capacity, resources and funding available for pandemic preparedness.

179. In England, DsPH are responsible for overseeing spending through the public health grant (allocated by the Department of Health and Social Care). The grant determination requires local authorities to fund certain prescribed functions and services. It also outlines other non-prescribed areas of spending which are not mandatory, this includes infectious disease surveillance and control. Significant cuts to public health funding have reduced the ability of local public health services to plan and prepare for pandemics.

180. Budgets had to be transferred from existing local services to cover pandemic responsibilities not nationally funded.

The role of DsPH in the allocation of local public health resources and funding

181. DsPH across the UK oversee public health budgets relating to their functions and services they oversee. For example in England, DsPH are responsible for the public health grant. DsPH across the UK engage with colleagues and partners across local government, the NHS and other bodies over the use of resources across various budgets to improve public health and reduce health inequalities for their populations.

The reduction in the public health budget and local authority funding

182. According to the Health Foundation, there has been a 24% 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 have led to cuts in staffing levels and services.

183. In respect of local authorities, the LGA estimates that by 2020, local authorities will have faced a reduction to core funding from the Government of nearly

£16 billion over the preceding decade. That means that councils will have lost 60p out of every £1 the Government had provided to spend on local services.

The impact that funding cuts across the UK, in relation to local pandemic preparedness functions

184. The overall extent of cuts to public health funding across the UK has inevitably impacted upon the capacity available in local public health teams to plan and prepare for pandemics. In particular the budget for health protection locally was tiny to non-existent which led to a lack of specific expertise which was needed during the pandemic.

Inter-organisational Cooperation

The relationship between DsPH and the Chief Medical Officer (CMO)

185. The CMO for England is based at the Department of Health and Social Care (DHSC) and acts as the professional head of all DsPH.

186. Across the four nations, interactions between DsPH and the CMOs occur on an individual basis and engagement occurs within a range of meetings and forums on specific issues.

187. Throughout the pandemic (from 31st Jan 2020 onwards), ADPH organised regular calls with Sir Professor Chris Whitty for all DsPH. 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 incredibly valuable and more detail on their interactions with the CMO can be found in Annex 2.

188. In Scotland, Wales and Northern Ireland there were, and are, 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.

189. DsPH are also present in the administrations of Crown Dependencies and Overseas Territories where they have dual responsibilities as DPH and CMO.

Key partners DsPH work with

190. DsPH work with the partners identified at local, regional and national levels. In addition, the following types of organisations were important links for DsPH across the UK in the proposed date range:
Businesses and their representative local forums e.g. British Chamber of Commerce
Early years, education and university settings
Public transport providers
Health service user organisations e.g Healthwatch

191. ADPH aimed to work with national bodies and organisations across a range of public health issues during the proposed date range. Key partners are listed on our website (please refer to appendix 13).

192. The nature of the relationships DsPH have with the partners outlined varies to some extent depending on which nation they work in.

193. **England**: Public Health England (PHE) was established in 2013, its responsibilities were then transferred to the UKHSA and OHID following its abolition in August 2020. It is responsible for protecting and improving the health and wellbeing of the population and reducing health inequalities. Local authorities employ

DsPH, the majority singly, though some do share. There are 134 DsPH across 152 local authorities in England.

194. **Northern Ireland:** The Northern Ireland Public Health Agency 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, accountable to the Chief Medical Officer.

195. **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 Local Authorities. Each Health Board employs a DPH.

196. **Wales**: Public Health Wales was established in 2009 with the remit to protect and improve health and wellbeing and reduce health inequalities. Each Health Board employs a DPH.

197. The role of ADPH is to work with partners, as outlined, at a national level, to fulfil our charitable objectives. This work could be categorised in two ways:

a. **Quality improvement**: Public Health has a quality improvement function built in to its professional validation and performance criteria. In England, it includes Sector-led improvement (SLI) which is an approach to improvement ADPH put in place together with local authorities and the Local Government Association (LGA) after the abolition of the national performance framework. It aims to provide assurance to both internal and external stakeholders and the public, as well as demonstrate continuous improvement to public health improvement. More information is available on our website.

b. **Policy**: Our policy work is collaborative, based on our members' priorities and is always evidence led. We undertake both reactive and proactive activities including, but not limited to, development of policy position statements, consultation responses, representation at meetings with government department and national agencies, and joint work as part of coalitions. We have a range of policy and system focused advisory groups, made up of members with a particular subject interest, who advise on latest evidence and good practice to inform our policy positions.

Emergency Prevention, Preparedness and Response (EPRR) functions of DsPH

198. The Civil Contingencies Act 2004 sets out the legal framework for preparing for, and responding to, civil emergencies. This is defined as an event or situation which threatens serious damage to human welfare or the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.

199. In England, DsPH should be the person who elected members and senior officers look to for expertise and advice on a range of public health issues, from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services. Section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to the public's health.

200. In the early stages of the Covid-19 pandemic, DsPH across the UK were the go-to, trusted local officer for colleagues in local government, the NHS and other public services – as well as businesses, community groups, the media and others – to offer advice on the virus and its implications. They were often referred to as the local CMO.

201. DsPH are sometimes members of 'local resilience forums' (LRFs), which are aligned to the boundaries of 42 police areas across England and Wales. However DsPH do not routinely sit on LRFs (see Annex 2 for further information). These forums are partnerships of representatives from several statutory services, including NHS, local authority and emergency services. Local resilience forums plan and prepare for a range of civil emergency situations, including flooding, terrorism and infectious disease outbreaks. Since 2012, they have held a specific influenza pandemic plan as an influenza pandemic has been recognised as a significant national risk. Local resilience forums have the function of leading the local public service response to civil emergencies, which includes the police.

202. Local Health Resilience Partnerships (LHRPs), bring together local health organisations, regional representatives of the PHE, and subsequently UK Health Security Agency (UKHSA), and others agreed locally. LHRPs were established as part of the Health and Social Care Act 2012 to ensure that 'nothing falls through the cracks' in the public health system. DsPH are occasionally co-chairs of these partnerships (see Annex 2 for further information). They are responsible for identifying risks and developing plans relating to health and emergency preparedness, resilience and response and linking in to the LRF and wider emergency response.

203. The Secretary of State for Health and Social Care is ultimately accountable for emergency response, supported by the CMO and the DHSC, supported by the UK public health agencies which provide public health emergency preparedness, resilience and response (EPRR) leadership and scientific and technical advice at all levels, co-ordinating their activities closely with the NHS and DPH.

204. ADPH, alongside key partners, published *Public Health Leadership, Multi-Agency Capability: Guiding Principles for Effective Management of Covid-19 at a Local Level* in June 2020. This document intended to outline principles for the design of Covid-19 Local Outbreak Plans led by the DPH at Upper Tier Local Authority level, working with all key professions and sectors, with outline responsibilities for each defined.

205. The Covid-19 Local Outbreak Plans are intended to: build on existing plans to manage outbreaks in specific settings, ensure the challenges of Covid-19 are understood, consider the impact on local communities and ensure the wider system capacity supports DsPH. Local authorities and partners will utilise local governance and partnership arrangements to ensure Local Outbreak Plans are developed and delivered to meet local needs.

206. The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits:

a. With PHE under the Health and Social Care Act 2012
b. With DsPH under the Health and Social Care Act 2012
c. With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
d. With NHS Clinical Commissioning Groups to collaborate with DsPH and PHE to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
e. With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004
f. In the context of Covid-19 there is also the Coronavirus Act 2020.

207. This underpinning context gives local authorities (public health and environmental health) and PHE the primary responsibility for the delivery and management of public health actions to be taken in relation to outbreaks of communicable disease through local Health Protection Partnerships (sometimes these are called Local Health Resilience Partnerships) and local memoranda of understanding. These arrangements are clarified in the 2013 guidance Health Protection in Local Government.

208. PHE is mandated to fulfil the Secretary of State's duty to protect the public's health from infectious diseases, working with the NHS, local government and other partners. This includes providing surveillance; specialist services, such as diagnostic and reference microbiology; investigation and management of outbreaks of infectious diseases; ensuring effective emergency preparedness, resilience and response for health emergencies.

209. At a local level PHE's regional health protection teams and field services work in partnership with DsPH, playing strategic and operational leadership roles both in the development and implementation of outbreak control plans and in the identification and management of outbreaks. The DPH has and retains primary responsibility for the health of their communities. This includes being assured that the arrangements to protect the health of the communities that they serve are robust and are implemented. The primary foundation of developing and deploying local outbreak management plans is the public health expertise of the local DPH.

ADPH's Perspective on Preparedness for Covid-19

The state of readiness for the Covid-19 pandemic

Local authorities and local public health services

210. The Covid-19 virus was a novel coronavirus identified towards the end of 2019 in China, so a specific pandemic plan for this virus had not been developed before January 2020 in the UK's local authorities.

211. The UK national risk register had identified an influenza pandemic as the highest risk in the UK. Most health professionals will be familiar with a pandemic of this nature in the UK as a result of the H1N1 pandemic, which had a significant impact on the UK across 2009.

212. Local authorities had plans in place in the event of an influenza pandemic, which could be adapted during the start of the Covid-19 pandemic. Local authorities had prepared a variety of elements, including planning, which key organisations they would need to work with, MOUs and training exercises.

213. As outlined elsewhere, due to the extent of cuts to the Public Health Grant, services and teams were less resilient and responsive that they would otherwise have been.

214. Public health services were adapted to meet the challenging circumstances and the need for prioritisation as the pandemic developed. In response to the Covid-19 public health emergency and its impact on maintaining 'business as usual' across health and social care; NHS England and Local Government were tasked with undertaking a rapid review of community health services with a view to detailing the elements of each that can be 'stopped', 'partially stopped', or should 'continue'.

215. In relation to essential sexual & reproductive healthcare, the British Association for Sexual Health and HIV (BASHH); The Faculty of Sexual & Reproductive Healthcare (FSRH); and the British HIV Association (BHIVA) published a paper on 26 March 2020 titled Sexual Health, Reproductive Health and HIV Services: Emergency Covid-19 Contingency Plan Paper for Government.

216. It was the position of the ADPH that the recommendations, outlined in the documents below, summarise the urgent steps that needed to be taken to maintain, to our best ability under the unique circumstances, the wider public's sexual & reproductive health. The protection of essential sexual reproductive health (SRH) services, and the changes in delivery necessary due to Covid-19, stand too as recommendations for essential provision aligned to Primary Care settings, both General Practice and Community Pharmacy.

ADPH UK Recommendations for Essential SRH Services during Covid-19

ADPH UK Essential SRH Services in Specialist Care Settings

217. The Local Government Association (LGA) and the Association of Directors of Public Health (ADPH) jointly produced a briefing for Directors of Public Health (DsPH) about the public mental health and wellbeing issues arising from the COVID-19 outbreak.

Issues with the state of readiness for a Covid-19 pandemic

218. There are three important factors affecting the state of readiness for Covid-19 as at 21 January 2020 – how the public health system is structured, and the role and understanding of DsPH and their teams; the funding context for public health and local government going into the pandemic; and the overall health of the population.

Communication

219. DsPH had a clear role to play and worked relentlessly to ensure that the local response was as effective as possible across the UK. In the early stages of the pandemic, DsPH produced local guidance and information for other council departments, elected members and the wider community, as well as adapted local services to ensure resources were focused on the task at hand e.g. enhancing the online offer of sexual health and drug treatment services. DsPH were the 'go-to' source of knowledge and information for numerous agencies when it came to planning and providing local analysis and worked closely with the local media and community groups to promote clear public health messages and advice. In May/June 2020, DsPH developed Covid-19 Local Outbreak Plans (many based on existing more generic outbreak plans) – working with colleagues in local government, the NHS, Public Health England (PHE) and other partners - to deliver a coordinated place-based approach.

220. Despite leading so much of this work locally, DsPH were repeatedly not included in key communications or guidance developed by NHS England (NHSE) and Government departments.

221. We recognise 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 – for example 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.

222. For example, guidance on Personal Protective Equipment (PPE) was often unclear and not backed by sufficient supplies, particularly in care settings. Government guidance (which came into effect on March 23 2020) encouraged care homes to accept discharged patients if they were asymptomatic, without any testing or sufficient access to PPE in place. This severely impacted the situation in care homes. Later, there was greater involvement by DsPH in overseeing testing and outbreak management in care homes. This was hugely valuable – however, engagement should have come earlier. The best decision making can only happen if the right people are in the room – that must include those working on the ground in local government.

Disconnect between national and local government

223. Whilst some aspects of the Government's response to Covid-19 have been commendable, the centralised nature of some elements has, in some cases, significantly impeded effective collaboration and communication with local authorities. DsPH, and local government as a whole, were not engaged and involved early enough in national plans for Covid-19 generally and contact tracing specifically. This improved considerably as the pandemic continued.

224. There was a significant disconnect between how policy was formed nationally and how it was implemented on the ground. The top-down approach by government meant that DsPH – particularly in the early months of the pandemic – were side lined in terms of the national decision making and centrally run programmes (eg PPE and the testing regime). There was an assumption decisions could be made at a national level that would be suitable for all local areas and that proved costly.

225. With testing for example, ambitious targets were set without a clearly communicated rationale for the testing programme overall. The focus should have been on setting out this rationale, with the support of local partners, to better understand local needs and how it can be effectively implemented on the ground.

DsPH are the local experts. DsPH and their teams 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 (from language to inequalities). DsPH played a key role in stitching together the different elements of the pandemic response - whether it be on PPE, volunteering, or testing - to ensure that the system joined up.

226. The confusion around local lockdowns provides an example of where there was a considerable disconnect and a lack of coordination nationally. There was much focus on the idea of 'local lockdowns', but the Government took too long to define what the term meant, outline how, where and when they could be applied, or consider the question of whether they would be either desirable or practical – or even whether they would work.

227. Looking forward, greater local involvement is needed in formulating national policy. This means bringing in bodies such as the Association of Directors of Public Health, the Local Government Association and Association of Directors of Adult Social Services to collaborate and inform national decisions.

Poor recognition of the role of DsPH and the local public health system

228. The local public health system has been undervalued. The response to the pandemic and in particular, the limited engagement with DsPH in the early stages, reflects the historic lack of understanding of the importance of public health and the role of DsPH in creating healthy populations and places. As a society we tend still to think that a healthy population is created by the NHS – it is not.

229. DsPH are trained in containing infectious diseases, both understanding and interpreting data, recognising risk factors, understanding the evidence base and what motivates behaviour change, and helping develop policy interventions. Contact tracing is also a tried and tested public health intervention.

230. DsPH - and their teams - have extensive experience and knowledge of contact tracing, their local communities and the wider health and social care

system. Within local government, there were numerous people with the skills – from environment health officers to public health specialists and sexual health staff – to support the contact tracing efforts in response to the coronavirus. However, the involvement of local councils and DsPH in the Test and Trace service was, in the beginning of the pandemic, fairly limited.

231. As the pandemic progressed, there was increasing recognition about 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, ensured the challenges of Covid-19 are understood, considered the impact on local communities and ensured the wider system capacity supports DsPH.

232. Developments, such as the secondment of Tom Riordan to lead on the Trace element of the programme, significantly boosted local government's role and voice nationally. However, the overall programme still maintained its 'top down' approach with DsPH having to knit together how things worked on the ground.

233. Adult social care was the first area in which the role of the DPH was strongly recognised. Largely championed by PHE, DsPH were brought in and given more ability to influence. Alongside their Director of Adult Social Care (DASS) colleagues, DsPH played more of a leading role in outbreak management, and this included enabling DsPH to use to their local expertise to prioritise the allocation of testing in care homes.

234. As the pandemic progressed, ADPH welcomed increased engagement with colleagues from the Department of Health and Social Care (DHSC), in particular, the Minister of State for Care. This allowed DsPH to provide the necessary input into national policy, engage in joint problem solving and feedback key issues and how things are working on the ground.

235. While there is no doubt that some elements of this response needed to be done nationally at scale, there needs to be greater recognition of the role of local government in the planning for future pandemics. A key lesson that must be reflected on as we move forward, is that locally driven processes and responses are more effective than those prescribed centrally through 'top-down' approaches and enable improved co-ordination and collaboration between agencies. It is important that the UK government understands the distinct role of DsPH when engaging with local government.

Local readiness

236. There was a degree of consistency between localities based on the fact that the role of a DPH was reasonably well-defined generally and in respect of local pandemic plans. National planning documents existed across the UK which DsPH could draw on although, as previously stated, these were based on the presumption of an influenza pandemic. Forums and mechanisms for local and regional partnership working existed and could be convened at short notice.

237. Differences will have occurred based on the specific demographics and geography of areas, the capacity of a DPH and their team and variations in roles and responsibilities across the UK.

Factors that impacted local government's state of readiness for Covid-19 pandemic

238. Several factors impacted the state of readiness of DsPH and their teams across the UK. The scale and severity of the Covid-19 pandemic was not anticipated in national plans, nor did they consider the specific implications of a coronavirus. Capacity in the public health system at all levels had been depleted over several years limiting the availability of staff, skills and funding. Whilst engagement between parts of national government and DsPH varied across the UK, there were concerns about a 'top-down' response – this was especially true in England. Communication and data sharing channels were not sufficiently prepared, delaying discussions and information in the early stages of the pandemic.

How the UK government disseminated guidance at a local level

239. As highlighted elsewhere, the DHSC did not have an up-to-date contacts list for DsPH which led to delayed or absent communication. ADPH utilised its communication channels with members to disseminate information, guidance and resources provided to us.

L**ocal risk assessments and plans**

240. Local plans were largely based on an influenza type flu, this reflected the government's view that this was the most likely prospect as identified in the National Risk Register. It will be essential that, as part of future pandemic planning, consideration is given to different types of viruses and how responses may need to vary.

241. DsPH - and their teams - have extensive experience and knowledge of contact tracing, their local communities and the wider health and social care system. Within local government, there are plenty of people with the skills – from environment health officers to public health specialists and sexual health staff – to support the contact tracing efforts in response to the coronavirus. However, the involvement of local councils and DsPH in the Test and Trace service was, at the beginning of the pandemic, fairly limited. It appears that local capacity to carry out testing and contract tracing was not recognised at a national level.

Communication between DsPH and the CMO

242. There may have been communication between individual DsPH and the CMO, but ADPH did not have oversight of these of these interactions, therefore is not well placed to comment. ADPH facilitated regular CMO calls starting from 31st January 2020.

The impact UK's decision to leave the European Union on emergency preparedness

243. ADPH has not undertaken any work to assess the impact of Brexit on the availability of resources and levels of funding available for local public health services.

244. It is, of course, a matter of reality that infectious diseases, like Covid-19, know no borders. Whilst ADPH has no formal position on Brexit, we would wish to make some observations about the implications of this decision:
Restrictions on the movement of people between EU and the UK
Less cooperation and communication between the EU and UK
Limited collaboration in relation to key common issues such as vaccine supply and equity and PPE supplies as the pandemic developed

Planning for Future Pandemics

Planning for, preparing for and managing future whole systems civil emergencies at a local government level

245. ADPH took an active learning approach to the pandemic, capturing lessons from our engagement with members and publishing documents that would help improve practice and policy throughout the response to Covid-19.
    a. Statement of Principles: Covid-19: Contact Tracing **May 18, 2020**
    b. Guiding Principles for Effective Management of Covid-19 at a Local Level **June 12, 2020**
    c. Explainer: Local Outbreak Plans **June 30, 2020**
    d. Explainer: Data **July 17,2020**
    e. Protecting our communities: Pulling together to achieve sustainable suppression of SARS-CoV-2 and limit adverse impacts **October 11, 2020**
    f. Explainer: Test and Trace Service **October 30, 2020**
    g. Statement: Mass testing **November 09, 2020**
    h. Explainer: COVID-19 Vaccination **January 11, 2021**
    Covid-19 Public Inquiry Briefing: Learning Lessons for the Future **July 9, 2021**
    i. ADPH Consultation Response: UK Covid-19 Inquiry Draft Terms of Reference **April 7, 2022**

A chronological list of initiatives or actions involving, overseen or responded to by ADPH, DsPH and/or local government organisations concerning the making of changes to any of the local entities, structures and processes

246. Here, ADPH would like to focus on the documents relevant to DsPH.

    a. Covid-19 Prioritisation of Sexual and Reproductive Health Services **(April 8, 2020)**
    b. Parliamentary Briefing MHCLG Oral Evidence Sessions – COVID-19 **(April 2020)**
    c. House of Lords Inquiry on Lessons Learned **(June 2020)**
    d. MHGLG Oral Evidence Briefing – Contract Tracing **(June 2020)**
    e. PACAC – Data Transparency & Accountability **(November 2020)**
    f. STC – Science Research and Tech Capability and Influence **(January 2021)**
    g. COVID-Status Certification Review **(March 2021)**
    h. Directors of public health and the Covid-19 pandemic 'A year like no other' **(September 2021)**
    i. Covid-19 Vaccine Programme Consultation **(March 2022)**

Conclusions and recommendations of the documents outlined above

247. In June 2020, ADPH provided extensive evidence to the House of Lords Public Services Committee Inquiry on Lessons Learned up until that point in the pandemic. It captured the main themes that concerned DsPH.

A summary of our recommendations is below:

248. Communication with DsPH was inadequate, hampered by the DHSC not holding or maintaining a list of contact details for DsPH at the start of the pandemic. Data sharing was also limited and left DsPH in the dark about the presence and spread of Covid-19 in their communities

249. There was a disconnect between national government and local government, DsPH were not consulted and engaged with sufficiently in the early stages of the pandemic and their expertise was overlooked in formulating policy and guidance

250. The knowledge of DsPH about health protection, local communities, and their role was not valued by national government and the early design of systems, such as the Test and Trace Service reflected this

251. Covid-19 did not impact all communities and groups in the same way. Transmission occurred more rapidly in certain settings where close contact between people was more likely e.g. food processing factories and crowded accommodation. It is also the case that those with underlying health conditions, many with strong links to poverty such as smoking or obesity, were more likely to be hospitalised and die from Covid-19. The early response to the pandemic did not sufficiently recognise these realities.

The extent of response to any conclusions, and implementation of any such recommendations

252. Given the unprecedented nature of the Covid-19 pandemic and the waves inherent in a pandemic of this nature, the response was evolving throughout. Whilst change in relation to the above did take place, for DsPH, this often took too long. However, we acknowledged and welcomed progress on the following:

    a. Improved communication channels between DHSC and DsPH, and better data sharing arrangements
    b. There was increased engagement between DsPH and central government, often facilitated by ADPH. As time went by, ADPH provided the collective DPH view on a range of matters including, but not limited to, local outbreak plans, test and trace, vaccination, funding, public messaging
    c. DsPH were increasingly able to use the health protection knowledge held by them and their teams to improve national systems and services. For example by delivering local contract tracing schemes or making the vaccination more accessible to deprived and disadvantaged groups
    d. During the course of the pandemic the issues around health inequalities became more prominent and programmes adapted to address aspects of the response where these could be created or exacerbated. Local authority-led local champions schemes, for instance, were crucial in helping to reach diverse and disadvantaged communities with key public health messaging and services

Reflections on the UK's preparedness and resilience to the Covid-19 pandemic, nationally and locally

253. Our overall view is that the UK could take steps to improve future responses for a pandemic of this nature. At a local level, DsPH – working with partners and colleagues in local authorities, NHS, the voluntary sector and other emergency responders – had plans in place for an influenza flu (as required by national governments based on working assumptions of what was most likely) and adapted arrangements to meet the challenges presented by Covid-19. Clearly, in future, national and local plans will need to be more flexible to respond to different types of viruses.

254. However, 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 earlier and more comprehensively by national bodies with responsibility for health protection.

255. **DPH role** - clarify and strengthen the DPH role and their powers, including the function of providing strategic coordination and coherency at a local level; especially in regard to pandemic preparedness and emergency planning

256. **LRF/LHRP structure -** review to ensure that LRF/LHRP roles and responsibilities are well-understood and there is cohesive approach to emergency planning across all sectors and government departments at national level. Further ensure that these groups are fully representing the needs of all the local population

257. **National Risk Register** - reform the National Risk Register and approach to mitigation and planning

258. **Health protection capacity** - ensure sufficient health protection capacity and resourcing at all levels, including both standing and reserve capacity, to improve the preparedness and resilience of their organisations working with relevant partners in future

259. **Investment** - increase investment in local public health budgets

260. **Coordination** - Adopt a cross-government approach to responding to pandemics, with a recognition of the DPH as a local system leader. Multi-agency testing across the NHS, local government, PHE/UKHSA would benefit from more coordination as would national resilience coordination arrangements across DLUHC and DHSC/UKHSA. Additionally, coordination with the VCS sector should be strengthened so that it can be better harnessed in emergency planning strategies going forward

261. **Multi agency responsibility** - clarify and codify the multi-agency leadership role of UK and national public health agencies around infectious disease incident and outbreak management, particularly in large scale incidents and outbreaks

262. **Tackling inequalities -** 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. In addition, the UK government and devolved nations need to commit to bold plans to reduce health inequalities because a more equal and healthier society will be more resilient to future pandemics

What investment is needed to ensure that the UK has a resilient locally led health protection scheme

263. ADPH advocated for more investment in public health across the UK.

264. Likewise, the UK needs a public health workforce that is fit for the future – both in respect of health protection and improvement. This is likely to include a clear plan for recruiting and retaining public health specialists, at all levels, with expertise and knowledge in health protection. ADPH is committed to working with relevant national agencies on an ongoing basis to put these plans in place by presenting the DPH perspective in a coherent and credible way.

Future plans for resourcing and prioritising the UK's pandemic readiness at a local government level

265. Based on the findings from this Public Inquiry, the UK must take a holistic view on the following:

a. The priority given to pandemic planning and preparedness The role of key agencies and professionals in the planning and responses phases
b. The level of standing resources that should be committed to maintaining an adequate state of readiness in respect of staffing levels, funding, equipment and infrastructure

266. The DPH role – whether based in local government or the NHS - should be clarified as part of this process and funding assigned should be commensurate with the scale of the intended contribution through the normal funding routes.

267. It is the view of ADPH that, across the public health system, funding and staffing levels had been rundown to such an extent – at all levels – that it severely hampered the response to Covid-19. It is often said that defence of the UK, and its people, is the first priority of government. Protecting public health should be viewed as a key component of keeping our nation safe and secure, and our systems and resources for doing so should be considered a vital national asset and provided with adequate investment.