

Directors of public health and the Covid-19 pandemic

'A year like no other'

Shilpa Ross
Deborah Fenney
Clair Thorstensen-Woll
David Buck

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Foreword

As the full extent of the Covid-19 pandemic began to unfold in April 2020, it became clear that for those working in public health, this was to be a career-defining experience. At the heart of the response – building the plane in mid-air – a few public health professionals were taking decisions by the minute that were shaping the experiences of the many. Making essential services safe, protecting the vulnerable and doing their best to contain the virus.

At the Health Foundation, we wondered how we could contribute to the events around us. As knowledge is our core business, thoughts quickly turned to how we could capture insights from the momentous events.

Public health professionals' real-time learning emerged as a vital body of knowledge. How were decisions being made, what supported local responses, what got in the way and what legacies were being built? And what does this tell us about the future role of public health?

Working with The King's Fund to develop and deliver this idea was the obvious partnership, having articulated their *Vision for population health* in 2018 ([Buck et al 2018](#)). Now is surely the time to see how these principles of cohering approaches for improving and protecting population health were supporting local action.

This report distils hours of conversations with public health professionals – and colleagues – across the United Kingdom. It identifies the critical importance of the place-based response to the pandemic, the leadership roles that directors of public health played in convening action across the public, private, voluntary and community sectors. In doing so, the importance of relationships emerges repeatedly. Locally, as the basis of trust and collaborative action; nationally, to inform (not always successfully) the overarching policy frameworks. The interviews also brought into sharp focus the real-world impact of the £1 billion funding gap in the public health grant, with teams entering the pandemic pared back and with limited capacity.



The insights from these interviews provide a window on the leadership, energy and resilience shown by the public health community. The Health Foundation and The King's Fund are immensely grateful that, amid the unprecedented demands of the pandemic, leaders from across the United Kingdom were willing to contribute to this study.

The 2013 move of public health into local government was not without its detractors. But, if the pandemic has taught us anything, it is that health starts and ends in place. And that this decision enabled directors of public health to lead a whole-system response when our lives depended on it.

Dr Jo Bibby

Director of Health

The Health Foundation



Key messages

- Before the Covid-19 pandemic hit, the public health system in England had undergone a major reform and, since 2014/15, has faced significant financial challenges.
- The pandemic has been an unprecedented situation that has tested local public health systems to the extreme for more than a year. It has been 'a year like no other', as one director of public health (DPH) told us. And the pandemic is not over yet.
- Given the stark health inequalities that the pandemic in the United Kingdom has exposed so far, and the knowledge and expertise that directors of public health (DsPH) have in addressing these, DsPH will continue to play a critical role in the recovery from the pandemic.
- Our study highlighted two key aspects to directors' involvement in responding to Covid-19. On the one hand, there is their formal role in the local public health system; they have helped guide and shape the response within regional and local emergency structures and committees. On the other hand, there is the striking role that DsPH have played more broadly in engaging local communities, facilitating vital social support and acting as a lynchpin within the broader response.
- DsPH encountered various challenges over the year under study. Key examples include: workforce shortages within public health teams; and central government not engaging properly with DsPH regarding major elements of the overall response to Covid-19, most notably the national coronavirus testing strategy and the roll-out of NHS Test and Trace.
- A key part of the DPH's role is to build relationships, working across sectors to advocate for the public's health and wellbeing. The public health crisis has demonstrated the value of these existing relationships and directors' ability to build new connections, to convene and to bring people together from different parts of the system.



- These relationships (new and well-established ones) will continue to be important in tackling the aftermath of the first three waves of Covid-19. Therefore, they need to be nurtured in the long term, beyond the crisis phase.
- The government made available emergency funding to support public health teams to tackle Covid-19. This helped DsPH to build capacity in their teams. However, the short-term nature of the funding leaves uncertainty about solutions for longstanding challenges in the public health system.
- The Covid-19 pandemic has increased the public profile of DsPH. Their skilled leadership of the local response to Covid-19 has also helped to build trust among other stakeholders. If this support can be secured in the long term, there is a unique opportunity for DsPH and their teams to develop a central role for population health management within emergent integrated care systems and place-based partnerships.
- However, there is a risk that workforce shortages in local public health teams could undermine the recovery from the pandemic. There is also uncertainty in the wider policy environment about the functions of the body that has replaced Public Health England – the UK Health Security Agency – and the funding settlement for local teams. It will be essential that the future funding allocation for public health matches up to the scale of the public health challenges that the pandemic has left and that it is placed on a more sustainable footing.
- Given the significant toll that the pandemic has taken on the population, it is crucial that the role of public health is fully recognised and valued as an integral component of the integrated care systems and place-based partnerships that will become key features of the health and care system in England in the coming months.
- The findings of this study provide a consolidated overview of the public health response to Covid-19. This initial appraisal should be of value to a future public inquiry to assess the overall response to Covid-19.



1 Introduction

On 1 March 2020, the then Secretary of State for Health and Social Care, Matt Hancock, set out the government's 'battle plan' for Covid-19 and said at the time: 'The UK is a world leader in preparing for and managing disease outbreaks and I have every confidence in our nation's ability to respond to the threat of Covid-19' ([Hancock 2020b](#)). As well as signalling a cross-departmental response at a national level, the battle plan required a similar joint approach to be adopted at a local level to fight the outbreak of the virus. In some local areas, emergency structures had already been 'stood up' to prepare and plan for Covid-19 outbreaks.

Since that time, directors of public health (DsPH) – who have a key role in protecting and improving the health of their communities, including being responsible for infectious disease control – have played a significant role in the United Kingdom's response to the Covid-19 pandemic. Their knowledge of and expertise in population health (and that of their teams) have been vital in addressing its immediate impacts on health, as well as understanding and mitigating the economic and social impacts of the pandemic, which will affect the health of their populations in its aftermath. Their understanding of local places and resources, and their broader role in local authorities, situate them at the centre of local decision-making that affects public health.

There is little research available on how local and national systems – particularly those that lie outside the National Health Service (NHS) – have prepared or acted for civil emergencies on the scale of the Covid-19 pandemic. This insight is critical to understanding the effectiveness of the roles of DsPH, how they might be developed in the future and how any re-emergence of the coronavirus (or similar viruses) is dealt with in the future. Also, understanding how the local public health system has responded to the pandemic can help maximise the effectiveness of the health and care system overall – not just in responding to future health crises, but also in responding to disasters or emergencies such as flooding, fires or terrorist incidents. There are few individuals better placed to tell this story than DsPH themselves.



Our research

The Health Foundation and The King's Fund want to tell the story of Covid-19 and the local public health system – not just as a 'snapshot', but through a near-contemporaneous study of the experiences of DsPH in England from the start of the pandemic in 2020 up until May 2021. We set out to understand:

- the experiences of DsPH at different stages earlier on in the pandemic (for example, their leadership of local structures and committees set up to manage outbreaks, the decisions they made and the barriers and enablers they came across)
- how local systems responded to Covid-19
- the wider impacts of Covid-19 in local areas (in addition to incidence and mortality) and plans for recovery.

Although it is important to note that this is not an evaluation or assessment of the local public health system's response to Covid-19 and that the response to the pandemic is ongoing at the time of writing, we do intend to draw out some key learning points to highlight what is important in responding to a public health crisis. These include:

- how prepared local areas were for responding to a pandemic
- what actions were undertaken to protect the health of local communities and minimise the impact of Covid-19
- what the learning from the pandemic means for the role of the local public health system in the recovery.

We believe our research findings will be of particular interest to:

- the DsPH community, who have worked non-stop throughout the pandemic and have had little time to reflect on or process their experiences or those of the teams they lead
- those working in public health teams



- leaders in wider local systems, some of whom worked closely with DsPH over the year under study as well as others who are not as familiar with DsPH
- policy- and decision-makers at a national level, particularly those who are currently engaged in planning the reform of public health
- other stakeholders, including the media, who are seeking to understand what DsPH and public health teams have been doing throughout the pandemic and are planning to do in the future.

For more detail about our research methodology, see Appendix 1. In brief, our research study consisted of the following components:

- interviews with DsPH from England (up to three times) between September 2020 and April 2021
- interviews with other leaders (twice) in two local areas where we carried out a 'deep dive' between December 2020 and March 2021
- interviews with DsPH from Northern Ireland, Scotland and Wales (twice) between October 2020 and March 2021
- interviews with five leaders who have been involved in the national or regional response to Covid-19
- a focus group discussion with DsPH from England in May 2021
- a review of documents, such as local outbreak management plans and other strategies produced during the pandemic.

We felt it was important to interview DsPH and other leaders multiple times to obtain rich, detailed information and get a sense of what was happening in local systems at different points in the pandemic. We have drawn most on the interview data for England in this report as that was our primary area of focus.

We have chosen not to name the individuals who participated in our study and have ascribed code numbers to the areas in which they work. We took this decision in order to help DsPH and others to speak candidly in their interviews,



especially if what they were saying was critical of others. We wanted to ensure that respondents felt comfortable sharing their personal reflections without risk to ongoing and future collaborations with other partners. Throughout the report we have included anonymised quotations from DsPH and others where we feel it is particularly valuable to use their own words to describe their experiences and express the strength of feeling on different issues.

In Table 1 we present some information about the subsample of eight DsPH who have informed most of our analysis. The table includes a column showing our judgement as at August 2020 regarding how much the area in question had been impacted by Covid-19 mortality (high, medium or low) in the first wave according to the Office for National Statistics and, where we knew it, how likely they were to be impacted by further waves (high, medium or low). For the latter we utilised an analysis that the University of Liverpool undertook, which sought to identify the likely risk to populations of further outbreaks and impact based on local characteristics such as Covid-19 mortality rate, prevalence of chronic health conditions, levels of overcrowded housing, age profile, ethnic diversity, numbers of care home beds and levels of deprivation (using Index of Multiple Deprivation scores from 2019) (Daras *et al* 2021). We have also provided an indication of the approximate length of service as DPH in the area. These are very broad approximations so that the DsPH are not easily identifiable. However, we can say that two of the eight DsPH were only recently in post at the point of the Covid-19 outbreak in England and the others had been in post relatively longer. There were four women and four men in the sample of eight.

It is difficult to describe the sizes of the local public health teams in the areas because the make-up of these teams was different in each area, particularly in terms of numbers of support roles and posts funded through non-public health budgets. Where we could collect the data from the DsPH, we have indicated the numbers of key staff who were common across the teams, that is, directors, deputy directors and consultants, as at March 2020, which was the approximate starting point of the pandemic. We discuss later on in this report how some public health teams increased capacity to help tackle the pandemic.



Table 1 Directors of public health and high-level description of areas (subsample, n=8)

Director of public health (DPH)	Approximate length of service as DPH in the area	Region	High-level description	Our judgement of how the area has been impacted by Covid-19	Interview points	Core staff in team
DPH 02	< 5 years	West Midlands	Mostly rural	Low mortality Risk of future waves unknown	September 2020, January 2021, April 2021	1 DPH 0 deputy 1.6 WTE consultants
DPH 04	< 5 years	London	Urban	High mortality High risk of future waves	September 2020, January 2021, April 2021	1 DPH 0 deputy 3 consultants
DPH 05	< 5 years	North West	Urban	High mortality High risk of future waves	September 2020, February 2021, May 2021	No data
DPH 06	> 5 years	London	Mixed urban and rural	Medium mortality Medium risk of future waves	September 2020, January 2021 (unavailable for third interview)	No data
DPH 07	> 5 years	South West	Mostly rural	Medium mortality Risk of future waves unknown	September 2020, January 2021, April 2021	1 DPH 1 deputy 3.2 WTE consultants
DPH 08	> 5 years	North East	Urban	High mortality Risk of future waves unknown	September 2020, January 2021, April 2021	1 DPH 0 deputy 2 consultants
DPH 10	< 5 years	West Midlands	Urban	High mortality High risk of future waves	September 2020, January 2021, April 2021	1 DPH 2 deputies 0.6 WTE consultant
DPH 11	< 5 years	South West	Mixed urban and rural	Medium mortality Risk of future waves unknown	September 2020, January 2021, April 2021	1 DPH 0 deputy 1.8 WTE consultants

Notes: In Appendix 1, we describe the full sample from which the subsample was drawn.
WTE = whole-time equivalent.



The structure of this report

The report is structured in the following way.

- Section 2 provides the relevant context about the public health system, explaining how the local public health system is structured in England and the role of DsPH, how public health is funded as well as the population health context going into the Covid-19 pandemic.
- Section 3 sets out the extent to which local areas were prepared to respond to the pandemic and how they went about responding, including the formal role of DsPH within that.
- Section 4 looks at the critical role DsPH have played as leaders.
- Section 5 explores how relationships have acted as critical enablers (and occasionally as barriers) to the public health response.
- Section 6 focuses on resources for the local response to the pandemic.
- Section 7 considers the journey of DsPH over the pandemic and what that could mean for their role in the recovery.
- Finally, Section 8 looks across the findings and considers the implications for national policy- and decision-making and local implementation.



2 Context: the public health system in England going into the Covid-19 pandemic

To make sense of the role of directors of public health (DsPH) and their teams, it is important to have an understanding of their responsibilities and how they work alongside others. This section therefore sets out three important contextual factors for interpreting the rest of the report: how the public health system is structured in England and the role 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.

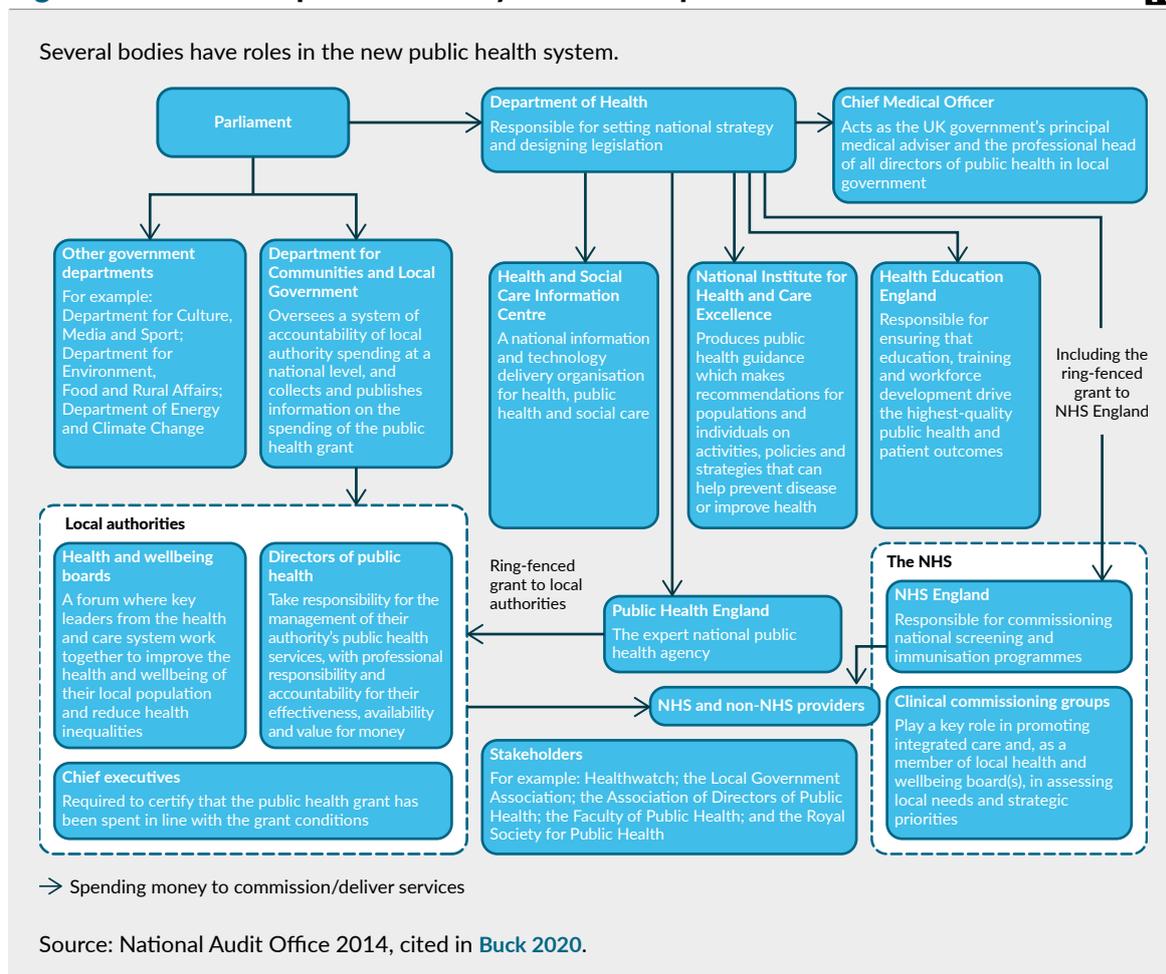
The new public health system in England in 2013

The National Audit Office has set out a useful map of the public health system in England as it stood in 2013 (see Figure 1, cited in [Buck 2020](#)). At the national level, the Secretary of State for Health (now for Health and Social Care) set strategy and policy. While existing bodies (such as the National Institute for Health and Care Excellence and the Health and Social Care Information Centre, now known as NHS Digital) supported the system, the big changes ushered in by the coalition government's reforms to the public health system were in the creation of Public Health England, intended to bring disparate and fragmented public health expertise into one organisation nationally, and the shifting of significant responsibility and funding from the NHS to local government locally.

DsPH and their teams therefore now lie at the heart of the public health system locally in England, based in upper-tier and unitary local authorities, previously being employed by primary care trusts in the NHS. The reforms transferred the commissioning responsibility for specific functions – such as smoking cessation services through sexual health services to obesity prevention – to local authorities, while retaining the delivery of some more clinically focused services, such as immunisation, in the NHS. The reforms also transferred a ring-fenced budget to commission these services.



Figure 1 Roles in the public health system from April 2013



The Department of Health (now the Department of Health and Social Care) set out the specific role and responsibilities of DsPH in the new system as a factsheet, which has been periodically updated, including to reflect the Covid-19 context ([Department of Health and Social Care undated](#)). To complement this, the Association of Directors of Public Health published *What is a director of public health?* outlining the wider skills and leadership required for a director of public health (DPH) to be an influential system influencer and leader in place ([Association of Directors of Public Health 2016](#)). Many of these aspects have been tested during the Covid-19 experience, as our findings show.

Basing DsPH and their teams in local government had a wider purpose than the commissioning of specific services: for DsPH to be better placed to influence and



support wider local government decisions that impact the public's health, given the strong evidence that while the NHS has a significant role to play, local government influences much of what determines a population's health – including good-quality homes, access to stable and rewarding work, safe and secure streets and a good environment – more strongly (Buck and Gregory 2013). DsPH have a statutory place on local health and wellbeing boards to help them fulfil this broader role, as well as strong connections back to the NHS, and they are the local leader for health protection issues, such as terrorism and infectious disease outbreaks. To achieve this, they need to cultivate strong relationships across the local authorities, with elected members and with the leadership team, including their chief executive. Their relationship with their chief executive is particularly important to help bring all of the council's resources and skills to the table for public health and to provide mutual support and challenge – particularly in the context of an emergency when DsPH are an important conduit between the national response and the local one.

The role of directors of public health in health protection

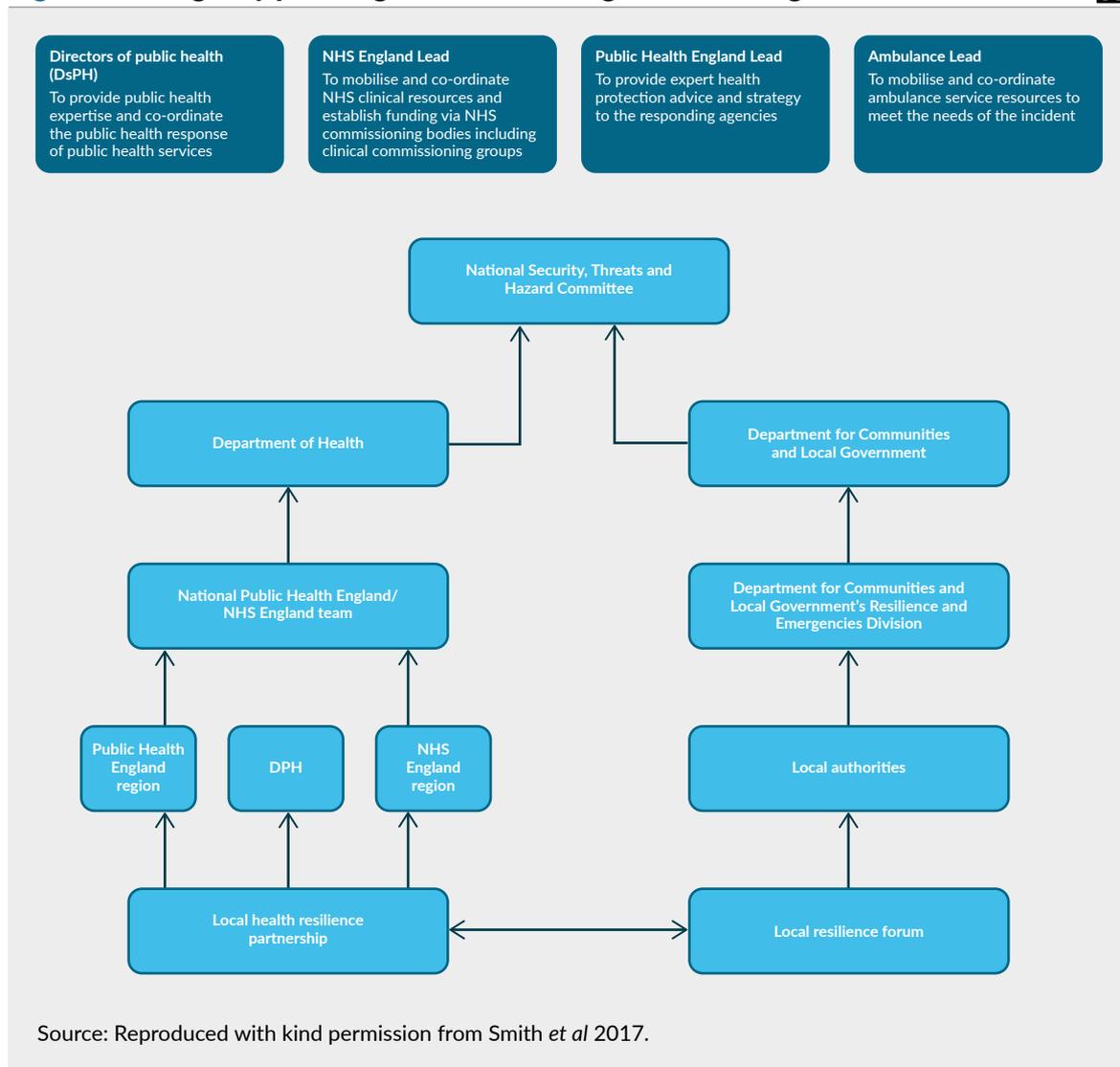
DsPH are important members of 'local resilience forums', which are aligned to the boundaries of 42 police areas across England and Wales (Cabinet Office 2013) in the context of the Civil Contingencies Act 2004. These forums are partnerships of representatives from several statutory services, including 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 future¹) and ambulance services.

¹ The government announced that Public Health England would be abolished in August 2020, in March 2021 it announced that it would be succeeded by two new bodies, the UK Health Security Agency and the Office for Health Promotion, following a transitional period as both bodies were set up fully, with the transition completed by autumn 2021 (Department of Health and Social Care 2021b). At the time of researching and writing of this report, the transition was ongoing and Public Health England was still operating in practice.



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 (see Figure 2). 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 (see [Department of Health et al 2013](#)).

Figure 2 Emergency planning structures in England following the reforms





Public health in the rest of the United Kingdom

The main focus of this report is on the experience of DsPH and their teams in England. However, we also interviewed public health professionals in the rest of the United Kingdom to help understand what has happened in England, and whether it mirrors that in other parts of the United Kingdom. While the essential roles, training and expertise of DsPH and their teams are broadly similar across the United Kingdom, the organisation of public health differs. While each nation has a national public health agency, they are of differing maturities. For example, Scotland's has only been in place formally since 2020. Furthermore, in Wales and Scotland, DsPH remain primarily part of NHS structures rather than local authorities', while in Northern Ireland there is no direct equivalent of a DPH due to its small scale as a nation (see Table 2). The scale of the other nations also means that the 'chain' between national and local policy, practice and decision-making is shorter, which

Table 2 Where the public health systems are located in the UK nations

	England	Northern Ireland	Scotland	Wales
Where located	Local government	Health and social care (which is integrated in Northern Ireland)	Health boards (x14)	Health boards (x7)
Notable features	Public Health England ² was established in 2013. 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 153 local authorities.	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.	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. Health boards employ multiple DsPH.	Public Health Wales was established in 2009 with the remit to protect and improve health and wellbeing and reduce health inequalities. Health boards employ multiple DsPH.

² See footnote 1, which sets out the timetable for the abolition of Public Health England and the transitional arrangements to the new system from October 2021.



changes the nature of decision-making, who makes the decisions, how they are reached and the speed with which they are reached. We reflect on the implications of some of these differences as appropriate in this report.

The public health funding and wider resource context since 2013

Despite some teething troubles, and legitimate concerns about the fragmentation of some services, particularly those that have a strong clinical component such as sexual health services ([Robertson 2018](#)), most have judged the location of DsPH and their teams in local authorities in England as one of the successes of the 2013 reforms ([Buck 2020](#)). Indeed, since 2013 the government has looked twice at the decision to locate public health primarily in local authorities – once alongside the publication of *The NHS Long Term Plan* ([NHS England and NHS Improvement 2019](#)) and more recently following the abolition of Public Health England and the creation of the UK Health Security Agency and the Office for Health Promotion at the national level – and on both occasions it has decided to keep public health in local government.

But while there has been reasonably strong consensus on public health being in the ‘right place’, there has been far more concern about whether it has had the right level of resources, both through the ring-fenced grant specifically and through the wider funding of local government.

It is important to recognise that in the first few years following 2013, the ring-fenced public health grant saw significant cash growth of 5 per cent each year in total, and for some particularly poorly funded areas, more than that ([Buck 2017](#)). However, in 2015/16 this came to a halt, as part of the government’s response to financial pressures. From that point, like-for-like funding (taking into account funding for additional responsibilities related to child health) through the public health grant fell right up to the Covid-19 pandemic. The King’s Fund and the Health Foundation calculated that, given population increase and inflation, the like-for-like purchasing power of the public health grant fell by almost a quarter per head of population between 2015/16 and 2020/21 and that an extra £1 billion a year would be required to fill the gap ([The King’s Fund and Health Foundation 2019](#)).

Further, given the intention of the public health reforms – for DsPH to be able to better influence the wider local authority decisions that have an impact on their



population's health – the much larger overall resources at local government's disposal are as important as the specific grant. These overall resources have shrunk much more significantly since 2010, with the National Audit Office stating that funding reductions and growing demand have meant that authorities' finances have been potentially more vulnerable to the impact of the pandemic than they would have been otherwise ([National Audit Office 2021](#)). The overall spending power dropped by more than 20 per cent to 2015 and remained around that level as local government entered the pandemic. There was therefore less money spent on areas that protect the public's health such as housing, economic development, regulation (for example, food safety) and environmental health services. Further, these cuts were deeper in areas of higher deprivation, and therefore with a population in generally poorer health, to start with (Gray and Barford 2018).

The health of the population going into the Covid-19 pandemic

Finally, it is important to understand the population health context going into the Covid-19 pandemic. Like in all developed nations, the broad sweep of the 20th century saw an unparalleled increase in prosperity and health in England. Life expectancy at birth in 1900 was around 49 years for a male and 52 years for a female; by 2011 it had increased to 79 and 83 respectively ([Office for National Statistics 2015](#)). However, in around 2010, the steady growth in life expectancy began to slow and stall – not just in the United Kingdom, but across much of Europe as well. However, the slowdown was more marked in the United Kingdom than in other countries. Furthermore, among females in more deprived areas, life expectancy fell. Inequalities in life expectancy between different parts of the United Kingdom – always large – also widened after 2010, following a narrowing to some extent in the 10 years previously ([Raleigh 2021](#)).

There are many potential explanations for why this has happened, including:

- reaching the limits of some important medical advances (for example, in cardiovascular disease treatments)
- the impact of severe outbreaks of influenza in some years, such as 2015
- the impact of 'austerity' on public services following the 2008 financial crisis
- longer-run trends such as a slower decline in smoking prevalence in females in the United Kingdom, and widening inequalities (Raleigh 2018).



Emerging evidence suggests that the most important factors in explaining differences in the international experience of Covid-19 were about how the response was managed – such as the timing of lockdown measures (Balmford *et al* 2020). However, the structure of England’s population and society and pre-existing inequalities may have also led certain groups to be more vulnerable to a pandemic, such as the quality of the housing stock and houses of multiple occupation (Thorstensen-Woll *et al* 2020), working conditions and a myriad of other social and economic factors (Marmot *et al* 2020), as the Health Foundation has documented in its Covid-19 impact inquiry (Suleman *et al* 2021).

In conclusion, DsPH and their teams are part of a broader public health system in England, rooted in local government but with important wider roles regionally as part of local resilience and health protection functions, supported by national bodies (particularly Public Health England) and working with partners including the NHS. The broad consensus is that they are in the ‘right place’ to be most effective in protecting and supporting the health of their populations. However, the public health system itself and local government more broadly have been under consistent financial pressure for many years (pre-pandemic), while trends in population health and inequalities have also been unfavourable. It is this context in which the following findings and lessons need to be viewed.



3 'Response at place': the local public health response to the Covid-19 pandemic

Key points

- While formal emergency planning structures were well established before the Covid-19 pandemic and went into action promptly, the broader circumstances of funding reductions over the past decade impacted the resources that directors of public health (DsPH) could draw on when the pandemic hit. DsPH mitigated this by using the relationships they had built across their local councils to draw on staff from other departments to support the local response to Covid-19.
- Since early 2020, local public health teams have been heavily involved in infection control efforts and managing outbreaks of Covid-19. It has been challenging to establish a central contact-tracing system for people testing positive and DsPH in England described difficulties in accessing the data they needed to trace contacts. On the other hand, DsPH and public health teams described a more positive experience of working with local partners, the voluntary and community sector (VCS) and volunteers in co-ordinating different forms of support for local people.
- Directors' time has largely been spent focusing solely on Covid-19 and they have helped guide and shape the local response within regional and local emergency structures and committees.
- The role that DsPH have played in supporting local communities over the course of the pandemic is particularly striking. Community engagement has been a major priority and focal point in directors' work – particularly in how they have been able to support local people in managing outbreaks and in taking up the vaccine.

When we were in the pandemic originally, we were very much in a response mode, and we were looking at managing and trying to contain spread, and outbreaks, and clusters of [Covid-19] during that time... we've remained largely in response.

(DPH 11, South West, third interview round)



In this section, we outline the specific activities public health teams have carried out since March 2020 in local areas – or as one director of public health (DPH) described it, their ‘response at place’. By ‘place’, what they were referring to is the local level and that could be within the formal local authority boundary, but often it was more specifically about the response at community or neighbourhood level based on different needs and circumstances. According to the DsPH we spoke to, the response of public health teams was typically guided by their insights into how neighbourhoods and communities differ and what that might mean for local people’s experiences of Covid-19. We also take a look at particular activities that DsPH described being responsible for or directly involved in. This gives us rich insight into how public health teams and DsPH have been best situated to understand the specific needs of the local population and provide support accordingly.

Based on the interviews we carried out, it was clear to us that it took a multifaceted approach to respond to what was a complex and ever-changing situation. Rightly, there was an urgent need at the beginning of the outbreak to assess the capacity of the NHS to treat people, but perhaps that meant it was not as apparent what was happening in local communities to protect and support people. ‘That’s probably my final reflection... I hope the history books just reflect the wider system response and not just focus on the NHS’ (DPH 11, South West, second interview round).

The public health response to the Covid-19 pandemic

January–March 2020: first cases of Covid-19 in England and early public health response

From December 2019, the world was watching events unfold in China following an outbreak of a virus called ‘SARS-Cov-2’ – more commonly referred to as Covid-19, the name of the disease that the virus causes. It became apparent that this virus could transmit from person to person rapidly and cause severe illness in infected people, possibly leading to death. The first cases of Covid-19 in England were confirmed and announced in late January 2020 ([Department of Health and Social Care 2020a](#)).

In many respects, the Covid-19 pandemic has been described as ‘unprecedented’. However, the risk of pandemics more generally has long been on the radar of professionals with roles related to emergency planning. One of the DsPH we interviewed in the first round, for example, had been closely involved in regional emergency planning for several years alongside an NHS colleague (whose remit



involved emergency planning) and described previous involvement in developing an Ebola plan for their area. This kind of planning happens at the level of local resilience forums, described in section 2.

One local leader described the local resilience forum delivering ‘peacetime relationship building’, which enabled local leaders to work effectively together when a crisis occurred. As a national leader from Public Health England reflected, local resilience forums’ planning and processes meant areas were well prepared in respect of understanding that a pandemic might arrive and how to respond, but equally Covid-19 was hard to plan for because of its ‘novel’ nature. They summarised it as, ‘we were prepared but not at the scale that we needed to be’, in that the virus was novel, there was no vaccine and there was not enough data about effective treatment in the early stages.

In the south-west of England, DPH 07 recounted the beginning of their Covid-19 story starting on 28 February 2020, with the first confirmed case in the area. They recalled that it felt ‘inevitable’ that it would happen and it was ‘a little scary’. During the following week, more cases were confirmed among school staff and DPH 07 noted how this created a ‘huge amount of anxiety’ in the community, but also that it ‘felt good’ to be able to work with school staff (in person) and answer their questions. Moving forward just a few weeks, Covid-19 outbreaks were occurring more frequently all over the United Kingdom, the government announced that millions of ‘clinically extremely vulnerable’ people would have to ‘shield’ (stay at home and stop most contact with others) and it was clear the country would need a strong response for a complex situation. In local areas, this meant taking a broad approach to public health, thinking through the immediate threat as well as the ripple effects.

A big feature of that stage [of panic buying] was really identifying very early that as well as the infection control dimension... we were on the verge of a very significant humanitarian situation, particularly in a place with high levels of poverty like [Area 04]. And so probably a few weeks before the national shielding programme was announced, we’d already started organising a humanitarian response focused on food delivery, befriending, prescription delivery.

(DPH 04, London, first interview round)

For many DsPH in our sample, 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. This established a rhythm of regular – sometimes twice-daily – meetings with other leads in the local system to respond to outbreaks and support the public with escalating measures, culminating in the Prime Minister announcing the first national lockdown from 23 March 2020, with measures legally coming into force from 26 March.

March 2020 to the present: ongoing support from public health teams

Public health teams have been working intensively on the response to Covid-19 for 18 months at the time of writing. Our interviews with DsPH, the system leaders working around them and a review of plans show the wide range of support that public health teams have been involved in. The roles they took on to protect the public evolved over time as we learnt more about Covid-19.

The Association of Directors of Public Health, the Faculty of Public Health, the UK Chief Environmental Health Officers Group, Public Health England, the Local Government Association and the Society of Local Authority Chief Executives published advice on the guiding principles for the effective management of Covid-19 at a local level in June 2020, which include the role of local resilience forums ([Association of Directors of Public Health et al 2020](#)). This built on existing guidance that Public Health England and the Association of Directors of Public Health jointly published on what good health protection looks like and was produced to help local authorities and their partners develop local outbreak management plans for Covid-19 ([Association of Directors of Public Health 2016](#)).

To help place directors’ reflections in context, Figure 3 outlines some key events that had occurred by the time of, or coincided with, the three interviewing rounds and the focus group discussion. An expanded version of this timeline can be found in Table 5 in Appendix 2.



Figure 3 Brief timeline of milestones and key events



<p>First round of interviews: September 2020</p>	MARCH 2020	A national lockdown is announced on 23 March 2020
	APRIL 2020	A five-pillar strategy for scaling up Covid-19 testing programmes is published in early April <i>Deaths from Covid-19 peak in April (first wave)</i>
	MAY 2020	Local authorities are asked to produce local Covid-19 outbreak management plans at the end of May DsPH are given responsibility for the testing of residents and staff in care homes in May NHS Test and Trace is launched at the end of May
	JUNE 2020	Easements of national lockdown start from June The first local lockdown (in Leicester and parts of Leicestershire) occurs from late June – other areas follow
	SEPTEMBER 2020	Covid-19 cases start to rise across England from September and new restrictions are announced
	OCTOBER 2020	A three-tier system of restrictions is announced in October A second national lockdown is announced on 31 October
	NOVEMBER 2020	Mass testing to detect asymptomatic Covid-19 cases is introduced in November The Alpha variant of Covid-19 is first detected in November
	DECEMBER 2020	Rising cases in December are attributed to the Alpha variant National lockdown is lifted on 2 December and replaced with a stricter three-tier system Vaccination roll-out begins in early December (the first injection outside of clinical trials is given on 8 December) A new fourth tier of restrictions is announced on 19 December, starting with the south-east of England and then spreading to more areas across England
	JANUARY 2021	A third national lockdown is announced on 6 January 2021 <i>Deaths from Covid-19 peak in January (second wave)</i>
	FEBRUARY 2021	Vaccination roll-out continues Surge testing in specific postcode areas is carried out to catch cases of the Covid-19 variants from February A roadmap out of lockdown is announced on 22 February
	MARCH 2021	There is a return to school from 8 March for primary and secondary school children The 'stay at home' rule is lifted from 29 March
	MAY 2021	Covid-19 cases (particularly the Delta variant) begin to climb in May
<p>Second round of interviews: January 2021</p> <p>Third round of interviews: April/May 2021</p> <p>Focus group discussion: May 2021</p>		



Health protection, infection control and managing outbreaks

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.

Very early on in the pandemic, capacity for processing Covid-19 tests was limited and there was no formal system for tracing the contacts of people who tested positive. NHS Test and Trace (designed to give coverage across England) was not launched until late May 2020 and a key challenge for DsPH (situated in local government) was that they did not have access to case-level data (Briggs *et al* 2020), which was a source of frustration for them and a key constraint on their ability to contain outbreaks.

The experience of something like NHS Test and Trace has highlighted that really unless there's a real need to do things at that, kind of, scale, that local is better... and a need to devolve resources so that local can do this work more effectively... The problem is that a national call centre has no understanding of the needs of the people living in our community, and no understanding of the support that's available to people on offer... and a lack of sensitivity to build the relationships. [It]... isn't going to have the community languages, whereas we can build a system and a team that can engage with our local community, understanding the languages that they speak.

(DPH 04, London, third interview round)

The contrast between this and the experience in Wales was notable; the Welsh government introduced the ‘NHS Test, Trace and Protect’ system, which DsPH (situated in health boards) had responsibility for – thus enabling relatively better access and more direct ownership.



So Test, Trace, Protect, we were in control of that for our own region, just as other regions were. And I think that's the difference between us and England, where I suspect there was a whole host, well I know from other colleagues a whole host of other frustrations, because there... [is] a much bigger geography, and layers of complexity, I guess. So maybe some of the frustrations were slightly different. At least we were in the driving seat of Test, Trace, Protect.

(DPH, Wales, first interview round)

As time progressed and laboratory capacity was ramped up to meet increased demand for processing tests, DsPH were then given responsibility for the testing of residents and staff in care homes in May 2020 (Whately 2020). This continued to develop, with local public health teams becoming more involved in testing in the community, contact-tracing and managing outbreaks. More recently, following the identification of Covid-19 variants, public health teams have worked in partnership with other local authority teams and NHS Test and Trace to carry out 'surge testing' in local areas to identify infection among people without symptoms.

Although it has been a vital tool in tackling Covid-19, testing has at times been challenging terrain for public health teams and DsPH. Central government has not engaged DsPH well in terms of asking them to contribute to the shaping of the national testing strategy – but they have been expected to take responsibility for local implementation. One DPH described it as 'always running to catch up with the government' without having time to think through how public health teams can support local businesses and people with the latest developments, such as rolling out mass testing. DsPH also expressed other frustrations about the national testing strategy, including the lack of testing of patients prior to discharge from hospitals to care homes and a lack of processing capacity leading to slow turnaround on results (both earlier on in the pandemic), also the challenges in meeting targets for testing. That said, there were signs by the second round of interviews that public health teams were pushing through with embedding testing locally and ensuring it was a core part of the efforts to manage Covid-19. For example, one area was part of the pilot for mass testing. Another area piloted lateral flow testing in educational settings and targeted lateral flow testing in communities where there was a higher proportion of minority ethnic residents and/or people working in frontline roles who were more susceptible to becoming infected and severely unwell.



Learning from the management of an outbreak

DPH 05 shared with us some of the learning taken from a review of managing an outbreak in a local authority ward in July 2020. An analyst in the public health team identified a cluster of Covid-19 infections among working-age adults living in a particular postcode area known to be a deprived community where multi-generational household occupancy was commonplace. This set off a series of actions, including daily outbreak control meetings led by DPH 05, enhanced (that is, door-to-door) contact-tracing, calling an early stop to care home visiting and offering asymptomatic testing to local businesses.

This example of managing an outbreak highlights the importance of understanding 'place' and tailoring responses to the needs of local people, for example:

- public health teams having access to postcode-level data on Covid-19 infections
- using teams with local knowledge to go door to door to carry out contact-tracing
- ensuring testing sites are accessible, that is, people can 'walk up' without needing a car
- working with the community to ensure communication is available in appropriate languages and easily shareable.

Supporting local communities

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. In the first round of interviews with DsPH, the impact on children of school closures was highlighted 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. 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.

Interviews with DsPH and their timelines show that public health teams have also provided specific support to different community groups over the course of the pandemic. For example, in their timeline, DPH 04 noted 'support for local Chinese community' in February 2020 because Chinese people have been targeted with abuse due to the first known cases of Covid-19 occurring in China. In another example, DPH 02 noted in their timeline an outbreak of Covid-19 among Travellers in late July 2020 and how the public health team provided targeted support, such as tests, encouraging members of the community to isolate in household groups, providing essential items to help people to self-isolate, contact-tracing on the site and communicating about what they were doing on social media to advise residents in the wider area. DPH 10 described extensive engagement activity with local community leaders, ensuring accurate and consistent information was being disseminated to help support local people: 'There has been a huge amount of effort, most of it unrecognised – engaging in communities, working with communities, getting community leaders to give them the right information so they're then saying the right things' (DPH 10, West Midlands, third interview round).

Co-ordinating and mobilising

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.

We had obviously very good voluntary organisations, we already had a foodbank, we already had a church offering meals, they did that to day services already and it was how we could bolster some of what we had already and so it gradually became



this [Area 06] 'Stronger Together' hub. As I say, I chaired this workstream initially and then handed it over as it got too busy... What it was, was four tiers if you like, so tier zero was advice and information, so if people just needed to know how they could book a slot for shopping deliveries, what was in their area and then people could fill in a form if they needed more help... So, the shopping service, pharmacy collection... and then there were those that were needing that chat and check-in or befriending services. So, we had a hub where calls came through and you had a conversation, found out what they needed or people could do it online and you could do it digitally and we set up a whole data system, so we could find out who had done what, make sure that everybody that was on the shielding list and that was nearly 6,000 for us, had been contacted. We tried different methods, we did have a door-knocking, a keep-safe system and we literally contacted every single person on that list. Then we had a triage system, so we had people like social workers in there, mental health workers, so for those higher-need individuals.

(DPH 06, London, first interview round)

DPH 10 described commissioning a community organisation to set up 'telephone trees' from the time of the first national lockdown to offer phone calls to local people who were lonely and isolated. In Area 10, extra bereavement support was commissioned from the VCS to respond to increasing need. In Area 06, the DPH established a central 'hub' of local VCS organisations just before the first national lockdown was announced, that is, when it became apparent that the escalation in Covid-19 measures meant more and more people would be isolated at home with uncertainty about their usual access to care and support. The purpose of the hub was to provide a central point of contact for the most vulnerable residents so they could access befriending, emergency food parcels and help with picking up medication and other essentials. Residents could also be triaged for onward referral to formal care services if needed.

The role of directors of public health in the pandemic response

This is what you train for and hope you're never going to have to do.

(DPH 02, West Midlands, third interview round)

Pre-pandemic, several DsPH in our sample had responsibility for additional functions or commissioning responsibilities, such as leisure, community safety and equality cohesion. As the pandemic took hold, DsPH invariably found that almost all of their



time was dedicated to planning and directing the local response to Covid-19 in their areas. We outline below some of the specific duties and responsibilities of DsPH during the pandemic, particularly focusing on how they led community engagement locally and supported the Covid-19 vaccination programme.

Community engagement

Community engagement was a strong theme in interviews with DsPH. They described their prioritisation of community engagement in the local response to Covid-19 – often being the public face or voice of the local authorities they represented in communicating messages and engaging with local groups directly.

DsPH used a wide variety of routes to engage, consult and involve their local communities during the pandemic. The level of engagement also varied and included:

- use of social media and local media
- both broadcast and live question and answer sessions with local communities
- direct communications with local groups
- door knocking
- community champions schemes
- more formal routes.

Some DsPH described in detail their approach to engaging people – not just the medium they used but also how they brought people on board or worked with particular communities during the pandemic (for example, Travellers or specific communities with micro-local outbreaks). Two DsPH spoke about how their approach to community engagement had evolved over the course of the pandemic, for example by shifting from broadcast information (updates shared on social media), to developing a shared response and brokering understanding of national guidance with local communities. This work had several specific features, including: showing respect and humility; the importance of working in a collaborative rather than commanding manner; and taking a multi-pronged approach to engagement. 'If you want people to comply and respond to Covid, it's not done from a



call centre, it's done by people who have already got those really good and trusted relationships. People will open up to people they trust, they're not going to open up to a stranger' (DPH 01, North West, first interview round).

A major test of the abilities of public health teams and DsPH to engage meaningfully with local people was the roll-out of the national Covid-19 vaccination programme from early December 2020 onwards. It began to emerge that take-up of the vaccine was not universal and that a number of community groups were hesitant about being vaccinated or finding it difficult to access a vaccine (Osama *et al* 2020). At this point, DsPH as the public faces of local authorities had to urgently work in partnership with local people, community champions and different community group leaders (as well as formal organisations such as the NHS) to listen to concerns and help build trust in organisations seen as 'authorities' and promote culturally sensitive messages about the safety and efficacy of the vaccine.

By the time of the third interview round (April 2021), DPH 04 described the relationship between the local authority and local communities as having undergone a 'massive transformation' and said of the public health team, 'we've really put that community voice much more central to the way we work'. Our wider research on recovery following disasters shows that involving communities at the heart of recovery efforts is important to how successful that recovery is (Cream *et al* 2021). This shift in the nature of the relationship between public health teams and local communities could therefore be a positive lasting legacy of the Covid-19 pandemic and help prepare communities for future threats.

Supporting the Covid-19 vaccination programme

The NHS has been delivering vaccines for Covid-19 across the United Kingdom since early December 2020, as already noted. Alongside this, local public health teams have been working hard to support the roll-out – particularly through the lens of reducing health inequalities. In January 2021, the Association of Directors of Public Health identified two main challenges to large-scale vaccination of the population:

- health inequalities being further exacerbated by the roll-out
- low uptake of the vaccine, including vaccine hesitancy.



The Association of Directors of Public Health (2021) made the following recommendations for DsPH in order to address these challenges and these were generally reflected in the interview data:

- targeted and locally led communications
- using local insights and interventions to engage vulnerable and marginalised groups
- limiting physical barriers to access.

Reflecting on the roll-out of the vaccination programme, DsPH were generally positive about their role in the process and identified enablers such as their deep understanding of the local population and the data on differential uptake of the vaccine, as well as good co-ordination between various services to prepare for vaccine delivery.

So the relationship with the third sector has been brilliant, we've built on the work we did in [local ward] over the summer with the Faith Network, so we use the Faith Network... But again using them right now, to help shape our vaccine hesitancy communications. So, we had an event yesterday where we had lots of BAME [black, Asian and minority ethnic] groups together, really getting into the detail of why people might be suspicious of taking up the offer of [a] vaccine and what messages we might be able to put out to support us addressing that and that's all being written up at the moment and will be turned into our comms [communications] campaign around that. The VCS, the Faith Network and our broader networks are just incredibly helpful in shaping all of that. I've done loads of work with the football clubs, which is still ongoing, so was just on to them yesterday, they're going to support us around pushing the vaccine to our white working-class men, type groups who we know will be less likely to take it up.

(DPH 05, North West, second interview round)

In the early days of the vaccine roll-out during the second interview round (January 2021), another DPH described some frustrations about the lack of data sharing locally by NHS England and nationally by the Department of Health and Social Care and not being able to have further influence on vaccine equity locally as a result. They said that it felt like being pigeon-holed into operational planning and not



being able to bring the full breadth of their expertise on the local population and reducing health inequalities to this crucial component of the response to Covid-19.

...because I don't care about how many syringes you've got... that's not the best use of time, my team don't need to be involved in that. I want to know how many people are in each group [of people who have been vaccinated], because actually the numbers you've given me won't even get us to herd immunity, so as a director of public health, I've got a statutory duty to be assured about this, and I'm not.

(DPH 07, South West, second interview round)

Learning how to manage the Covid-19 pandemic

Perhaps understating things, DPH 02 noted at their second interview (January 2021) that there has been (and still is) a 'huge amount to learn from this'. Adaptation to the circumstances – 'learning as you go' – has been constant for DsPH throughout the pandemic; it has also been the key to managing the local response to Covid-19. The DsPH described using some of their experiences in the first wave of Covid-19 to plan and guide the work of public health teams – although implementation was still hindered by short notice of changes in government guidance.

Learning from the first wave of Covid-19

When we first spoke to DsPH during the summer of 2020, most were experiencing a quieter period and valued our interview as an opportunity to reflect on the first wave of the pandemic. This was a period both to ensure they and their staff took much-needed annual leave to rest and recuperate, but also to plan, embed local contact-tracing and pilot-testing regimes, and support local colleagues to think about a forthcoming second wave. DsPH described tackling micro-level local outbreaks, for example in a particular neighbourhood or area, demonstrating positive joint working but also a relentless intensity of work. Maintaining the momentum and motivation of colleagues and local communities was sometimes challenging.

September 2020 and the reopening of schools for all children meant a rapid rise in cases, but the rise still felt surprising, even if now DsPH felt more prepared than at the start of the year. When we next interviewed DsPH in January 2021, just as the second wave was peaking, the strength of their local relationships was still



evident. They were also now using additional resources to support the Covid-19 response and noticing their effects – although the struggle to recruit was also a feature. What was also clearly demonstrated was their ability to use their deep local knowledge of their communities to co-ordinate the local response. While in the first interview round a common challenge had been lack of access to data, by January DsPH had more examples of using data to plan and support their response, for example:

- planning and preparing for rises in cases, particularly tracking school cases
- identifying testing and vaccine uptake in the community to target interventions
- having conversations to prepare themselves and leaders across the local system, both mentally and practically.

However, they were still not being informed in advance of government announcements, which hindered their ability to respond effectively.

One of the challenges throughout and still maintains a challenge is the broadcast from the podium, as it's been called, so the briefings where the announcements would be made, where local areas that were going to have to implement these announcements had no prior knowledge of them, no process necessarily set up to implement them and would expect it to just happen.

(DPH 06, London, second interview round)

DsPH also reflected on the challenges of keeping communities engaged and bought in to messaging even as cases began to fall.

It isn't just about getting it down, it's about keeping it down and we have to learn the lessons from December and make sure that everyone doesn't relax too much because this is our opportunity to keep things as long as possible, buy us as much time and get as many people vaccinated as possible. Alongside all of that is the vaccination programme of course.

(DPH 05, North West, second interview round)

Some DsPH acknowledged they did not have all of the answers in the earlier stages of the pandemic and they were learning as it took its course. With the benefit of



hindsight, they were able to pick out things that could have been done differently or actions that could have been taken earlier.

So would I have liked to have done other things earlier based on stuff that I didn't know at the time but know now? Yeah, absolutely. And they are the obvious ones like getting more PPE around and securing our own stock of PPE or putting stronger, clearer advice out to care homes at an earlier stage or rather not sending the same message 20 times in a slightly different way because it's difficult for them to understand. And some of the political conversations where there's been a balanced judgement [to make] about opening up before Christmas.

(DPH 05, North West, third interview round)

Other components of the local response that DsPH highlighted as crucial include:

- a testing strategy (including targeted testing)
- contact-tracing
- financial support for people who test positive to self-isolate, which is timely, sufficiently incentivises people and is easy to access
- strong communications
- community engagement
- partnership working at a local level.



4 The critical role of directors of public health as leaders

Key points

- Directors of public health (DsPH) were critical in leading the local response to Covid-19 and had a central role in influencing key decisions across their local authorities.
- The leadership style the DsPH adopted evolved over the course of the pandemic, demonstrating their adaptability.
- The increased profile of DsPH offered an opportunity to showcase their skills, expertise and themselves as leaders.

DsPH have been described as 'influential system leaders' ([Department of Health and Social Care 2020b](#)), and hold a varied skillset that spans beyond their statutory responsibilities of health improvement and protection. In a time of crisis, they have provided critical leadership to their local authority colleagues and to their local community in responding to the Covid-19 pandemic.

Pre-Covid-19 influence in the system

DsPH have a key role in protecting the health and wellbeing of local populations and have varying degrees of influence in their local system (Jenkins *et al* 2016). 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.

However, this has not been as common as it could, or should be ([Terry *et al* 2017](#)). The DsPH in our sample reflected that the roles and responsibilities of DsPH could have been better understood or acknowledged within the system and more



widely in national and public spaces. Partly this reflection may be attributed to the structural organisation and decision-making power across local authorities. The legacy of the 2013 wider system changes left DsPH exposed to holding a lot of responsibility but often without the management teams or resources responsible for delivering them (Jehu *et al* 2018). Prior to the upheaval in business as usual that Covid-19 brought with it, the DsPH 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 described the structure as more akin to a two-tier system of DsPH, where their role was positioned at a lower level, in some cases under other directors in the council, and they were further removed from the decision-making table. Yet, despite some DsPH being well situated to influence decisions, they too described challenges and the concerted effort they had to make to have their voices heard and to secure the public health agenda a place on the strategic radar among competing priorities. The directors' time in post and existing relationships with colleagues in the local authority and wider local patch played a role in the extent to which they were able to have influence in the system.

Covid-19: from the sidelines to the centre

...if before the pandemic we were like a, kind of, feisty start-up, now I think we are a think-tank engine room of the local authority and the local system.

(DPH 04, London, third interview round)

Gaining recognition and influence

The Covid-19 public health emergency catapulted DsPH and their teams into the epicentre of the response to it. In some areas, colleagues have described DsPH as a 'mini Chris Whitty within each local authority' (DPH 02, West Midlands, third interview round) as a result of their influence and expertise in leading the local response (Professor Chris Whitty being the Chief Medical Officer for England and the UK government's chief medical adviser). DsPH in our sample who did not usually sit on executive teams still described a high level of influence, partly through being brought into emergency structures and meetings and because of the increasing recognition of their role and unique skillset. DsPH described an intense



period at the beginning of the pandemic – and for several months thereafter – during which it was common for them to be called into daily meetings across different structures and committees. Some DsPH were called on to lead the local emergency response, including chairing the council ‘gold command’ meetings and the strategic co-ordinating group. They were often the first item on the agenda to share data, to help interpret the guidance being issued at a national level and to participate in, or lead, key decision-making about the local response to Covid-19.

I think the benefit of being director of public health and the chair [of ‘gold’] is that I could more or less, with colleagues’ support, say what I felt needed to be done and ask for their support, debate it and it would get done. So, I think it was the benefit of both having the knowledge, sharing it with colleagues who may have the workforce or... may have the finances, clearly with some of the grants we did have, to make it happen.

(DPH 06, London, first interview round)

However, the DsPH reflected that the level of their influence varied across different local authorities. For DsPH who were not on the executive leadership team, their access to other council directorates was more limited. While the pandemic gave them greater influence and access than they had before, such as having a direct line to the chief executive, the DsPH questioned whether this level of influence in their local system would continue after the Covid-19 pandemic. One director of public health (DPH) newer to their local area reflected on the relationships that had been built across the council and considered whether they would have built such broad relationships had the pandemic not necessitated it. Similarly, DsPH who already sat on their executive teams also spoke about whether other DsPH in a different position in their organisational structure would have had quite the level of autonomy that they did.

It’s been clear to me that we can have a very, very, powerful voice, and that... isn’t quite like the normal corporate voice.

(DPH 04, London, third interview round)

In addition to a greater understanding of the skills and capabilities of DsPH within their local authorities, the public’s understanding of public health has grown over the course of the pandemic. The directors’ heightened public profile among their local communities partly stemmed from the increased engagement and support



activities they had been directly involved in. At times, DsPH described how being the public face of the pandemic response was exposing, particularly when receiving pushback from their communities; and this could be uncomfortable at times.

...people don't see you as a person, people see you as a job. And actually there's no forgiveness, I think, if you're not there, the very fact that the media would criticise the DPH for... having two days off during an outbreak that was likely to run 28 days.

(DPH, Scotland, first interview round)

However, this wider awareness of public health and the trust DsPH had developed with their local populations aided communicating public health messages and 'myth-busting'. A DPH in the north-west of England described their approach as focusing on the 'hearts and minds' of the public, and bringing communities along with their strategy, making the case for the proposed action, not imposing a 'top-down' approach on what they should or should not do, and being honest with the public. As one voluntary and community sector (VCS) leader in Area 10 reflected, the actions of the DPH in engaging with the community, unlike previous attempts by other parts of the local authority, were not perceived as a 'tick-box activity'. The leader praised the conscientious involvement of their DPH in developing an 'organic', community-led approach. It had opened up opportunities for the DPH to support and influence their local populations better.

Making difficult decisions

The shift in recognition of directors' unique skills, relationships and expertise brought opportunities to influence and lead pieces of work locally – and in spaces they previously had less opportunity to directly influence or be at the forefront of decision-making. For example, DsPH spoke about working with the local VCS around mobilising foodbanks, about facilitating conversations about reopening schools, universities and leisure centres, and about the safety and testing procedures for sporting events.

I've never remotely been in a position where you can do that, you're operating from such a place of political and moral authority to be able to call on people's resources in that way.

(DPH 04, London, first interview round)



With the doors having been opened wider for DsPH to have influence, this facilitated a collaborative environment in the local authority – not just DsPH ‘knocking on their door’. A number of decisions and actions could be taken with less bureaucracy, which enabled DsPH and their teams to work, and make difficult decisions, at pace.

I've been able to direct that pandemic response and call on any resources I want and my chief exec was very clear to me as chair of [the] silver [tactical arm of the strategic co-ordinating group]... you just need to tell people what you want them to do and they'll do it, you don't need to worry about it, just go and tell them what you want to do, and that's absolutely the approach I took, and by and large it's worked exceptionally well.

(DPH 05, North West, third interview round)

However, decision-making in responding to the pandemic has been challenging for DsPH at times. Some also spoke about having to make decisions that were unpopular, or described how it was their role to ‘hold’ the tension around decisions that could have negative impacts or unintended consequences. For example, in one area (the identity of which we are deliberately not indicating) the public health team produced guidance about care home visiting in order to prevent Covid-19 infections and mortality. As the number of cases ramped up in the autumn of 2020, the public health team launched a series of new interventions. As part of this plan, the DPH had recommended, in a letter to care home managers, to suspend care home visiting. This local guidance, however, came at the same time as a national campaign against loneliness. The DPH received pushback and criticism from local residents as they saw the plans as exacerbating the isolation of care home residents. The local guidance was then revised after the announcement of national guidance from the Association of Directors of Adult Social Services and the Department of Health and Social Care, which included a risk assessment tool. The DPH reflected that the guidance was broadly similar in approach anyway, but, in the eyes of some local people, it was the public health team and the DPH who were at fault.

We put it [the guidance on care home visiting] through a whole range of different governance structures. We went through the infection prevention cell, it went through the silver, it went to gold, [the tactical and strategic arms of the strategic co-ordinating group] so we all had lots of discussion about it, and at no point, I think because we were so internally focused, had anyone clocked this massive...



public campaign against loneliness and isolation in care homes. But we were still thinking about, 'we must preserve life', because we've lost so much life. So then we went and produced this plan and all hell broke loose... It was like we'd just unleashed this massive can of worms.

(DPH)

In Scotland, the DPH described the impact of the government decision to make DsPH responsible for care homes there. They were struck by the significance of the decision, which came with relatively short notice.

[I then had the] understanding that [the decision had] big implications in terms of care homes, [which] were having outbreaks and unfortunately deaths, but knowing then as a result of that, we were being held to account, we'd have to answer to the public inquiry – it was quite a big responsibility to be put on directors of public health.

(DPH, Scotland, first interview round)

Another example of decisions where DsPH have held the tension is the 'trade-off' between 'business as usual' and protecting the community. For example, a DPH spoke about influencing difficult or unpopular decisions around reopening businesses. They talked about advocating for a slower, more cautious approach and needing to resist pressure locally to reopen businesses and shops that had been closed during the second national lockdown.

DsPH have often found themselves as the 'arbiter' of national policies or government guidance on Covid-19, even when they came at late notice, had not involved people at a local level and were difficult to implement. For example, one DPH recalled a discussion with an official from the Cabinet Office about the roll-out of home-testing kits to employers and why it appeared that there was low take-up of the offer. The DPH felt there was little notice given to businesses to register and order free home-testing kits for their employees. With no publicity or campaign to back up the drive to register, only a relatively small proportion of businesses in the DPH's area had been able to sign up before the deadline. While DsPH emphasised the challenges of working in an environment of short notice and rapidly changing guidance from the national level, the DsPH spoke in earlier interviews about how this had facilitated closer system working.



One DPH also pointed out the challenge of being tasked with planning for recovery from Covid-19 when there were multiple issues that needed immediate attention too. It is practically difficult both to lead on all things (although DsPH often acknowledged the strong support they had from deputy DsPH and members of the wider public health team) and to prioritise different plans with so much uncertainty about future stages of the pandemic.

DsPH also frequently cited the importance of the support of their chief executive – backing them on difficult decisions and helping to mediate relationships with other colleagues across the local council where necessary, as well as looking out for their personal and professional wellbeing. In Wales, the DPH described the support of their chief executive and other executive members of the health board as helpful, and that they had an understanding of the pressures placed on public health teams. The DPH described how the members were prepared to smooth the path for DsPH to implement critical parts of the response to Covid-19.

I felt that I then had chief executive backing so that if people were asking me to do stuff within the organisation, I could say, no I've agreed with my chief exec, we are not doing this.

(DPH 11, South West, second interview round)

And then the... sheer ambition in our organisation. So our chief exec, collectively with the chief execs of the two local authorities... And I'd framed it actually [as] let's vaccinate the adult population as quickly as we possibly can. But the ambition of, you know, let's be in a position to deliver that really, really quickly if vaccine supply wasn't an issue. And so our chief exec also brought our director of transformation in to lead a piece of work... around what would it look like if we were able to do this.

(DPH, Wales, second interview round)

Demonstrating different leadership approaches

I think [it's] a situation where you need that leadership and people to make decisions, not talking about what we might decide to do.

(DPH 06, London, first interview round)

The DsPH have demonstrated adaptability and resilience through their leadership style during the pandemic. Having previously adopted collaborative and distributive



approaches, some DsPH found they needed to tailor their leadership to meet the demands of the crisis. In the early stages of the response (March to November 2020), some DsPH felt that an authoritative and decisive approach to leadership was a necessity.

...to be a good leader, you've got to be able to flex your leadership style.

(DPH 07, South West, third interview round)

This shift in approach was partly attributed to the DsPH themselves feeling the need to 'front' the response as part of their statutory duty for health protection. In some cases, a command-and-control approach was adopted to assure colleagues, both in their public health teams and in the council, that someone was taking control over an unprecedented and unpredictable situation. For example, in the south-west of England, the DPH chairing the strategic co-ordinating group instead of the usual chairing by the police was seen as the 'right approach for being a public health crisis' (Area 07, local leader). While this approach to leadership was generally well supported in local areas, some local leaders expressed alternative views, suggesting that delegating some of the tasks the DsPH were holding may have been more effective both in responding to Covid-19 and for the directors' own welfare and resilience.

Fostering resilience

No matter how well trained you are, none of us have been in a situation where a crisis has gone on so long. But also, make sure that you're protecting the resilience of your team as well, because if you fall, they'll fall, and if they fall, you'll fall.

(DPH 11, South West, third interview round)

Over the course of the pandemic, the DsPH were able to reflect on themselves as leaders. The leadership approach they took evolved as the local response did. Some DsPH recognised the need to revert their leadership style from a predominantly command-and-control approach (in earlier months) to more distributive and collaborative approaches (in later months). They highlighted the importance of having a strong team with different skillsets around them to support them and help fill gaps during the response. In part, the gradual change was recognised as a move to support their own resilience, noticing the unsustainability of approaches where the DsPH held all responsibility.



The resulting distributive leadership saw DsPH attempting to mitigate workloads by dispersing activity, drawing on the skills and expertise of other parts of their teams and mobilising the system to lead on aspects of the response work. There were several examples of DsPH intentionally allocating areas of work to staff who complemented the team members' interests and expertise as well as to provide them a development opportunity. Another route was borrowing staff with particular expertise or transferrable skills. For example, in one area, the director of culture led on the local community testing initiative because of their expertise in hosting events. In another area, the director of children's services led the work with schools. Environmental health staff, who already knew about contact-tracing for food outbreaks, were brought in to hold responsibility for aspects of this stream of work, and leisure staff were given additional training to provide extra capacity for contact-tracing.

The DsPH also demonstrated adaptable leadership approaches in how they ensured the welfare of their teams. Almost all the DsPH expressed concern for their team's welfare, describing how they were attempting to mitigate the pressures they and their team were experiencing. The DsPH facilitated this in various ways, including creating opportunities for their team to connect with each other about wellbeing, modelling self-care, encouraging staff to take breaks or bringing in external psychological support. However, despite these efforts, some DsPH felt they had not been as available to their teams as they would have liked at a time when their teams were stretched. They expressed pride in the work their teams had achieved and the resilience they had demonstrated.

Learning while leading

I think if ever there were any remnants of imposter syndrome left after six years in DPH, I think it's probably gone.

(DPH 07, South West, third interview round)

The directors' perceptions of themselves as leaders strengthened as they grew in confidence throughout the pandemic. One DPH in the Midlands described the DsPH who have led through the pandemic as a 'new breed of DPH that have been battle tested through [Covid-19]' (DPH 10, West Midlands, second interview round).



It was notable that DsPH have learnt about the value of partnerships and collaboration during the pandemic.

...you don't have to do everything, would be my other lesson I think, in that other people have taken things on and really run with it, but with any form of delegation or... you've got to trust them, and that I think comes back to the relationships.

(DPH 07, South West, third interview round)

The DsPH spoke about the value of learning from other DsPH. When seven of the DsPH came together in a virtual focus group discussion, the sense of camaraderie and shared experiences of Covid-19 was palpable even through a computer screen. Many DsPH are in formal or informal networks with each other and the pandemic, through social media and other forums, has provided rich grounds for learning from each other in real time.

I have to say, also, just finally, thanks to [DPH 04], because I... totally ripped off what [DPH 04] was doing over the summer, when [they] very kindly shared it. And that's one of the things that has been amazing over the last year, is whenever one of us has broken new ground, we've just pinged it round. There's been none of this protectionism, it's been, great... share it with everyone. We've all slightly tweaked it, built on it, and we keep sharing. We've never had that in public health before, it wasn't like that before Covid, you know, I think we were a much more tribal group, and I think that [sharing] is going to be fundamental to this next phase, moving forward as well.

(DPH 10, West Midlands, focus group discussion)

The strength of these networks of DsPH, whether existing or new ones built out of the pandemic, was important not only in giving DsPH a collective and unified voice in communicating messages and encouraging national bodies to allocate resources to them, but also in supporting each other's wellbeing.



5 The role of relationships in responding to the Covid-19 pandemic

Key points

- Strong, broad-ranging local relationships have been critical to the pandemic response. These need continued investment, with particular attention paid to the engagement of voluntary and community sector (VCS) stakeholders to be most effective.
- The pandemic has presented opportunities, with partners willing to work across organisational boundaries. This has enabled the building of wider relationships across a system, or enhanced joint working at the regional level. These budding relationships should be nurtured into the future to address the future challenges that the pandemic presents.
- The relationship between local directors of public health (DsPH) and the Chief Medical Officer has the potential to mitigate some of the longstanding barriers to relationships between the national and local levels. As the public health reforms move forward, maintaining and strengthening this link is important to provide critical feedback to national organisations of their impact at the local level.

There was no question around what your organisation was, what your department was... whatever your normal day job was. It was actually how can we come together and respond to this collectively? And actually that's not just as organisations, I think that was the community as well.

(DPH 08, North East, third interview round)

The impact of relationships and resources on the local pandemic response was a key theme throughout our conversations with DsPH. How DsPH built, maintained and strengthened their relationships in their local systems, made best use of Covid-19 funding grants and managed uncertainties around their yearly budgets



were vital aspects of their work, but also revealed common issues across areas that challenge some of the assumptions in the national response.

A major – and perhaps obvious – piece of learning from our study was the importance and power of relationships in responding to the pandemic. This theme recurred across the groups of people we spoke to: DsPH and local and national-level leaders. Through interviews with DsPH and local leaders in particular it was clear that relationships acted as both a barrier and an enabler of the local public health response to Covid-19. The nature of relationships also changed and shifted over the course of the pandemic. While the previous section focused on the ability of DsPH to influence and thus focused primarily on their relationships within their local councils, in this section we explore how relationships between DsPH and other stakeholders played out over time and across three different levels: local, regional and national.

Local relationships

The power of relationships within a local area, and the strength of these to facilitate an effective response to the pandemic, came through consistently from the start of our conversations with DsPH. Whether new to a system or established in their local area before the pandemic, DsPH paid attention to these relationships. They described various ways in which they had built or strengthened them throughout the pandemic, including frequent conversations to get to know people or share information, and identifying the right people for particular work and trusting them to do it.

Our two ‘deep-dive’ sites provided a broad perspective on how local relationships had worked during the pandemic. They were very different areas with very different contexts. Area 10 was an urban area with complex overlaps between different organisational boundaries, and a history of challenging circumstances and relationships, in particular in the local authority. These had been acknowledged in recent years and were improving before the pandemic hit, but Covid-19 meant a need and an opportunity to test and deepen system relationships. The clinical commissioning group leader highlighted the work their relatively new director of public health (DPH) had done locally to rebuild relationships between public health and the NHS before and during the pandemic after public health had ‘got lost’ in the 2013 reforms. More broadly, local leaders acknowledged the history



of challenging circumstances, but they also described the DPH's particular ability to build relationships across sectors and with local communities. While some of this work had started before the pandemic, the impact of Covid-19 had been to accelerate and highlight this work.

You know, it's been actually a very difficult two years or so, in the build-up to Covid, making some of those changes; and the same is true for all of our partnerships. We've done a huge amount of work in the city on partnerships... And, I think all of that has been put in place in advance of Covid and we've really benefited from the dividend of that.

(Local system leader, Area 10, first interview round)

Features of these positive working relationships included honesty and openness, the ability to disagree and challenge but still work to the same shared purpose, and taking time to learn about and be empathetic to different communities. Political tensions were not frequently cited here, and leaders talked about the work they had done to 'get that balance right' around open communication and role definition while officers held emergency powers and politicians had to support and work alongside them.

Statutory sector leaders frequently highlighted the strength of local relationships and how they had enabled these, for example including a broad range of local leaders (including business representatives) in their local emergency structures to facilitate and strengthen partnership working across the local area. They also described how the DPH prioritised investing in community engagement during the pandemic. However, the local VCS leader we spoke to in this area gave a slightly contrasting narrative. While they valued their relationship with the DPH, other relationships with the council had felt like a tick-box exercise, uncoordinated and with a poor understanding of the community and its particular needs. They also highlighted a contrast between statutory and voluntary ways of working – with unpaid volunteers not constrained to nine-to-five ways of working, but struggling to communicate effectively with statutory sector staff and to operate under processes that were less flexible. More broadly, there was a sense that the community this leader worked with had been overlooked long before the pandemic, and so had low expectations and low levels of trust, and perceived solutions offered as being short term or not targeted at the underlying issues.



Area 07 was a mostly rural area with largely coterminous system boundaries, longstanding, embedded relationships and a well-established DPH. The system was 'used to' working together across organisations. Local leaders consistently highlighted these pre-existing mature and strong system relationships (across the police, the fire service, the local authority, the health service and the VCS) as vital to facilitating joint working during the pandemic. One local leader described how they had recognised early on the need to pace themselves in relation to the multi-agency meetings that were central to the Covid-19 response: 'We quite quickly did start to manage the battle rhythm and our own health and wellbeing so that we could keep it sustainable for the long haul.' They cited their shared vision and aims as a reason why, even with challenging conversations, they still worked positively together. Leaders recognised that part of what enabled their close relationships was the scale and context of the local area – a single DPH, and most of the statutory services sharing the same system boundaries. However, they had also developed inter-agency ways of working before the pandemic (for example, joint appointments between the clinical commissioning group and the local authority), which supported closer working relationships. Even so, they also highlighted how the level of close working during the pandemic had strengthened their partnership working.

We're a very simple system... It's all very neatly coterminous which really, really makes a huge difference... so as a health system we are used to working together collaboratively, so I think if you weren't in that sort of situation it would be difficult because you've got to build those relationships and relationships are absolutely key to making it work. And we had those relationships all well embedded across [Area 07] already.

(Local system leader, Area 07, first interview round)

They modelled some of their joint working during the pandemic on pre-existing arrangements, including sharing staff across organisations, and a jointly run service supporting influenza vaccinations that they repurposed for the Covid-19 vaccination roll-out. A key example of multi-agency working was of access to personal, protective equipment (PPE) at the start of the pandemic. Co-ordinated by the strategic co-ordinating group (which the DPH chaired), the fire service and the clinical commissioning group had worked together to ensure local health and care workers had swift access to PPE. There were challenges however – when local



organisations faced particular strain, leaders described a tendency for retrenchment and a focus on organisational rather than system accountabilities. The local political context also created challenges for the DPH, which other leaders supported them to negotiate. There was also room for improvement regarding VCS relationships. Area 07 had experienced a loss of community engagement capacity as council spending had reduced over the previous decade. The DPH described having to restart that engagement ‘from scratch’ with the support of the local VCS, while the VCS leader described a reactive rather than proactive approach to dealing with issues that arose initially. While they also described significant involvement during the pandemic, the VCS leader felt it had taken the crisis to really allow the statutory sector to view the VCS as a crucial part of the system, and they still did not feel as involved at the design phase as they were in the delivery phase.

These accounts demonstrate the complexities of local relationships, even in systems that view their joint working as good. In particular, in both sites the DsPH described their commitment to – and the significant time and resources they put into – community engagement, both directly and through their local VCS organisations. This was also a feature in our interviews with other DsPH, including those who played a leading role in overseeing and facilitating voluntary sector partners to lead the community response, and in work involving a joint effort between the local authority, the fire service, the police and the VCS to connect to local communities during the early stages of the pandemic. The challenges that the local VCS leaders in our deep-dive sites raised, however, highlight the complexity of this work and aspects that are beyond the control of DsPH, for example wider commissioning processes. As we have seen in previous research ([Weaks and McKenna 2015](#)), meaningful VCS engagement requires not just individual effort and good will but also sustained system-level commitment and attention.

Another vital aspect of local relationships, seen in the deep-dive sites and described by other DsPH we interviewed, was understanding and collaborating around a shared vision or goal and recognising the different contributions that individuals and organisations could make. The DPH or another senior leader could set out the vision, but consensus was key. However, there were also questions about how to embed this for future work. ‘All this stuff takes investment, you know, time, resource, mutual understanding’ (DPH 05, North West, third interview round).



As the pandemic progressed, we continued to hear positive examples of the strength of local relationships and how they enabled the response to the pandemic. For example, one DPH worked with universities on the testing of, first, their own students and, later, local school staff to facilitate the reopening of schools in January 2021 (although the national government then delayed schools' reopening). Another built relationships with local businesses in the hospitality sector to increase their preparedness for and amenability to the Christmas restrictions and third national lockdown. A third described a new apprenticeship scheme for young people in their local area, designed to provide options on leaving school in the predicted poor economic context ahead, which placed them in statutory organisations across the system.

Covid-19 vaccination programme roll-out and relationships

The Covid-19 vaccination programme roll-out provided another insight into some of the strengths and limitations of local relationships. The early days of the roll-out coincided with our second interview round. As an NHS-led initiative, the extent to which DsPH and local authorities were involved varied, but their engagement (or lack of it) made a difference. One example was the practicalities of making available a local authority site for an area's main vaccination centre. One DPH described this positively; for another, only the area's strong local relationships had prevented a clash over whether a local site would be used for a mass testing centre or a vaccination centre, because there had been no formal co-ordination on this issue. Similarly, while some DsPH described being left out of vaccination planning and information sharing, in one area the DPH and local clinical commissioning group leader made a decision to work outside of the NHS England and NHS Improvement guidance to share data on local vaccine uptake. This implied a strong level of trust between the two, but the work it enabled led to significantly improved local uptake rates, particularly in areas where initially uptake had been low. There were also examples of tensions between staff in NHS and other statutory organisations because of national decisions about prioritisation. These varied experiences with the vaccination programme highlight the potential for improved working between NHS and local authorities as well as issues that still need to be addressed, such as data sharing across a local system.



While DsPH frequently pointed to good local relationships as a stand-out feature of the pandemic response in our final interview round, inevitably they also raised several challenges to this way of working across the interview rounds. Keeping people engaged and maintaining momentum in the face of uncertainty and frequent changes were a continuing concern in the last two interview rounds. DsPH also had to negotiate the local politics and manage their relationships with local politicians. This latter task featured more heavily for some DsPH, as indicated by the deep-dive sites. It related not only to the pandemic response, but also to wider political concerns such as the overall political make-up of the council and its relationship to national political leadership, and the impact of upcoming local elections. The complexity of these relationships within areas, and the need to give them sustained attention and investment, also resonated with the complexity of relationships beyond local areas.

Relationships at the regional level

Most of the DsPH discussed having strong pre-existing relationships with regional partners – Public Health England, neighbouring DsPH and city-region or other combined-authority arrangements – based on years of working together and getting to know each other. For some, these relationships were rooted in joint working across combined local authorities or geographical patches. In such areas, the DsPH spoke about the existing structures in place prior to the pandemic, such as sharing local resilience forum footprints and emergency planning teams.

When we have our regional DPH, ADPH [Association of Directors of Public Health] meetings, which, pre-Covid were once a month, at the moment are three times a week, and have been more at other points. PHE [Public Health England] are part of that call, you know, that's kind of how we work. So... I guess, people say, once you're in the North East you stay, so we know each other really well.

(DPH 08, North East, focus group discussion)

Over the course of the pandemic, by and large the DsPH felt that relationships at the regional level had strengthened and partners had been drawn closer around areas of common interest. DsPH made this observation as early as the first interview round. For example, DsPH worked with their counterparts in their regions



to develop local outbreak management plans for care homes, schools and the wider community, and to share intelligence and data; this was not deemed to be as effective between national and local levels.

Similarly, DsPH were generally positive about their relationships with the regional Public Health England departments in the earlier stages. In their final interview, DPH 07 described the regional Public Health England as ‘phenomenal’, having shared data with local public health teams and ‘facilitated brilliant partnership working’. (These relatively good working relationships and data sharing at the regional level contrast with what we describe later on regarding relationships with national bodies.) One of the regional directors at Public Health England spoke about regularly connecting with DsPH in the region to share information.

We have the weekly Friday meeting, which is a sort of touch-base, end-of-the-week review, what are the hot topics for this week, what’s coming up next week... We have people coming in and briefing from the Department [of Health and Social Care], from [NHS] Test and Trace, on particular policy initiatives. We work closely with the Association of Directors of Public Health [ADPH] network, and the chairs of the ADPH [regional] network meet with us as leaders in PHE [Public Health England region] on a fortnightly basis.

(Regional director at Public Health England)

The same regional director talked about using their influence and relationships, when cases of the Beta variant of Covid-19 were rising in the region, to speak to local authority chief executives about the support that DsPH would need in carrying out surge testing. They also asked chief executives to contact them directly if they had any concerns about the process of surge testing, instead of putting pressure on DsPH during an ‘intense time’.

However, positive working relationships with regional Public Health England departments were not a universal experience for the DsPH we interviewed. As the pandemic worsened, one DPH described the regional team as becoming ‘overwhelmed’, meaning DsPH in the region had to take on a larger role in health protection when they were already stretched.



Covid-19 had also provided the opportunity to reinforce and enhance some regional relationships with partners sitting outside of public health – potentially setting the stage for future collaboration as we move into the next stages of the pandemic.

Relationships with national bodies and government

The role of DsPH requires them to work with various other organisations including a number at a national level, for example Public Health England, the Department of Health and Social Care, NHS England and NHS Improvement, the Association of Directors of Public Health and more. Throughout the course of the pandemic, DsPH have needed data on Covid-19 incidence and vaccination and various pieces of guidance. They have also been required to relay local data and intelligence to national bodies.

However, during the first interviewing round, DsPH described having a largely one-sided relationship with government, Public Health England and the Department of Health and Social Care. They felt that the national leadership of the pandemic, based on a ‘command-and-control approach’, left little opportunity for DsPH to have an input into decision-making and policies that would have implications for local implementation, such as DsPH being made responsible for testing in care homes or mass testing in the community but not necessarily having the mechanisms in place that were needed. The fast-moving pace of national decision-making and announcements that came at short notice compounded this, with local public health teams having to mobilise quickly to implement plans and deadlines that felt imposed and unrealistic – what DPH 06 noted in their first interview as being the ‘disconnect between the media headline and then everyone having to rush and try and get it in place’. This was also sometimes at odds with local decision-making and plans about contact-tracing or the reopening of schools.

The experience of disconnect between announcements and guidance from central government resonated with the DPH in Wales we interviewed. They reflected that sometimes there was a wait for specific guidance from central and devolved-nation governments. Regarding planning for health protection in care homes, they said: ‘One of the challenges was, it was just highly political, and just a really difficult arena. And, you know, often we would wait for guidance before we would put



different approaches in place, but sometimes the ministerial announcements were four days before the guidance came out' (DPH, Wales, first interview round).

However, this also indicates part of the adaptability and innovation that DsPH have had to demonstrate in response to short-notice and rapidly changing guidance from the national level. While DsPH emphasised the challenges this created, we also heard early on how this had facilitated closer system working. 'It has led us to... and maybe that is one of the things that helped us pull together as a system more actually in the lack of the kind of, the national support, has meant that, as a local system, we've worked much closer together to fill the gaps' (DPH 05, North West, first interview round).

DsPH expressed frustration about their lack of 'voice' or influence at a national level, particularly during the earlier stages of the pandemic. Adding to that, they said that it felt insulting for the then Secretary of State for Health and Social Care to mistakenly refer to the role of DsPH as 'a relatively new invention' created out of the Health and Social Care Act 2012 when the role has existed for many years and it was Public Health England that the Act created. However, in the same speech in April 2021, the Secretary of State acknowledged the 'absolutely invaluable role' that DsPH have played during the Covid-19 pandemic and will continue to play in the future ([Hancock 2020c](#)).

Most DsPH in England acknowledged that there was an attempt to strengthen the local-national connection through the weekly teleconferences with the Chief Medical Officer for England. They described this as a way to obtain information although there were still some constraints around what data could be shared and also the extent to which the Chief Medical Officer could make decisions as opposed to advise the government. The calls were also an opportunity to speak candidly about challenges in a relatively confidential space – even if DsPH did not always get sufficient airtime (given the number of other DsPH on the call) or the outcome they desired. A national leader at Public Health England noted that the relationship between the Chief Medical Officer and local DsPH has never been as close. DsPH have also been positive about the work of the Association of Directors of Public Health to raise the profile of DsPH and communicate with them on Covid-19 guidance. 'The previous chief medical officer did meet them [DsPH] annually, but the current chief medical officer meets them weekly, and has always been clear that



they're a very important part of the, kind of, public health jigsaw' (national leader, Public Health England).

Similarly in Scotland, the DPH described the importance of establishing a communication channel with the Chief Medical Officer there and how regular two-way discussions were key.

But actually it's the communication bit I think is really, really important. And my early... [in] those first two or three weeks, my early learning was give heads up to the CMO [chief medical officer] who represents public health in Scotland government discussions, so they're clear about what's happening. And that if they need to have conversations with you, they can.

(DPH, Scotland, first interview round)

Over time, there were some signs of improvement in the relationship between DsPH working at the local level and those working at the national level in the Covid-19 response. This likely coincided with better recognition of the important role of the local public health system in responding to the pandemic at all levels. At their second interview, DPH 05 reflected that relationships with civil servants and the Department of Health and Social Care were positive and that being 'very upfront' about working with them and sharing learning from community testing had helped build those connections, although they added that the 'trick' would be maintaining those relationships when politics get in the way. It was also evident in our second round of interviews that there were still concerns about DsPH not being involved in key decisions affecting their work, such as not having sight of the criteria for the tiering system in place in autumn 2020.

The government did make funding resources available to local public health teams and that eased some of the difficulties they were experiencing, although as we go on to describe in the next section, the extra funding for Covid-19 was a temporary fix for a much wider problem in public health.

The cash was great, first time in my career as a director of public health I've actually had some money to spend, rather than having to cut services. So, a test-and-trace grant was very welcome. That felt like we'd been listened to, that they'd heard us, that felt really good.

(DPH 07, South West, first interview round)



6 Resourcing the local response to the Covid-19 pandemic

Key points

- In the context of a decade of austerity, short-term funding offers – while welcome – cannot solve underlying issues such as a lack of appropriately skilled capacity in the available workforce. As well as direct money to directors of public health (DsPH), there needs to be sustained investment in developing the workforce to support recovery from the Covid-19 pandemic and future pandemic responses.
- DsPH are well positioned to know the needs of their local areas. Consulting with them, or giving them greater autonomy in using the funding offered, would allow them more flexibility to meet the needs of their local populations rather than simply satisfying the criteria of the grant.

What this has shown is that we – as directors of public health that are driven by population need and by values and with that cross-cutting mentality – can achieve a lot if we're given the sufficient resources.

(DPH 04, London, third interview round)

The Covid-19 pandemic has brought longstanding concerns about resources for public health into sharp relief. As discussed in section 2, since 2014/15 the purchasing power of the public health grant has fallen significantly, while broader local government finances have been shrinking since 2010. As the first wave of the pandemic receded, resource concerns were high on the agenda: whether the resources for the Covid response were enough to cover the actual costs; financially challenged local authorities having to closely scrutinise what was spent; and limitations on work (beyond the Covid-19 response) or specific parts of it (such as translating resources into different languages).



However, the pandemic has also created an unprecedented context for doing things differently. When we first spoke to DsPH in summer 2020, we heard examples of improved influence leading to greater mobilisation of local authority resources for tackling inequalities. There were also glimpses of how broader collaboration across organisations and departments could work differently when ‘who pays’ was not a barrier in the urgent need to act – for example getting people out of hospital and into care homes quickly. We were also told about local areas pooling some of their resources with neighbouring authorities in order to more efficiently manage things like test-and-trace capacity.

This contrast – on the one hand, ongoing resource concerns; on the other, new opportunities – was a continuing and deepening theme over the nine months of our fieldwork.

Starting points

The impact of the past 10 years – the context of austerity in local government and the reforms that located DsPH within local government – was a recurrent theme across the accounts that DsPH gave. We heard about a loss of money, and of capacity and capability, in several relevant disciplines: emergency planning, health protection and community engagement. This was not a universal story – in one area, the director of public health (DPH) described how work undertaken in their local authority to prioritise community engagement before the pandemic meant there were already established networks and ways of reaching different parts of the local community. However, for most, this wider disinvestment and loss of connections to community groups had several consequences. DsPH were on the ‘back foot’ entering the pandemic and in some cases had to ‘start from scratch’ to build up the community engagement they needed to spread vital public health messages. Teams were already under pressure with reduced staff to manage their business-as-usual work. Additionally, new asks, for example around health protection, did not always come with the resources to back them up.



Covid-specific funding

Central government financial support to the economy and public services throughout the pandemic has been unprecedented. By May 2021, the government was estimated to have spent more than £372 billion on the Covid-19 response, with more than £95 billion spent on health and social care ([National Audit Office undated](#)).

A key development during the pandemic were the various un-ring-fenced ‘tranches’ of funding that central government made available to local authorities to mitigate losses in income, such as the collapse in business rates due to the shutdown of the economy, losses related to council tax and commercial income, and to support the additional costs for the Covid-19 response. The National Audit Office reported specifically on the support to local government in March 2021, estimating up to that time, additional cost pressures on local government of £9.7 billion, attracting additional resources from central government of £9.1 billion ([National Audit Office 2021](#)). As part of this, by the end of December 2020, almost £1 billion had been committed for the Contain Outbreak Management Fund, allocated on the same proportionate basis to areas as the 2020/21 public health grant.

The Contain Outbreak Management Fund, intended to support test, trace and contain activity ([National Audit Office 2021](#)), was of particular relevance to DsPH – as well as other, smaller pots of money such as the funding for Covid-19 communications with at-risk groups ([Ministry of Housing, Communities and Local Government 2021](#)). DsPH have made the most of this short-term or emergency funding while it has been available, and they said it has been unusually ‘easy’ to get funding for Covid-related activities. There has also been flexibility for DsPH to use this resource as they saw fit (but this has not always been the case, as discussed below). DsPH gave various examples, including:

- using additional money for public health to increase the size of their team
- using agency staff to support the local testing programme (enabling them to bypass a lengthy recruitment process)
- building local test-and-trace capacity
- investing in the local voluntary and community sector (VCS) through ‘straightforward’ grants that could be easily accessed and through locality networks.



However, this funding was not always straightforward to get hold of – or sufficient or flexible enough – for the work DsPH felt was needed. There were concerns that the approach was not sustainable. ‘We also need to see people as whole people. And I think again the way funding comes down doesn’t really enable us to do that’ (DPH 08, North East, third interview round). Also, DsPH were not always in the right position in their local authorities to influence decisions about where money was spent. This was linked both to their formal position in the local authority structure – whether part of the executive team or one step removed – and to their more informal influence and length of relationships. One DPH described being the lead officer in their council for additional Covid-19 funds, contrasting this with examples of less well-established DsPH who had had to access these funds via their chief executive. Similarly, DsPH frequently highlighted concerns about how funds were made available from the national level – including concerns about seemingly ‘random pots of money’ or requirements attached that limited flexibility. They were keen to use the money in the most effective way for their communities, but felt hampered by the grant restrictions.

The funding made available for Tier 2 weight management services, announced in March 2021 ([Department of Health and Social Care 2021a](#)), was a key example of this and a recurrent topic in our last round of interviews and in the focus group discussion. Tier 2 weight management services are those delivered by local community weight management services and commissioned by local authorities, as opposed to Tier 1 (delivered by local public health and primary care) or Tier 3 (commissioned by clinical commissioning groups) ([Obesity Empowerment Network undated](#)). The Department of Health and Social Care made this funding available in response to growing evidence of the link between more severe Covid-19 illness and obesity. However, DsPH described it as ‘random’, and an additional task coming in the context of still an intense workload relating directly to the pandemic. They also raised concerns that it was unrealistic in its aims, as well as not being well targeted at the people who are most in need locally – one described food poverty being a bigger issue than weight management in the immediate term.



Sustainability of additional resources

The amount of one-off monies that's getting thrown at us is unbelievable, and I can't find a way to spend one-off monies. And obviously, it takes time and resource to find a way to spend one-off monies. So it's not a solution. It isn't even a sticking plaster. It creates a problem.

(DPH 05, North West, focus group discussion)

In the context of a long period of funding reductions, 'one-off' money was widely seen as unsustainable. DsPH made it clear to us that one-off or non-recurrent funds were not a long-term solution. This kind of funding 'forced' short-term thinking and made it very difficult to plan into the future, creating uncertainties. This was a lesson that some DsPH felt did not seem to have been learnt. There was also a time and resource element to working out how to spend a pot of money – which could in itself create challenges. Short-term funding limited a public health team's capacity and their ability to retain staff (due to the precarity of short-term contracts), as well as requiring available workforce capacity to spend it on. DsPH were concerned about the impact of spending one-off money and the potential for harm rather than good due to raising expectations.

A further impact has been the lack of time and resources to focus on 'business as usual' and non-Covid-related business. 'Everything else apart from Covid has been deprioritised because we haven't got the resources to do anything else' (DPH 02, West Midlands, first interview round). In particular, in the second- and third-round interviews, several DsPH were flagging unmet need in relation to rising mental health need locally and widened inequalities. This highlights the need to remember that while Covid-19 is a serious threat to health, it is far from the only threat that DsPH need to have on their radar, and there is a significant risk that DsPH have not had sufficient 'bandwidth' or resources to address or plan for this.



Workforce capacity in public health teams

In some ways, the money has created challenges for us because actually what we really needed was people resource, and no amount of money actually allows you to be able to recruit that. If the people aren't there, the people aren't there.

(DPH 11, South West, third interview round)

The DsPH we spoke to were responsible for teams and budgets of varying sizes. All had increased their team size during the pandemic (by either recruiting new staff or redeploying existing local authority staff, or a mix of both). Additional funding available through the Contain Outbreak Management Fund facilitated this and increases ranged from a handful of additional staff members to almost doubling total capacity – and in some cases against a context of a team with already reduced capacity due to previous funding cuts. DsPH had increased their teams in diverse ways. For example, one team had added an additional analyst and public health practitioner, another had gone from seven to thirteen public health practitioners, and one had recruited an extra three consultants. Regardless, recruiting additional staff was a widely shared experience during the pandemic.

This was positive – extra capacity in teams helped with workload and expanding what could be achieved locally, for example recruiting more community engagement officers. However, expanding team capacity also involved access to particular expertise, not just increased headcount. In this, it exposed issues with capacity and the relevant skills of the potentially available workforce. There was a widely acknowledged sense of competition for consultants and that the workforce was not 'out there' to recruit, with DsPH 'fishing in the same pond' for consultants. They described several examples of recruitment processes with either no applicants or applicants withdrawing due to being successful in other appointments.

Directors' concerns about the lack of availability of consultants and the future shape of the workforce reflect wider calls from the Faculty of Public Health and the Royal Society for Public Health to increase capacity and capability in the public health workforce through increased training and support ([Faculty of Public Health 2021](#); [Royal Society for Public Health 2021](#)), with the Faculty describing a 'workforce crisis' in the sector.



Making the most of funding opportunities

How do I use my leadership and influence and that of my team to influence a system that is really switched on to inequalities with still no recurrent funding? We've got loads of bits and bobs of non-recurrent funding all over the place, but how do we make best sense of it and how do we link it all together?

(DPH 07, South West, third interview round)

In the context of the challenges described above, DsPH used various workarounds to support their local communities. Examples included:

- exploring alternative ways of supporting services or boosting their local workforce capacity, such as developing skills within their existing teams, providing additional training to other local authority employees with transferrable skillsets or hiring agency staff
- using the resources available in different ways, such as planning on the basis of current resources to try to establish initiatives that will have a sustainable impact and thinking about the learning potential or legacy of projects beyond available funding
- working alongside colleagues in their local authorities to think about the long-term use of resources to target spending at those in need
- interpreting Covid-19 grant conditions as broadly as possible to allow them to spend the money to build capacity in their local VCS.

Utilising the VCS was another route to meeting needs, although DsPH discussing this also acknowledged that this was not a 'free' resource and needed more sustained investment. Voluntary sector representatives in local areas highlighted the issues they and their wider sector were facing in terms of struggling to access funds other than those focused on the Covid-19 response, and anticipated increases in demand not being matched by resources available to them. While they were also making the most of short-term and emergency funding, these longer-term issues were evident and reflect broader concerns across the sector – see, for example, the Covid-19 Voluntary Sector Impact Barometer that tracks the impact of Covid-19 on the VCS over a range of metrics including finances ([Nottingham Business School 2021](#)).



Wider resource issues and implications

At the time of our second interview round, the public health grant for 2021/22 had not yet been announced. In its absence, DsPH were making assumptions about what their budget would be in order to make even short-term plans. This uncertainty was an additional pressure – and the ongoing uncertainty and complexity that this yearly cycle led to in terms of budgeting was also highlighted in the focus group.

The experiences of these DsPH reinforce the need for a longer-term correction to local authority funding and the public health grant in particular. However, there was a concern that the new public health structures of the UK Health Security Agency and the Office for Health Promotion (to be established later in 2021) would not learn from this – for example, a local leader with public health expertise noted uncertainty about the role of DsPH in relation to the continuing reforms, which suggested that national policy-makers were not recognising the importance of local public health expertise. Without a collaborative approach to developing messages at the national level, DsPH could continue to see disparate, short-term pots of money. This in turn would hamper their ability to deliver the right support to their local communities, for example with a focus on prevention.



7 From ‘feisty upstarts’ to system influencers: the role of directors of public health and public health teams in recovery

Key points

- The Covid-19 pandemic has exposed the scale and complexity of health inequality issues in the United Kingdom. Recovering from the pandemic presents both a challenge and an opportunity for local directors of public health (DsPH).
- Given their expertise in tackling health inequalities and improving population health, DsPH are in a key position to lead recovery in local systems, although there are major areas of uncertainty (such as funding and the wider reforms to public health at national and regional levels) that need to be addressed.
- The pandemic has inadvertently created the conditions in which DsPH can build on their own knowledge and skills, the growth in the levels of trust in their leadership and the wider buy-in for public health. There is strong potential for DsPH to take a central role in influencing and shaping the future direction of health and care at place.

The big question right now is how we can build on this really. How we can build on the recognition of health inequalities as an important social issue... Defining social issue... How we can build on the centrality of the DPH [director of public health] as part of developing those systemic approaches to dealing with health inequalities and not... go back into our little box [as] the feisty upstarts, you know?

(DPH 04, London, third interview round)



The multiple impacts of Covid-19

In this section, we discuss our final lesson from the study, that is, the role of DsPH in relation to the recovery from the Covid-19 pandemic in local areas. First, we need to step back and look at the impact of Covid-19. Deaths from Covid-19 are one of the most obvious and tragic outcomes of the pandemic. In England, by the end of July 2021, more than 130,000 people have died with Covid-19 being stated on their death certificate ([Public Health England undated](#)). One of the most troubling aspects of the pandemic is that it has had an unequal impact on society in terms of mortality, loss of income, mental health and other issues. In many places, the pandemic has worsened challenges and inequalities that people had already been experiencing ([Marmot et al 2020](#)). The impacts that DsPH spoke about and had gleaned through formal or informal impact assessments in their areas included:

- the impact on people's mental health and sense of wellbeing (this affects the general public and also particularly those who have worked on the 'front line' of the Covid-19 response)
- the increase in unemployment and resulting or exacerbated financial insecurity (there has been a big increase in the number of people claiming Universal Credit since the beginning of the pandemic) ([Mackley and McInnes 2021](#))
- the increased reliance on foodbanks
- the disruption to children and young people's education (and the knock-on effects in terms of their employment prospects)
- the increase in reported cases of domestic abuse (sometimes resulting in children being taken into care)
- the substantial 'backlog' in health and care services.

In their first interview, one DPH described how the Covid-19 crisis had made a difficult situation even worse for people in their area.

...people struggling with debt, people with mental health, anxiety, depression, quite extreme that weren't known to services, people that were struggling to have food in their cupboard and actually it wasn't just a short-term thing, they were quite hand to mouth before. Quite a lot of families living very close to the edge that when



one partner has lost employment, it was enough to tip them over into needing to use foodbanks.

(DPH 06, London, first interview round)

Back in September 2020 when we interviewed DsPH for the first time, they were describing multiple ‘opportunity costs’ as they focused their energies on dealing with the immediate issues related to the pandemic and had to pause their focus on longer-term planning, preventive work and health improvement, including taking a population health approach. They were also concerned about future impacts of Covid-19 on their communities, given the damage to the local and national economies.

While some DsPH were facing barriers to their work on health inequalities, for example Covid-19 consuming all of the time, energy and focus of public health teams and local health and wellbeing boards, for others the way Covid-19 had spotlighted inequalities was creating opportunities for an increased focus on this work. Some DsPH described using the pandemic as an opportunity to focus on health inequalities in a way they had not been able to before – really getting to grips with the ‘Building Back Fairer’ agenda ([Marmot et al 2020](#)). Two factors influenced this: the increased profile and importance of public health; and the ‘opportunity’ Covid-19 provided in terms of offering a different lens on existing issues, for example ensuring that recovery work is not just ‘getting back to normal’ but also focusing on how to reduce health (and other) inequalities.

By the third round of interviews in April 2021, DsPH were able to describe a few positive outcomes of the Covid-19 pandemic that offered opportunities (if they could be sustained) for accelerating the work on reducing health inequalities – once there is sufficient ‘bandwidth’ to think about life after Covid-19. These included:

- a sense that Covid-19 had made everyone pull together around a common cause and collaborate
- partners working at pace to respond to the crisis
- a wider recognition among partners (and within wider society) that health and other inequalities exist
- building recognition and support for what public health teams can do
- improved or new working relationships.



We have got deprivation [in Area 02], but I would have said it's very hidden and people are quite happy to think, well, if we do everything for everybody universally, then that's fine. But actually it [isn't]... so we're starting to see a change in that kind of focus, more of a shift towards communities, to neighbourhoods, to engagement, to engaging with different groups. I think at a structural level and a strategic level, there's a change in the system, but also in our response and that change in perception about what we need to do and responsibility, which is the conversation that we've been having about public health for years... feels like people are now getting it.

(DPH 02, West Midlands, third interview round)

Recovery planning

It is important to note that, at the time of writing, there was a changeable situation in England regarding Covid-19 infections. Cases of Covid-19 had risen sharply from May 2021 – coinciding with the Delta variant becoming dominant (Riley *et al* 2021) – and in July there was a dip. The situation may well change again by the time this report is published. Clearly, the Covid-19 era is not over yet.

Looking back on how the pandemic has played out in previous waves, Covid-19 has touched every part of the United Kingdom and left indelible marks, and public health teams are still caught up in the response phase. In several areas there is a high rate of enduring Covid-19 transmission, making it all the more challenging to think about what recovery might look like. Thus, at the time of writing it is understandable that different areas were at different stages of precision in their recovery planning processes.

DsPH gave us an indication of what the priorities will be in the recovery phase in their areas. These tended to be a continuation of existing health and wellbeing strategies (that is, those written before the pandemic), covering 'traditional' public health issues such as promoting healthy lifestyles and improving mental wellbeing, as well as addressing some of the wider determinants of health such as housing. The pandemic has pushed the need to tackle health inequalities by focusing on the wider determinants of health much higher up the list of priorities. For example, in Area 08 the DPH spoke about a 'roadmap for recovery' that will be wide-ranging (there are priorities around health and wellbeing as well as clean air and tackling unemployment, for example) and brings together multiple teams in the local authority and neighbouring local authorities.



And I think we've been... as public health we've focused on commissioned services because they're tangible and you can touch them. And it's much harder to describe what your role is in the wider determinants of health, which means that they get less attention even though we know that they would make a greater difference.

(DPH 08, North East, third interview round)

Also notable in Area 08 was the proactive and long-term approach to recovery that the DPH described. They felt that children and young people would need particular focus and attention in the recovery phase, given the disruption to education, training and employment they have experienced – not to mention the mental health impact of Covid-19 measures such as cutting off social contact (outside of household units) for long periods of time. Thus, in Area 08, plans were being made in advance of the end of the national furlough programme to create 'quick routes' into training opportunities and jobs for young people. Also, there were plans to engage local people who were on health care waiting lists around their general health and wellbeing, with a view to aiding their recovery from treatment. As the DPH is also responsible for leisure services, they had been thinking through how to increase the use of swimming and library facilities among the most disadvantaged groups in the local community. Finally, DPH 08 spoke about the importance of seeking qualitative data directly from the local community about the impacts of Covid-19, to help the public health team to act quickly – as opposed to waiting for the annual publication of data on alcohol use, for example.

Opportunities and risks for the local public health system in leading the recovery

During the recovery from the pandemic, public health teams will be seeking to improve people's health and wellbeing against a backdrop of further waves of Covid-19. Essentially, local public health teams will be 'double running' the response to Covid-19 at the same time as recovery efforts.

I think, for us now it's very much for [the] future is looking at how do we make our communities stronger knowing that Covid will remain with us, that it will remain inevitable that we'll see further waves. So, that when further waves do come that our communities are stronger, as individuals but also as communities, that they can manage those types of situations going forward, I think, are the key things.

(DPH 11, South West, third interview round)



As we have already outlined in this report, the public profile of DsPH and appreciation for public health expertise have developed substantially during the Covid-19 pandemic. The significance and implications of health inequalities have also gained prominence in the wider conscience. Thus, DsPH were aware that there is an unprecedented and unique opportunity for them and their teams to utilise this recognition. Along with strengthened working relationships and the willingness to collaborate with and involve public health, which have been seen during the pandemic, DsPH saw reasons to be optimistic about wider buy-in for bolder approaches to improving health.

I guess nationally there's been recognition, but there has been locally as well, of the importance of public health and population health and the need to respond to some of this, and I think that there's been a significant shift from my perspective within the local authority over the last year. And it was happening, but this is just taking it to a new level in terms of people appreciating the links [between economic health and population health]... So I think we've seen a significant change, and obviously that gives us more of a platform to get the weight of the council and the health system behind what we're trying to do [to improve population health and wellbeing].

(DPH 02, West Midlands, third interview round)

One of the... silver linings of the pandemic, if there are any, is that every council now understands what public health does and... values their public health team, their director of public health, and they understand practically why investing in public health is so important.

(Regional director at Public Health England)

DsPH also felt cautious about certain risks (not entirely within their control) that could undermine recovery efforts – not least being the sense that the pressure of responding to Covid-19 had not wholly abated and the pace and scale of work were still very intense. Even with a significant proportion of the UK population being vaccinated, uncertainties remained about the trajectory of the virus in the coming months, for example variants triggering further waves.

As we discussed previously, there are significant challenges for public health teams in terms of funding and capacity. DsPH articulated some uncertainty about whether or not to retain the additional members of staff who were employed earlier on in



the pandemic to support with recovery work. It is an open question whether DsPH and their teams will be able to sustain the support (financial and relational) they had during the earlier stages of the crisis in the months and years to come. This in turn has knock-on effects in terms of the sustainability of services that were put in place for local people earlier on in the crisis, for example emergency accommodation for homeless people or befriending support for those who were isolated.

One DPH described their approach in the face of uncertain future funding available for recovery work.

We are trying to use Covid resources as widely as possible to try and address social determinants of health... whether that's through food poverty, legal advice for people with no recourse to public funds, social isolation, we've been using that resource, and trying... I guess, what we're trying to do is either invest in things where we're going to learn, or set up things that are going to have a legacy because we realise that the funding that we have now... that there's no evidence right now that the funding climate is going to get any easier... but it may well get harder... We're planning on the basis of, you know, we have some resources right now to try and get some things going that hopefully will have a sustainable impact... We're using the money we're receiving to manage the pandemic from the government in as broad a way [as possible] to... address the wider determinants of health.

(DPH 04, London, third interview round)

During the focus group discussion, DsPH considered the implications of recovery from the pandemic for the public health workforce. It was clear that DsPH would not be able to deliver everything on their own; they would need to call on a broader public health workforce that is appropriately skilled. However, there was a recognition that there were not enough public health consultants in particular with the necessary training, skillsets and experience; DsPH in our sample noted wryly that they have been in a position of 'poaching' each other's staff while they have been ramping up capacity in teams during the pandemic.

Another major area of uncertainty for DsPH was the reform of Public Health England that was announced part way through the pandemic ([Hancock 2020d](#)). The announcement came as a surprise to many in the midst of responding to a public health emergency and created a degree of anxiety about what would happen to those working in local public health teams as a result. There are still unanswered



questions about what will replace what Public Health England regional teams did in terms of health protection and connections with local teams.

At the focus group discussion in May 2021, the views of DsPH about the reform of Public Health England varied between concern to frustration about the timing of the decision and lack of opportunity to affect the outcome of the reform in terms of who will be responsible for what at national, regional and local levels.

I think that emergency response, you know, the urgent and necessary, has shown that when we're [local public health teams and DsPH] a bit clearer in what we're asking for, then people respond and partners respond... we don't want to lose this new way of working. And... public health leading some of that, and articulating... in a more direct way going forward, to reduce inequalities... making it understandable for local people, who can really be much more of our engine drivers, which will help mitigate those inequalities... But taking it up to the sort of, some of the national changes, you know, the Public Health England changes, and actually what that means as a system, I think is much less clear. I think I feel much clearer on the local, than I do on the national, and that's a worry. Because, clearly, that's where a lot of the financial decisions and accountability lie.

(DPH 06, London, focus group discussion)

I feel really annoyed that there's been NHS and public health reform happening in the middle of a public health emergency, that I have not been able to sufficiently contribute my voice to those changes... So I think, we do run the risk of those additional challenges... about how we try and... galvanise our own teams, against what's happening at regional and national levels.

(DPH 11, South West, focus group discussion)

The role of directors of public health in influencing a change of approach

I don't particularly want people to say, thank you, well done, because you've done a good job, what we want people to do is recognise it by... giving that emphasis to the role that we can bring and the part we can play.

(DPH 02, West Midlands, third interview round)

There were mixed emotions when we last caught up with DsPH for their individual interviews in April 2021. There was a degree of weariness, which was unsurprising



given how long they had been working on the response to Covid-19. Some were fairly upbeat as they reflected on the strength of the local public health response to Covid-19 and what had been gained in terms of relationships. There was also a sense of frustration and restlessness; they did not want to snap back to normal. As we have outlined throughout the report, 'normal' (or life before the pandemic) was an under-appreciated and under-resourced public health system. As DPH 04 recalled, before the pandemic it felt like public health was contributing 'bit-part stories in the council's set of objectives'.

Rather than public health being a kind of standalone team in a council, it becomes more of an influencer across the system.

(DPH 08, North East, third interview round)

You don't want to miss this moment. So I've never seen the stars so well aligned for what is truly our... purpose if you like, to reduce inequalities, [to] level up. So we're hearing it everywhere... We've got so many of those really big opportunities, and it's not just one, it's, you know, six or seven... And I think that's where we will be absolutely critical in aligning our NHS colleagues' work, our economic recovery work, lobbying government for the sort of policies that will level up... it's actually those policy decisions that will assist us in then making it local. So that's what I think the challenge is for now, moving forward.

(DPH 06, London, focus group discussion)

It was clear DsPH wanted things to be different in the future. A few DsPH could already sense a shift in their local authorities towards a more population health approach. Others spoke about wanting to continue building the visibility of the public health system and use their increased sense of influence to guide the direction of travel in the recovery stage. They said that a key part of the challenge was maintaining this momentum against a need to ensure their own resilience in the context of a relentless workload – but the opportunity was hard to ignore.



8 Implications

In England, by the end of July 2021, there had been more than 113,000 deaths within 28 days of a positive Covid-19 test, and more than 130,000 where Covid-19 was mentioned on the death certificate ([Public Health England undated](#)). The longer-term consequences for health may be as significant, with many experiencing 'long Covid' and uncertainty about how people who have had Covid-19 but seemingly recovered may fare in the future. In addition, public services have suffered dislocation, backlogs of care have increased, children's education has suffered, many people have either lost their jobs or seen them change significantly and many individuals and families find themselves in much more precarious circumstances. The directors of public health (DsPH) in our study have had to prioritise their Covid-19 roles, meaning much other vital work for population health has suffered. This is all despite an unprecedented government response. The economic and social and, therefore, health fallout will be felt for many years.

In order to meet this challenge, local, regional and national system leaders have a duty to learn from the pandemic and these experiences, including through a public inquiry ([Warren and Murray 2021](#)). This report is part of that learning, based on the experiences of people at the epicentre of the local response: DsPH. In this section we set out the key implications, in our view, based on the privilege of time spent listening to and making sense of the experiences that have been shared with us during 'a year like no other', to quote one of our study participants. These implications are relevant not only to local and regional leaders in the new emerging health and care system in England, but also to those responsible for the design and improvement of the complex systems that underpin the population's health: the Department of Health and Social Care, the UK Health Security Agency, the Office for Health Promotion, wider government and politicians.

For starters, the gains that DsPH have made in terms of wider understanding and recognition of their role during the pandemic must be secured for the long term. The strengths of DsPH and their teams, their leadership, their ability to see the big picture and the detail of their work based on strong relationships at all levels have been much more widely recognised because of the pandemic, but the pandemic did



not create them. We must not go back to a 'normal' where DsPH were sometimes viewed primarily as 'feisty outsiders'. Rather, they should be viewed as core players in the system leadership for health across their populations, while maintaining their role and ability in challenging established ways of doing things in the cause of population health.

This centrality needs to be secured in several ways.

- First, the span of influence through director of public health (DPH) roles in local authorities during the pandemic needs to be maintained beyond it. It is clear that the access that DsPH have had to their chief executive, and active support from them, have been very important in enabling them to influence and, where appropriate, lead the response to Covid-19. The ongoing relationship with the chief executive will be important in strengthening the role of DsPH as system leaders, as well as a critical source of expertise.
- Second, as the health and care system moves towards integrated care systems (Charles 2021), public health's role in them needs to be fully recognised and embedded (The King's Fund 2021). That does not mean a policy change at national level taking public health 'out of local government', but ensuring in practice that integrated care systems work fully with DsPH and their teams and do not develop in parallel. DsPH are already starting to become engaged in this within some of the more advanced integrated care systems and we would argue that this should become the norm to give the best chance of reducing health inequalities and securing good long-term health and wellbeing in the population.
- Third, it is clear that DsPH would not have been as effective during the pandemic without a symbiotic relationship with communities and community leaders, both directly and through the voluntary and community sector (VCS). Our DsPH recognised that this has not always been as strong as it should have been and that this will be as important in the recovery phase as it has been during the pandemic. The evidence consistently shows how important community bonds, connections and control are for health (Buck et al 2021) and in recovery from disasters (Cream et al 2021). Local systems, including integrated care systems, therefore need to support DsPH to deepen and strengthen this further and to learn from their experiences during the pandemic.



- Fourth, DsPH need to be engaged in the design of national population health activity and systems. They have often felt ‘done to’ during the pandemic and left to deal with the consequences of poor communication of decisions, and in some cases poor decisions themselves. They could not understand and did not unanimously welcome the decision to disband Public Health England in the middle of a pandemic and set up two separate entities in its wake. However, they welcomed the strong commitment of the Chief Medical Officer in England in keeping them briefed and in listening to their concerns on a regular and frequent basis. As the UK Health Security Agency and the Office for Health Promotion (headed by the chief medical officer) develop their roles, DsPH must be strongly involved in their design, as well as being involved in helping to adapt the reforms successfully as they are implemented over time.

But we have also seen that there are two fundamental capacity constraints that, until addressed, will mean that the capacity of DsPH to engage meaningfully with the above will be limited: funding and the workforce.

In terms of funding, DsPH, their teams and the local authorities in which they are based went into the pandemic after years of budget cuts, service reductions and reductions in grants and other support that enable strong connections and understanding of the communities they serve. The Association of Directors of Public Health and many others, including the Health Foundation ([Finch et al 2018](#)) and The King’s Fund ([Buck 2021](#)), have warned repeatedly about the long-term consequences of this generally and in specific service areas ([Robertson 2018](#)). The local government public health system has coped during the pandemic, but it has been severely tested. Central government should not make the mistake of thinking all is well. The public health system, and population health, would have coped better with a stronger, more certain funding base than the one that has been significantly eroded over time. Coming out of this experience of Covid-19, the lesson is to invest in the system to prepare us for other challenges ahead.

But there is nuance here: it is not only the amount of funding that matters, but also how and when it arrives and for how long it will last. DsPH have been grateful for the additional resources that eventually arrived through the Contain Outbreak Management Fund and other mechanisms. But they are unclear about how long they will last and it has led to competition, and scarcity in the supply of key staff



inputs. Covid-19 funding windfalls are not the way to sustainably fund public health over the long term. What is required is a government commitment to increased and sustainable long-term funding – at least an extra £1 billion a year for the public health grant, and multi-year funding – to give DsPH the certainty they require. This is a drop in the ocean compared with the hundreds of billions of pounds already spent on the short-term response to Covid-19.

Moving to workforce, this is the scarce resource that is now the biggest constraint and our DsPH were candid in our focus group that they were actively competing between themselves, especially for public health consultants. Workforce supply has been a problem for many years for public health and the specialist training programme is highly over-subscribed. They are facing significant recruitment problems for specialist staff. As many submissions (including that of The Kings' Fund ([The King's Fund 2021](#))) to the government's consultation on future reforms have argued there is an urgent need for a new public health workforce strategy; it is not only the NHS and social care where this is now the key constraint. The DsPH we spoke to have offered their views on how they would like to shape the future public health workforce – particularly with recovery in mind. They felt the following issues are particularly important to address:

- increasing the numbers of people being trained and reviewing whether the training on offer is still fit for purpose now that public health consultants no longer routinely come up through a health care route
- building a workforce that is more 'agile', with key skills in communications, engagement and relationship building
- diversifying the workforce so that it reflects the communities it serves
- upskilling consultants so that they are 'credible voices' in their local systems
- if local public health will be taking on a greater health protection function (still to be decided at the time of writing), having the budget and resources to grow the team in that way.

We have some personal reflections from the privilege of being alongside a small number of DsPH over the period of our study. The first is the clear commitment that DsPH have to the people, communities and population they serve. The second



is that, despite the horrendous year they have been through, they remain optimistic about the future, and they can see a way through to a stronger population health system. But they are also realistic that this depends on:

- their own leadership
- the recognition for what they have done over the course of the pandemic not being forgotten locally or nationally
- a sustainable level of resources for public health directly and for local government
- a reimagined workforce
- meaningful investment in communities and the organisations that support them
- a strengthened public and population health system around them.

It was an honour to take a close look through this research at what DsPH and public health teams have done to respond to the Covid-19 pandemic and its knock-on consequences. The reflections above are about DsPH in the system and how it responds to them. But we would also like to offer some reflections for the DPH community itself. We have grouped them into three areas: position and influence in local systems; collective voice and responsibility; and, last but not least, personal challenges and wider support. Within them we pose some questions that may help the directors' own reflection.

Position and influence in local systems

The opportunity has never been so prominent for DsPH and public health teams to translate the recognition gained during the pandemic into business as usual in the aftermath. The pandemic has spotlighted what DsPH contribute to strategic decisions in local places beyond their specific role, not only through their direct expertise but also through their strong partnerships with others, including local authority chief executives. The world will continue to change around them, including through reforms to the public health system and the development of integrated care systems. DsPH will need to continue to adapt to these changes and spend effort maintaining their visibility, partnerships and wider influence over decisions when local emergency structures are stood down.



Collective voice and responsibility

We have heard how DsPH supported each other during the pandemic, and the profile of DsPH collectively has never been higher through media appearances and the efforts and visibility of the Association of Directors of Public Health. This is important to the wider public health agenda, locally and nationally. Building on the experience of Covid-19, DsPH can work together collectively on other public health issues, drawing attention to them and helping to improve the chances of local and national policy change effectively addressing them. DsPH also have a collective responsibility to continue to invest in their relationship with communities that has been so apparent and powerful during the pandemic ([Strelitz 2020](#)).

Personal challenges and wider support

The pandemic has required DsPH to work in crisis mode: working long hours, shouldering the burden of difficult decisions and often being the media face of the Covid-19 response. However, once the adrenalin rush of the emergency phase has eventually worn off, what will withdrawal look like for DsPH? How will DsPH step away, practise self-care and create some space and time (for them and others) to plan strategically for population health? The Covid-19 pandemic was a novel situation and inevitably some DsPH might wish they had done things differently – not every judgement made will have been the right one. DsPH, like all other leaders, will need to find ways to share these uncertainties and reflect on them. They will need support and understanding to do so, to process what they and the populations they serve have been through. In short, DsPH need to be allowed to find the space and time to prioritise their own, and their team's, recovery from the experience of Covid-19, to be in a better position to help support the recovery of their place and populations.

In conclusion, like other frontline staff and leaders, it is clear that the year under study in this report took its toll on DsPH and their teams. Covid-19 was all encompassing; many did not take leave and most worked through evenings and weekends. When they could take leave, they were surrounded by Covid-19 in their personal lives and in the wider media; there was no true escape. Despite the toll it took, the DsPH in our study welcomed the central involvement they had had in responding to the pandemic and believed it had put them in a better



place to contribute to the recovery from Covid-19. Our work with them over the year convinces us that they should have important system leadership and wider influencing roles in responding to the health challenges that will face their populations in the future.



Appendix 1: Methodology

As we have outlined in section 1, the methodology involved interviewing several types of participants – some of them multiple times. We undertook 58 interviews in total, plus one focus group discussion. Our fieldwork began in July 2020 with the process of identifying directors of public health (DsPH) in England to take part in the study (see below) and concluded in May 2021 with the focus group.

All interviews and the focus group were carried out using Microsoft Teams. Interviews were recorded with the permission of participants and transcripts were coded against a framework of themes using the MAXQDA specialist qualitative data analysis software. The project team then analysed the coded data further to draw out themes.

Directors of public health (England)

We wanted a sample of 12 DsPH in England, to provide a wide range of perspectives, and then to undertake follow-up interviews with eight of the 12 to build up a picture of their experiences over time. We felt it would be more realistic to maintain connections over time with eight DsPH than with all 12, particularly in light of their intensive workloads over the pandemic period.

In selecting the sample of DsPH, it was important to factor in several issues, for example:

- how the area in which they work had been impacted by Covid-19 mortality in the local population during the first wave of the pandemic (based on data available as at August 2020)
- how vulnerable the area was to future waves of Covid-19
- an exploration of experiences in different areas in England
- an exploration of the experiences of DsPH who had been in the role for different lengths of time.

On this basis, we produced a long list of DsPH and approached 12 of them to invite them to take part in the study. A small number of DsPH declined or could not take



part and in those instances we substituted a demographically similar area and approached the corresponding director of public health (DPH). By September our 'baseline' sample was as presented in Table 3.

Table 3 Directors of public health and high-level description of areas (full sample, n=12)

Director of public health (DPH)	Approximate length of service as DPH in the area	Region	High-level description	Our judgement of how the area has been impacted by Covid-19	Interview points
DPH 01	> 5 years	North West	Mixed urban and rural	High mortality Medium risk of future waves	August 2020
DPH 02	< 5 years	West Midlands	Mostly rural	Low mortality Risk of future waves unknown	September 2020, January 2021, April 2021
DPH 03	< 5 years	East Midlands	Mostly rural	Data unavailable	September 2020
DPH 04	< 5 years	London	Urban	High mortality High risk of future waves	September 2020, January 2021, April 2021
DPH 05	< 5 years	North West	Urban	High mortality High risk of future waves	September 2020, February 2021, May 2021
DPH 06	> 5 years	London	Mixed urban and rural	Medium mortality Medium risk of future waves	September 2020, January 2021 (unavailable for third interview)
DPH 07	> 5 years	South West	Mostly rural	Medium mortality Risk of future waves unknown	September 2020, January 2021, April 2021
DPH 08	> 5 years	North East	Urban	High mortality Risk of future waves unknown	September 2020, January 2021, April 2021
DPH 09	> 5 years	West Midlands	Urban	Medium mortality Low risk of future waves	September 2020

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**Table 3 continued**

Director of public health (DPH)	Approximate length of service as DPH in the area	Region	High-level description	Our judgement of how the area has been impacted by Covid-19	Interview points
DPH 10	< 5 years	West Midlands	Urban	High mortality High risk of future waves	September 2020, January 2021, April 2021
DPH 11	< 5 years	South West	Mixed urban and rural	Medium mortality Risk of future waves unknown	September 2020, January 2021, April 2021
DPH 12	< 5 years	North East	Mixed urban and rural	High mortality High risk of future waves	October 2020

A total of 27 interviews with DsPH took place between September 2020 and May 2021.

During the first round of interviews, we used elements of a narrative interviewing technique (Flick 2006). This was in order to allow DsPH to speak without interruption for as long as possible so that we could gain deeper insights into what they experienced and felt in the first six months of the pandemic. Interviewers then prompted for additional details according to a pre-set topic guide. In subsequent interviews the DsPH picked out key events since the last interview and the reasons for their significance. Each time, DsPH were asked to describe future plans as well as they could, given the status of the pandemic. We also asked DsPH to provide a timeline of events in advance of the interviews to help aid their recollection of events (and their sequence) at their interviews. Unfortunately, it was not possible for all DsPH to do so each time due to time pressures.

We felt there would be advantages to bringing the eight DsPH in the subsample together for a focus group discussion towards the end of the fieldwork period so they could explore some key issues together. This means the DsPH in the subsample are now aware of each other's identities. On the day of the focus group discussion, one director was called away to an emergency meeting in the local authority and so the focus group proceeded with seven participants. This was recorded and the transcript has been analysed thematically.



Directors of public health (Northern Ireland, Scotland and Wales)

Our interviews with DsPH in the other UK nations were for the purpose of gaining insight into how their local public health systems responded to the Covid-19 pandemic. We used purposive sampling to approach one DPH in Northern Ireland, one in Scotland and one in Wales. The three DsPH took part in their first interview between October and November 2020. One of the DsPH left their post some time after their interview and we therefore sought to interview a different director in the second interview round (March–April 2021). Altogether we carried out six interviews with DsPH from Northern Ireland, Scotland and Wales.

Local leaders

We chose two areas for a ‘deep-dive’ study of the local public health system’s response to Covid-19: Area 07 (led by DPH 07) and Area 10 (led by DPH 10). The rationale was to build a wider picture of what leaders did to manage the pandemic, working in partnership with the two DsPH.

We asked DPH 07 and DPH 10 to identify a maximum of five other leaders they had worked with over the course of the pandemic – individuals who had been key to the local public health response in some way, either as partners within the local authorities or from other local organisations – who we approached for interview. The interviewees from the two areas are shown in Table 4.

Table 4 Description of interviewees in the ‘deep-dive’ study

Area 07	Area 10
<ul style="list-style-type: none"> • Chief executive of the local authority • Chief nurse from the local clinical commissioning group • Chief fire officer • Assistant chief constable of the police service • Chief officer of the local voluntary and community sector alliance 	<ul style="list-style-type: none"> • Assistant chief executive of the local authority • Cabinet member for health and social care • Head of emergency planning (local authority) • Chief executive officer from the clinical commissioning group • Leader of a local faith-based community organisation



We carried out interviews with the local leaders on two occasions: the first time between December 2020 and January 2021 and the second time between February and March 2021. Altogether, 20 interviews were conducted.

National leaders

We wanted to understand how national and regional leaders have (or have not) engaged with DsPH. Through our own contacts, we approached several high-profile leaders in England. Again, we have kept the identities of the leaders confidential given the sensitive nature of some of the relationships.

The five national-level leaders were interviewed between April and May 2021. These individuals were offering perspectives from the Department of Health and Social Care, Public Health England (x2) and NHS England and NHS Improvement (regarding the vaccination programme), while one individual had previously been seconded to NHS Test and Trace.

Advisory group and critical friends

At the outset of the study, we convened a group of expert advisers who are independent of The King's Fund. The main role of the advisory group was to advise on different aspects of the study (such as scope, methodology and emerging findings) and to ensure that the views and lived experiences of key stakeholders who are closer to either policy or practice in local public health informed the project team. The group met on two occasions over the course of the study. A full list of advisory group members and critical friends (individuals who have supported the team with background information and by piloting the narrative interview approach) is included in the Acknowledgements section of this report.



Appendix 2: Key milestones and events during the pandemic (England)

To give some context to readers about when we interviewed DsPH in England, Table 5 presents a general list of key milestones and events that had occurred by the time of, or which coincided with, the three interviewing rounds.

See also the Health Foundation's Covid-19 policy tracker, which documents the national government's health and social care system responses to Covid-19 in England over the course of 2020 (Dunn *et al* undated).

Table 5 Description of interviewees in the 'deep-dive' study

Interview round	Milestones and events during the Covid-19 pandemic in England
First round: September 2020	<ul style="list-style-type: none"> • The World Health Organization declares Covid-19 to be a pandemic on 11 March 2020 • National lockdown is announced on 23 March • A five-pillar strategy for scaling up Covid-19 testing programmes is published in early April • <i>Deaths from Covid-19 peak in April (first wave)</i> • Local authorities are asked to produce local Covid-19 outbreak management plans at the end of May • NHS Test and Trace is launched at the end of May • National lockdown eases and there is a phased reopening of schools (for some children) and a reopening of non-essential retail outlets starting from June • The first local lockdown (in Leicester and parts of Leicestershire) occurs from late June – other areas follow • Covid-19 cases start to rise across England from September and new restrictions are announced, for example 'the rule of six' for outdoor gatherings, a return to working from home and a 10pm curfew for the hospitality sector

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Table 5 continued

Interview round	Milestones and events during the Covid-19 pandemic in England
<p>Second round: January 2021</p>	<ul style="list-style-type: none"> • A three-tier system of restrictions is announced in October • A second national lockdown is announced on 31 October • Mass testing to detect asymptomatic Covid-19 cases is introduced in November • The Alpha variant of Covid-19 is first detected in November (from a sample taken in September) • Rising cases in December are attributed to the Alpha variant • National lockdown is lifted on 2 December and replaced with a stricter three-tier system • Vaccination roll-out begins in early December (the first injection outside of clinical trials is given on 8 December) • A new fourth tier of restrictions is announced on 19 December, starting with the South East and then spreading to more areas across England • The Beta variant of Covid-19 is detected and sequenced in the United Kingdom in December • The Prime Minister announces that school children should return to school after the Christmas break on 4 January 2021, but a third national lockdown is announced on 6 January • <i>Deaths from Covid-19 peak in January (second wave)</i>
<p>Third round: April/May 2021</p>	<ul style="list-style-type: none"> • Vaccination roll-out continues • Surge testing occurs in specific postcode areas to catch cases of the Covid-19 variants from February 2021 • A roadmap out of lockdown is announced on 22 February • Primary and secondary school children return to school from 8 March • The 'stay at home' rule is lifted from 29 March • Covid-19 cases (particularly the Delta variant) begin to climb in May

Sources: [Office for National Statistics 2021](#); [Department of Health and Social Care 2020b](#); [World Health Organization 2020](#); [Institute for Government undated](#)



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About the authors

Shilpa Ross is a Fellow in the Policy team at The King's Fund and works on a range of health and social care research programmes. Most recently she led our research on workforce race inequalities and inclusion in the NHS. Topics of her other recent reports for the Fund include the role of volunteers in the NHS, innovative models of general practice, transformational change in health and care and quality improvement in mental health. Shilpa specialises in designing and carrying out qualitative research and has extensive experience in interviewing practitioners, service users and policy-makers. Shilpa holds a BSc in psychology and criminology.

Deborah Fenney is a Senior Researcher in the Policy team at The King's Fund with a particular interest in health inequalities. Her recent research topics at the Fund include the role of the NHS in tackling poverty, health and care services for people sleeping rough, transitions to adulthood for young people with learning disabilities, and the role of volunteers in the NHS. Before joining the Fund in 2018, Deborah worked for two years as a senior analyst at the Care Quality Commission (CQC). Deborah holds a PhD in sociology and social policy from the University of Leeds, which explored disabled people's access to sustainable lifestyles.

Clair Thorstensen-Woll is a Researcher in the Policy team at The King's Fund. Her areas of interest include population health, health inequalities, and patient involvement and experience. Before joining the Fund, Clair worked for Healthwatch across three London boroughs where she led their policy and research functions and supported the representation of patient voices in local decision-making. She holds an MSc in social policy and social research from University College London.

David Buck is a Senior Fellow in the Policy team at The King's Fund, specialises in public health and health inequalities and has published widely in these areas (for example on multiple health behaviours, public health reform and the NHS's role in tackling poverty), as well as developing the Fund's vision for population health. Before joining the Fund, David worked at the Department of Health as Deputy Director for Health Inequalities. He managed the Labour government's targets on health inequalities and the independent Marmot Review of inequalities in health. While in the Department he worked on many policy areas – including on



diabetes, long-term conditions, dental health, waiting times, the pharmaceutical industry, childhood obesity and choice and competition – as an economic and strategy adviser. He has also worked at Guy’s Hospital, King’s College London and the Centre for Health Economics in York where his focus was on the economics of public health and behaviours and incentives.



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The Covid-19 pandemic has been an unprecedented situation that has tested local public health systems to the extreme for more than a year. Directors of public health (DsPH) and their teams have been at the forefront, playing a crucial role in leading the local response to the pandemic.

The King's Fund, supported by the Health Foundation, conducted interviews with DsPH and other leaders working at local, regional and national levels to better understand their experience of the pandemic, and what is needed for recovery and any future public health emergencies. This report highlights the key areas of influence and challenges local leaders faced, from the vital roles they played in shaping local responses, engaging communities and developing key relationships, to workforce shortages and navigating relationships with central government.

The report concludes by outlining implications for the future, underlining the importance of strong relationships and joint working between local leaders, the role of public health within integrated care systems, and a national role for DsPH in improving population health.

The King's Fund
11-13 Cavendish Square
London W1G 0AN
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