The Covid Reader – Reflections

A Collection of Personal and Professional Reflective Experiences Shaped by the Covid Crisis Curated by David Bates and Richard Shircore

This Reader consists of seven independent papers reflecting on the Covid Pandemic from March 2020 to October 2022. Its development has been prompted by the Hallet Enquiry (sic) into the crisis created by the event that continues to shape socioeconomic and political conditions in the UK and globally which continue to severely weaken human security. The team felt that although the strategic response to the pandemic was being considered in detail no strategy can be formulated without understanding how it impacts on the field workers, planning staffs and the public. This Reader seeks to redress this knowledge deficit.

The Editors used their personal contacts and social media to request contributions starting in October 2023 and are very grateful for the frank and fulsome response of contributors. Apart from editing some sections, for clarity and focus, the Editors have not attempted to influence any of the content, hence each paper appears unique in the author's original style including typography. This provides a strong ethnographic message that this is about individual understanding turned into intelligent discourse through personal reflection.

Each author was invited to reflect on the issues following their professional or clinical experience of 'Covid' that impacted on their responsibilities and areas of influence in order to address the challenge of how pandemics and epidemics could or should be managed better. A common theme is that both prevention and management of pandemics are significantly enhanced by political and health policy adhering to the key elements of the Ottawa Charter which has health security at its core.

The authors were therefore specifically requested to focus on their reflections with a view to gathering their qualitative opinions based on their expertise rather than crafting an academic paper for peer review with references. This collection may serve as the framework for a formal paper in due course, with the benefit of a 'Reader' keeping the Contributors free from Editorial direction.

We trust you will find their papers of use and interest. Your feedback and comment is very welcome. Please get in touch with David or Richard who will pass your feedback, comments or queries on to the team.

Thank you for your curiosity and interest.

DCB and RS March 2025

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David Bates is a Senior Lecturer in Disaster Response and Humanitarian Action at the University of Cumbria. He spent 42 years in the Army initially practicing as a burns trauma nurse and CBRNe health specialist and transitioned into Primary Health Care and Public Health following command and staff training from 1999. He continues to practice as a health and care adviser with a number of iNGOs and as a contractor globally maintaining his currency to inform his teaching. During the CoViD Crisis he supported the NHS on Operation RESCRIPT as part of the Army NHS Coaching and Mentoring in Crisis Scheme. He has analysed this and other recent disasters forensically with learners undertaking the Disaster Response Post-Graduate Certificate or individual modules in the Disaster Response series that he leads, with them collecting valuable data which is being inserted into the Institute of Health's Continuing Professional Development strategy including its transformative learning and leadership development program. We hope that this approach will mitigate poor preparation, planning, response and recovery in the disasters that we face as we move further into this century.

Global Health Security in the Age of CoViD -19

I started writing this short paper whilst the African Union is announcing another epidemic in Sub Saharan Africa, this time Monkeypox or '*mpox'* as it is becoming known colloquially. South Africa's President and the African Union's Champion on Pandemic, Prevention, Preparedness and Response Cyril Rhamaposa, stated in mid-August 2024 that 2 822 cases of mpox have been confirmed with another 14 719 suspected alongside a current mortality of 517. This could be higher as we publish this reader but with strategies unfolding including vaccination programs the epidemic might be arrested. On the other side of the Atlantic a newly elected Trump withdraws the US from WHO and savages US AID, one of its biggest funders, and one of the big powerhouses that can produce health and care products at scale as it did producing penicillin in industrial quantities during World War 2 making a phenomenal contribution to winning that war. The UK PM has just announced more cuts to the overseas age budget in order to channel funding into Defence. What happened to the comprehensive or pan – government approach and Diplomacy, Information, Military/Security and Economic defence lines of operation working in harmony? What effect will all this have on global health and human security as it has been demonstrated that reducing the aid budget only increases the number of economic and conflict related migrants along with global violent extremists that use this reduction in funding as a lever to exploit those who would have benefitted from advocacy, aid or assistance through it?

WHO has stated that global health security, simply defined as protection from threats to health but this needs to include environmental, animal and human health to be effective, is only as strong as the weakest partners and is recognised as being one of the most important 'non-traditional' security issues in a number of conferences and declarations that have taken place over the last 4 decades; such as WHO Ottawa 86, WHO WHR 07 and UNDRR Sendai 2015 where the Sustainable Development Goals were introduced. This was articulated particularly well in the Ottawa Declaration which remains the cornerstone of public health principles and healthy public policy and set the conditions for global health security in 1986. The 2014-15 Ebola outbreak in West Africa highlighted this once again alongside the SARS, Swine Flu, MERS and more recently the rapid global spread of CoViD 19. There is a challenge to be made here and lessons to be learned from some of the partners perceived to be weaker because of their less developed health services but they had learned health security the hard way during and following those earlier regional epidemics. Guinea, Liberia and Sierre Leone suffered during the last large regional Ebola Virus Disease outbreak in 2014 to 2015. With this experience of still in the memory of countries in West Africa and the Sahel they locked down almost immediately

after WHO began sharing information about the character of the SARS2 Coronovirus. Within months they were suffering severe socio-economic consequences and governments had to rapidly reverse the decree. This was illustrated by a BBC Monitoring report that amplified the fact that social reality and community context are key using Mali as a typical case. A landlocked country with an eight-year-old insurgency being supported by foreign nationals, Mali closed its borders early to prevent the rapid spread of the disease but crippled its national economies as traders and artisans were unable to move goods for sale or to import raw materials from seaports. Mali registered 6 000 cases and 200 deaths in the first year of the pandemic seeing a rise in December 2020 which resulted in more intelligent and targeted 10 days restrictions. Speaking to a clinical colleague in Northern Uganda about how they managed the pandemic it was as though it had passed them by! Their focus was on influenza, TB and malaria which were bigger threats than this novel virus being spread in concentrations of population and rapid transport movements, They were living in dispersed communities, reasonably static and not being visited by outsiders. Basic public health and biosecurity measures were routinely practised and working! So where is the real weakness? **Laura Morgan** covers this in her paper demonstrating where intelligence or transformative management and leadership from the bottom – up, another classic principle of maintaining the public's health, worked to keep the UK Armed Forces fit to fight! If the MOD and the Army could do it why could the rest of the country not? Is this the advantage of having an homogeneous organisation that is commanded, led and managed through a professional chain of command that delegates responsibility and trusts its people to complete their mission? My role in Op RESCRIPT[1] was as a mentor to senior NHS leaders sharing our recent experiences of planning and leading in crisis transferring knowledge, skills and behaviours from the battlefields of the Balkans, Iraq and Afghanistan to the Trusts' boardrooms. Bringing coherence to a heterogeneous organisation.

I spent the first few months of the declared pandemic in Saudi Arabia locked down and under curfew in Riyadh. I was able to watch the UK picture developing through the news both from domestic and international sources as well as from MOD information feeds as I was commanding a Capacity Building Team. It was interesting watching countries organising the repatriation of their holiday makers and expats including some Embassy and High Commission staff, increasing the risk of spreading the disease around the globe more rapidly than seaborne troop transports did with the Spanish Flu in 1918. No wonder the global mortality figures were classified secret as we were contributing to pushing the incidence and prevalence rates up as was experienced in Australia with their skiing parties returning from Italy. We were comfortable and feeling secure in Riyadh but were eventually repatriated by the Royal Air Force to the UK via Cyprus in April 2020 to a country that appeared post apocalyptical as in Val McDermid's novel '*Resistance*'! I continued to work and operate from home and peripatetically as I had been doing since 2016 so that had no impact on me. I did deploy to Abu Dhabi for four months the following year with CoViD Restrictions in place but again the atmosphere was comfortable, and the health regulations were intelligent but also well mandated. The Al Hosn app on the smart phone indicating your weekly status if vaccinated and having been screened and cleared allowed us to move and operate freely around the Emirate. This chimes with **John Ashton's** experience in Bahrain. On returning to the UK in October 2021 there was not the same sense of safety and freedom of movement with any relaxation of the rules resulting in spikes and further lockdowns.

[1] Operation RESCRIPT was the codeword for the MOD's support to the CoViD-19 response in the UK. There was a separate operation supporting Firm Base overseas.

This appeared to be worse in some regions of the UK which mapped across to the more deprived communities.

In the UK, Michael Marmot and his team spoke of public health inequities and inequalities in 2010 and updated their work in 2020 at the beginning of the CoViD - 19 crisis, which demonstrated a deterioration rather than improvement even before the issues of the pandemic began to take effect. But five years on we are no further forward in making the improvements that Marmot's team recommended, and the UK is left only as strong as its weakest communities. CoViD – 19 amplified Marmot's and other commentators' works with pockets of inequity and inequality illuminated by the public health and clinical care data being collected. However, government seemed more focused on technology, infrastructure and re-organisation rather than enhancing intelligence, education and leadership during the crisis. A theme that is amplified by **Maggie Rae's** paper along with the inability to learn from previous experience. I worked with Maggie during the 'Swine Flu' epidemic in 2009 -10, shaping a coherent plan that was worked up by the civilian Directors of Public Health and the military command of the Regional 43rd Wessex Brigade. A pragmatic, participatory approach that worked well but the generic lessons did not seem to make their way into the government response to CoViD-19 in late 2019 early 2020 alongside any lessons learned during the Ebola Virus Disease emergency in West Africa from 2014-15 or even major exercises conducted in the UK. **Anne Wylie** covers this in her paper which is focused on teaching principles of public health and biosecurity leaning into to taking action even before the causative organism and its disease process are fully characterised. This requires intelligent risk taking based on an all-hazards approach and the more successful communities and entities that practised within this transformative learning philosophy did better than others that waited for more information, government policy or simply followed government guidelines.

The current UK Government Health Minister recently stated the new administration's top priorities for transforming health, care and wellbeing in the UK as being a shift from hospital to community, analogue administration to digital and from treating illness to promoting health (or wellness/wellbeing). All are welcomed and should provide a more intelligent health protection, promotion and education platform that contributes to improving human security not only in the UK but also overseas. A major contribution to protecting the homeland at 'arm's length' by improving the health security of the weaker partners through the intelligent distribution of overseas aid. However, with the Prime Minister's announcement that he is cutting the overseas aid budget in order to raise security and defence funding as indicated in the introduction to this piece with the concomitant messaging (Information and Diplomatic Lines of Operation) that generates, our adversaries have already indicated that trans-Sahara migration to Europe will increase as the poor get poorer and weaker. I believed that CoViD-19 could be used as a lever to improve the situation in Mali with them learning from the failure of their first unsuccessful lockdown. Bringing all belligerents together to fight the common enemy. This was naïve to even consider because the politics and friction did not go away and there was not the foreign assistance to support such an objective. It is also a possibility that Putin picked his time in early 2022 to launch his 'special operation' into the Donbas and wider Ukraine because the world was weakened by the pandemic with countries having not invested or underinvested in mitigation against the risk of a major pandemic and the world responding incoherently with most countries acting in isolation and a mistrust of the WHO.

Similarly in the UK one would have thought that the first action the Prime Minister would have taken would have been to form a 'wartime' coalition. Although the parties cohered in the early

stages and the opposition appeared supportive of government's thought processes and decisions this did not last for long and broke down with the draconian legislation that was imposed then the seemingly optional requirement for government to adhere to its own policy. Contradicted with 'eat out to help out' following the re-opening of pubs and clubs which proved to be CoViD – 19 incubators as people concentrated in enclosed spaces again. A wartime coalition would have been a more effective brains trust supported by SAGE and the pan-government public health capability that is responsible for delivering healthy public policy in order to prevent or manage the threats to our biosecurity. **Richard Shircore** discusses an alternative to lockdown which again a wartime coalition might have been in a stronger position to develop and manage. With the common enemy's effects emerging and the requirements for the capability to defeat it being crafted and intelligent system would have identified those essential services and industries that were required outside of those defined as core eg the utilities, food, emergency and health services. A country on a war-footing would have kept those industries or created the conditions for industries such as PPE manufacture to be kept running and reinforced by those workers who's industries and business ewer not deemed essential. A much more effective system than total lockdown and furlough and reduced the temptation to fast-track procurement to companies who did not have the capability to deliver the requirements with the concomitant opportunity and risk of corrupt practices.

This lack of a wartime coalition cabinet and mistrust was amplified by the government's information campaign and messaging which was poorly managed throughout the CoViD crisis particularly from my perspective as an outsider looking in and as an operator during Op RESCRIPT. Controlling the media and messages with the Prime Minister's evening briefings did not cut it for intelligent individuals who were thirsting to know what the true situation was. Peter Sandman the US social scientist and risk communicator warns us that we need to manage our populations and communities' anger and outrage as part of the disaster risk assessment in order to reduce vulnerability. UK government arguably over- classified data eg mortality estimates presumably to prevent panic and disruption which led to mis, dis or mal information which had the opposite effect. Phrases such as: 'we're where we are', 'it is as it is' or 'this is unprecedented' are not helpful to anyone and had a major effect on the UK population's trust and confidence in the competence of the government to manage the crisis with legislation and policy often causing confusion and sometimes derision as **Iain Stainton** highlights in his paper. Both Iain and Richard recognise an element of coercion and control generated by the legislation of lockdowns and behaviours an observation made by other global commentators such as Bikash Koirala and their team's work carried out in Nepal. This highlighted a skepticism in Federal government of the local governments' capabilities to respond. This led to a lack of cohesion which was mirrored in the UK and other countries with a development chasm between the tactical and strategic levels which eroded the publics' trust in authority and the professions' confidence in government.

Even today the unintelligent are encouraging the ignorant and the enlightened to practise as if nothing had ever happened! NHS England who should be exemplars in promoting health security are stepping up drives to return their people to the office reported in the HSJ in February 2025. The politics and friction continues to frustrate transformative learning, capability development and leadership with managers insisting that we return to the transactional systems that they are taught such as LEAN, AGILE and PRINCE. Lean logistics does not work in a pandemic or any disaster and this was clearly demonstrated during the height of the CoViD-19 crisis. Countries such as UAE did well because of their prudent governance in mitigation and preparation, including stockpiling, that facilitated their successful response and recovery.

Intelligent all-hazards and a true multi agency response needs to be rehearsed and implemented early in order to learn quickly as more information becomes available about the threat and how to counter it. Good infection prevention and control measures are already in place across health and care settings and their people are aware if not proficient at protecting themselves and their patients against biological, chemical and radiological threats to biosecurity. Why was there a continuous change of policy which merely confused or irritated many health and care staff? Finally, why has the 'one health' or 'planetary health' concept never really been adopted globally despite the UN Sendai conference in 2015 advocating that disaster risk reduction, sustainable development and climate action should be fused and delivered holistically? Again these issues are highlighted in Maggie's paper.

Have we learned anything in the last five years? We hope that this reader will motivate you to challenge your own experience, beliefs and learning with the aim of improving our collective ability to meet the next pandemic head on and remain buoyant throughout the response with the resilience to return stronger rather than sleep – walking into the fragmented and weakened world that we are currently being forced to endure. Health security is only as strong as the weakest partners and is recognised as being one of the most important 'non-traditional' security issues by professionals and academics but not by all actors and audiences. Unfortunately for us our adversaries and potential adversaries know this and will exploit our weaknesses aggressively.

Biography: Richard Shircore M.Sc. FRSPH

My NHS career was in Public Health with a strong interest in Health Promotion. I co-wrote and taught a Post Graduate Professional Development Course in Health Promotion. From 1999 to 2002 I was seconded to a Crime and Disorder Charity. I published a number of papers on public health communication processes and techniques. I also specialised in child behaviour and assessment techniques. My experience of Covid was as a Community Responder with my local Ambulance Service.

An Alternative to Lockdown? Try a different paradigm

At the time of starting this paper (mid Dec 2023), the Covid enquiry under Lady Hallet is in full swing. Boris Johnson, the Prime Minster at the time, has said that the UK should have "locked down" sooner. It now seems that everyone appearing before the Hallet enquiry, is keen to agree on the "lockdown sooner" narrative. This "lockdown sooner", perspective is currently the only narrative in town.

In this maelstrom of self-flagellation by some and recrimination by others, some important considerations are in danger of being overlooked.

The most important being, was there any alternative to "lockdown", as it was actually implemented? It was implemented using both statutory action, such as the criminalisation of certain behavioural actions, with large fines. By the statutory closure of schools and other institutions and by allowing a climate of fear and dread to become widespread in the community, which was helpful in ensuring compliance with lockdown measures.

I shall argue in this paper that lockdown was driven by the adoption by health and social policy makers, of a paradigm around Covid that inevitably drove a coercive perspective with regard to managing the pandemic. I shall explain how paradigms are not necessarily "right" nor "wrong" but can be multivariate. In its pure form a paradigm is built around a set of scientific beliefs, frequently supported by available empirical evidence. However, what empirical evidence is adopted/chosen and for what reasons, is open to debate and revision as knowledge and the context changes. Moreover, in a real world situation elements of a Gestalt psychology come into play whereby even if there is little rational or scientific evidence for action, players and participants, create beliefs that bolster an accepted paradigm view to give credence (spurious or otherwise) to a specific policy position. This, I believe, is what happened during Covid.

I shall explain that there was an alternative to the draconian implementation of lockdown *once the mode of transmission had been identified*. Albeit with some need for specific contextual restrictions. I shall also argue that some of the enforcement increased likelihood of spread rather than restricting it. That much of the negative consequence of the pandemic, poor mental health, social isolation, interrupted schooling and personal distress could have been significantly mitigated if greater attention had been given to "following the science" rather than what was "thought to be" the science.

Preparing for Future Pandemics: If we are to manage future epidemics and pandemics without the dislocation, penury and the distress of pandemics like Covid, we must make sure we are knowledgeable of and appreciate the key elements of the paradigm which is guiding decision making. We need to appreciate that all

paradigms have limitations and weaknesses. In public health this is especially so as the Covid experience has shown us.

A two stage pandemic

A point rarely articulated was that the Covid pandemic was experienced by the public and many health professionals as a two stage pandemic in relation to the, "nature of the beast". The first stage of awareness say, January 2020 to June 2020, can be described as the "naïve" stage. Both medical, and government folk had little idea of what they were dealing with in respect to its nature, size and virulence. This confusion was not lost on the public. Was it contagious (transmission by physical contact) or infectious (spread via the environment)? This basic knowledge is important if an appropriate response is to be made.

There was confusion all round. I remember a TV doctor telling us to wash our groceries in a weak bleach solution to kill any infectious material on the packaging. Others took the advice and would put shopping in a different part of their house for 24 or 48 hours to ensure any infectious material would die off. We now know this was unnecessary but at the time we did not know any better.

However, by June 2020 it was becoming clear within medical circles that Covid was not a contagious (physical contact) disease but an infectious disease spread by aerosol droplets between an infected person and another. This realisation and appreciation was not readily made known to the general public. Quite why it was not remains a mystery.

What is a Paradigm? The term "paradigm" can be used different ways in different contexts. Within a science frame work it refers to shared, fundamental, beliefs regarding a subject. Without these very basic "shared beliefs" about the nature of their subject conversation and assessment of emerging outcomes would be impossible

In Western scientific medicine as an example, a key medical paradigm centres on the concept of *Homeostasis*. This refers to the ability of the body to keep its biological and chemical functions in balance and within parameters.

Thus specific benchmarks are accepted as indicating health. For example respiration (12 to 20 breaths per minute) and heart rate (adults – 60 to 100 beats per minute), blood glucose levels 4-7 mmol/l. Variation from these accepted indicators of *Homeostasis* indicating a biological pathology requiring further medical investigation.

Public Health being considered a scientific exercise is heavily influenced by paradigm perspectives. However, we need to know the limitations of using a paradigm as well as its strengths. We need to understand who contextual limitations impact on its veracity and capability to generate appropriate responses.

It is my contention that the Covid pandemic in the UK and the associated "lockdown" was the consequence of Government policy makers, adhering to a "set of beliefs" akin to a paradigm perspective regarding what they considered to be Public Health Practice. In consequence Covid strained the existing policy maker's idea of a public health paradigm for what turned out to be an aerosol borne disease leading to fundamental errors of risk assessment and public advice and information.

What then, were the constituent parts of the Covid "paradigm" that led inevitably to lockdown and the near paralysis of this country and other serious unintended consequences?

The Constituent Parts of the Covid Paradigm March 2020:

I suggest the constituent parts (beliefs) of the Covid paradigm as used and understood by policy makers (including public health leads) at the start of the pandemic were as follows.

The Disease Itself

1 The numbers of likely Covid patients in UK and the world constituted a pandemic.

2 That Covid was a highly transmittable. The infection route not known, and therefore a major threat to public health.

3 The disease constituted a national *medical* emergency as opposed to a major public health emergency

4 The mortality and morbidity rates would be high

5 The disease would be so virulent that it required statutory control of persons and property, utilizing coercion on public behaviour.

6 That Epidemiological Modelling was a reliable and objective science and that rates of infection can be accurately predicted.

The Public

7 People are incapable of exercising any form of agency, self-protection or personal risk management and that their behaviour must be managed, if need be, by coercion and criminalisation.

Public Health Resources

8 The loss of local Public Health capacity requires all decisions regarding the disease to be managed centrally.

It is instructive to reflect on the above paradigm and to identify which elements were relevant and appropriate and which were errors of perception and understanding.

Reflection and Deconstruction of Covid Paradigm Elements

1 *The presentation of the numbers of Covid patients in UK and the world constituted a pandemic. Comment:* This is correct. Data from China and then counties initially affected by Covid clearly showed that the rate of transmission, its morbidity and mortality clearly demonstrated this could be a very serious illness impacting on large numbers of people requiring action at the highest level.

2 *That Covid is a highly transmittable virus and therefore and a major threat to public health. Comment:* Initially knowledge of the virus and its mode of transmission was poorly understood. This reflected the belief that the disease spread could be by contagion, as referred to earlier. In reality the mode of transmission within the public sphere turned out to be by

"aerosol droplets" especially within confined spaces. The bottom line being that Covid in the public sphere was infectious not contagious. This is a very important distinction to make.

The failure to make known this fact generated some of the worst aspects of the public health management of Covid.

3 *The disease constituted a national medical emergency as opposed to a major public health emergency*. *Comment:* There is a considerable difference between a medical emergency and a public health emergency. The difference is that with a medical emergency to focus is on treatment of an individual with a pathology, in this case Covid. As such huge efforts were made to source ventilators and PPE (personal Protective Equipment) and to manage patient demand by building Nightingale hospitals. When considering a public health emergency the *focus is on public protection and prevention of the spread of the pathogen*. In this situation a very different mind-set is required.

The Ottawa Charter penned some years ago has pertinent things to say. It stipulates action on the following fronts:

- Build Public Health Policy: The UK did not have a well-developed public health policy for managing pandemics, starting with public health capacity. In times of austerity public health is seen as a public service that can be cut with little chance of public concern.
- Create Supportive Environments: One positive outcome was that there were plenty of examples of communities rising to the

challenge. But this type of response was generated by local people from the bottom up. Not aided nor organised from the top down.

- Strengthen Community Action: as with the above, much happened with local organisation but it was never planned centrally. It was never part of their paradigm. Individuals and organisation rose to the challenge.
- Develop Personal Skills: To develop personal skills requires knowledge. Apart from government mantras of "Hands, Face, Space" and "Stay Home and Protect the NHS", the amount of information on which to base personal or family "risk assessment and management" was very poor. The fear legacy was to be enduring. Particularly disappointing is the evidence that fear was deliberately used as a means of social control. An approach not to be found in any professional Public Health Ethics textbook.

4 The mortality and morbidity rates would be high. *Comment:* This was a correct assumption especially for those with chronic conditions of circulation or respiration. It was less accurate for younger people who may become ill but whose mortality rates would be significantly lower.

5 *The virus is so virulent that it requires statutory control of persons and property utilizing coercion of public. Comment:* Statutory control of people and places are not new. Probably the oldest and best known of such coercive practice being the quarantine acts whereby suspect persons,

cargos or animals are kept separate from the main population until a specific time lapse has passed.

Thus with Covid some control of people and places was inevitable and desirable. Yet its application by use of the legal system (Police and Courts) in many respects revealed the paucity of the paradigm being used.

This approach was not commensurate with the nature of the pathology of Covid being spread by air borne droplets when in prolonged contact with an infected person and in confined places. Open air car parks and other open spaces were closed off. People were told not to sit on park benches. This was irrational as being in the open air was one of the safest places to be. Certainly more safe than being cooped with others indoors.

6 *That Epidemiological Modelling is a reliable and objective science and that rates of infection can be accurately predicted. Comment:* Modelling can only be as good as the evidence supporting it. In the early phase of the pandemic the routes of transmission and inflection were poorly understood. You cannot therefore run a model with defective concepts of what you are modelling. Moreover people vary greatly in behaviour when threatened by a transmissible virus – the vast majority of people will act to reduce risk.

7 *People are incapable of exercising any form of agency, self-protection or personal risk management and that their behaviour must be managed, if need be, by criminalisation. Comment:* The use of the law was perhaps one of the most controversial aspects of the Covid Pandemic. As stated earlier statutory control of disease has a long and well established history. A blanket enforcement is however a

different matter. Again the mantra to "stay home" had a number of unfortunate results. When Covid is considered as a public health issue based upon it being an aerosol spread infection a calculation of "risk" become possible.

Clearly, enclosed spaces such as pubs and theatres are "high risk". Open air activities are generally "very low risk". Yet the statutory control led to the closure of carparks in the countryside and people fined for walking in parks and in the countryside. Again all "very low risk" activities. Similarly an open air funeral would be low risk, but not the wake if held indoors, but outdoors would have been possible at much lower risk.

We now know that the social isolation of people has led to an increase in metal health issues. It would have been far better if people had been encouraged not to be indoors but outside with others (taking precautions regarding close contact and aerosol transmission).

8 *The loss of local Public Health capacity requires all decisions regarding the disease management and public information to be managed centrally. Comment:* A further complication to the mind-set regarding pandemic management was the dilution of UK public health resources at a local level. Following the transfer of much population public health out of the NHS and into local authorities over an extended time frame 2005 – to 2015 funding has been systematically reduced as well as workforce numbers. *Quote: DsPH encountered various challenges over the past year. Key examples include workforce shortages within public health teams and not*

being properly engaged by central government regarding major elements of the overall response to Covid-19, most notably the national testing strategy and the roll-out of NHS Test and Trace. www.health.org.uk/sites/default/files/2021-09/Directors_of_Public_Health_and_COVID-19_Summary_WEB.pdf

With a poorly functioning and under-resources local authority based PH function policy makers had little choice but to plan and direct centrally. Thus the incapacity to engage with and to support local populations made a very bad situation worse.

Summary: The title of this paper posed the question of whether there was "an alternative to lockdown?" This paper suggests that some lockdown restrictions could be justified by the science, especially restrictions related to places with high concentrations of people in enclosed spaces such as pubs, clubs and theatres

Unfortunately, with regards to other aspects of Covid, public health and health information was off the mark, leading to unnecessary restrictions and legislative involvement. Critical deficiencies being:

- Failure to explain explicitly that, within the public domain, transmission was by aerosol droplet from one infected person to another non-infected person. Based on the above, a failure to explain or advise the public as to how "risk" could be managed.
- Statutory closure and control of open air public spaces which were "low risk" thus keeping people indoors where the " risk" was much greater as well as compounding physical and mental distress.

- Under-resourced and poor local public health capacity leading to a centralised public education programmes of poor factual quality and an inadequate ability to support local responses
- Failure to appreciate that Covid posed a public health challenge and not just a medical emergency.

Public Health and Ethics - a Postscript:

There is a need to reflect on the "fear" phenomena. This was a product of the messaging and reporting by central government consisting of various themes. These "fear" themes being: overwhelming the NHS, of transmitting infection to a vulnerable person, being prosecuted for an arbitrary "lockdown infringement". The virus being discussed by Government as if it was unstoppable and unquantifiable threat to all and sundry. This was, and remains a failure of professional and ethical standards of the highest order and is unforgiveable.

The Diary of a Plague- Covid 19; 2019-2023. Royal Society of Public Health.
Prof. John R Ashton C.B.E.

'John Ashton is regarded as one of the pioneers of the New Public Health for his work since the 1980's in the North West and internationally with the World Health Organisation. This has included innovative achievements in the fields of health promotion, teenage pregnancy, syringe exchange and responses to public health emergencies and clinical service failures. John was the inaugural coordinator of the WHO Healthy Cities Project in 1986. He is renowned as an advocate who is often an inconvenient witness. Awarded the CBE in 2000 and the Crown Prince of Bahrain medal for medical excellence for his work on the Covid pandemic. John's books include 'The New Public Health', 'Practising Public Health', and 'Blinded by Corona'.

The Diary of a Plague- Covid 19: 2019-2023

Introduction

As the year 2020 broke, and with it the first indications that a new virus was gathering momentum in Wuhan, China, the initial response of public health authorities in the United Kingdom was to play down any threat at home. This early complacency was surprising given that the public health community had long been expecting a pandemic equal to the so-called 'Spanish Flu' of 1919-1920 with its massive global toll of death. That public health catastrophe had occurred in a population whose health had been greatly diminished and made vulnerable by the privations of a long drawn out war in Europe in the years from 1914-1918. (1).

To understand the roots of this complacency it is necessary to register the sea change that occurred in attitudes to public health after the Second World War. As the world emerged from the second global conflict of the twentieth century, increasing hopes had begun to be held for the role of pharmacology and therapeutic medicine, reinforced by the miracle discoveries of insulin, penicillin and an increasing range of vaccines and other

pharmaceuticals; hygiene and environmental health had begun to take second place to the prescription pad and the syringe. In the new world the hospital was king and the achievements of Victorian public health based in the town hall were consigned to history. (2)

The belief that the advent of modern medicine, in its various forms, was leading to the demise of infectious disease was in part responsible for the run down in public health in many countries. This was not least in the U.K. where from 1974 the historic post of Medical Officer of Health in local government was actually abolished for a period, to be replaced by an administrative position in the hospital dominated National Health Service, devoid of levers to pull that might address the root causes of threats to population health.

A series of high profile failures in the resulting void created was illustrated by the deaths of 19 patients from salmonella food poisoning at the Stanley Royd psychogeriatric hospital in Wakefield and of 22 patients from legionella at Stafford hospital, both in 1988. Later that year a national epidemic of salmonella in poultry eggs ended the career of junior health minister, Edwina Currie and resulted in the slaughter of 4 million hens. Although the Chief Medical Officer of that time, Sir Donald Acheson, took steps to buttress public health arrangements, with the return of the Medical Officer of Health in the new form of Director of Public Health, albeit still within the NHS, the undervaluing of public health continued.

The salmonella and legionella incidents were but a foretaste of what was to come, not least from a series of novel infections and variations on old themes of influenza and other viruses. Also in the 1980's HIV/AIDS, with initially a 100% death rate, was followed by

Bovine Spongeiform Encephalitis, or Mad Cow Disease, caused by a novel prion organism, resulting from recycling animal meat into the feedstuffs of herbivores; Hong Kong or Avian flu occurred in 1997, caused by the H5N1 virus; Severe Acute Respiratory Syndrome, caused by the SARS-CoV virus, a relative of COVID-19 in 2003; Swine flu, caused by subtypes of the influenza A virus, including H1N1, H3N2, and H2N3 in 2009; and in 2014, Ebola , a severe viral hemorrhagic fever, with high infectivity and very high mortality, caused by the virus EBV.

In 2001 a massive outbreak of foot-and-mouth disease in cattle affected herds across the United Kingdom and to prevent them entering the human food chain tens of thousands were slaughtered and cremated with devastating impact on farm economies and the mental health of farm workers and their families. Taken together this series of traditional, infectious disease threats to the public might have been expected to produce a heightened sense of alert and for measures to be put in place, but it largely didn't happen.

The fallout from the terrorist attacks on the World Trade Centre in New York on September 11th, 2001, prompted an enhancement of emergency preparations against a range of threats, including those from biological weapons, with legislation defining clear roles and responsibilities, including a clear remit for local Directors of Public Health in the event of bio-terrorist incidents requiring specialist medical input. The remaining years of the decade were characterised by a continuing emphasis on health-emergency planning with regular 'table-top' and real-time exercises.

Following the 2009 Swine flu pandemic, a review in 2010 of the performance of the national public-health response, carried out by the former Chief Medical Officer for Wales,

Dame Deirdre Hine, concluded that the system had performed well. As a result of that report, and it's recommendations for further improvements, significant additional investment was made, including the provision of Personal Protective Equipment for frontline staff.

This momentum was not to be maintained. The combination of global economic turmoil that began in 2008, with a change in national government in 2010 ushered in a period of protracted austerity. The impact of this on public health resilience was compounded by a massive reorganisation of the National Health Service together with the arrangements for public health described by the NHS Chief Executive of the time, Sir David Nicholson, as being, ' So big you could see it from space'.

Although what was on the face of it a desirable move of public health directors and their teams back into the local authorities from which they had come 40 years before, the potential that this offered was compromised by other measures. The status of Directors of Public Health was diminished as they became line managed by Directors of Adult Social Care, their budgets and teams were significantly cut, and the settlement that had provided a pragmatic balance between central and local work for public health was abandoned in favour of centralisation under the new agency, Public Health England. This was to bring devastating consequences when Covid struck.

The Ebola outbreak in West Africa, in 2014, when Public Health England was caught flat-footed in its approach to screening airport arrivals from the affected areas, should have been a warning that all was not right when a high risk health worker, who had been nursing sick patients in Sierra Leone, slipped through the net.

More significant was probably the failure to update the 2013 Cabinet Office plan 'Preparing for Pandemic Influenza, Guidance for Local Planners' (July 2013). This would have made a useful starting point for a generic response to a novel virus, even though Covid-19 turned out to be different from influenza. The 2013 guidance was based on the underlying assumption of ' the rapid spread of (influenza) caused by a novel virus strain to which people would have no immunity resulting in more serious illness than caused by seasonal influenza'. Under such circumstances the guidance stated that the strategic objectives would be to minimise the health impacts by supporting international efforts to detect its emergence, and an early assessment of the virus by sharing scientific information; promoting individual responsibility and action to reduce the spread of infection through good hygiene practices.

Although the guidance started from the assumption of an influenza- like pandemic, the broad thrust of the detail went beyond the NHS to ensuring that the social care system would be able to cope and went on to consider the wider economic and social consequences for business continuity and to cope with other social disruption. Failure to adhere to what was set out in the 2013 Cabinet Office guidance would prove to be fatal in 2020.

When the COVID-19 pandemic gathered momentum, in March and April 2020, word got out about Exercise Cygnus that had taken place in England in October 2016. This had been a table-top training simulation of a pandemic caused by an unknown virulent Influenza strain. Cited in the New Statesman on her part in Cygnus, Chief Medical Officer, Dame Sally Davies, observed that "we've just had in the U.K. a three-day exercise on 'flu

in a pandemic that killed a lot of people. It became clear that we could not cope with the excess bodies". Additionally it was identified that there would be insufficient capacity for the artificial ventilation of those in respiratory distress and that there were insufficient supplies of Personal Protective Equipment (PPE). A full report of the exercise was produced in 2017 but it was never published and never acted on.
COVID-19 was a disaster waiting to happen.

The Plague Arrives

On 5th January 2020 the World Health Organisation reported that on 31st December 2019 its office in China had been informed by national authorities that cases of pneumonia of unknown cause had been occurring in Wuhan city in the Hubei Province. As of 3rd January, 44 patients had been reported of whom 11 were severely ill. On 7th January the Chinese authorities identified the pathogen responsible for the infections as a new type of coronavirus, similar to the SARS virus of 2002-3 and belonging to the same group of viruses as the common cold and epidemic viral pneumonia.

Early accounts of the illness caused by COVID-19 described a 'flu-like illness' characterised by cough, runny nose, sore throat, high temperature, and shortness of breath proceeding in a proportion of people to pneumonia requiring intervention with penetrative ventilation. The first death was reported on 11th January and the first confirmed case outside China on 13th January. As the numbers of confirmed cases in Wuhan neared 300 cases other began to appear in Japan, South Korea, and the USA, all among people who had visited Wuhan. On 21st January the China health ministry confirmed that person to person transmission

was occurring and on 23rd January Wuhan, a city of 11 million population, was locked down in quarantine.

On 24th January the Lancet published the first scientific paper on the epidemic by a group of Chinese clinicians and scientists reporting that one-third of those patients admitted to hospital required intensive care, with one-third of those requiring artificial ventilation. On 30th January the World Health Organisation declared that the coronavirus outbreak was a "Public Health Emergency of International Concern' (PHEIC).

As pandemic events came crashing down the news wires, the mainstream media became exasperated at the difficulty they were having in obtaining spokespeople at either national or local level; we subsequently learned that local Directors of Public Health in the United Kingdom had been forbidden to respond to media requests without national clearance. As a result, as a senior retired Public Health Director and former President of the U.K. Faculty of Public Health of the 3 U.K. Medical Royal Colleges, I soon found myself with regular requests for interviews as a public health expert.

On Saturday morning 1st February 2020 I stood outside Arrowe Park Hospital on the Wirral, being interviewed by SKY Television for their global news as buses with British evacuees from Wuhan arrived to be taken into quarantine. My message was succinct and clear, "What we are seeing now are the first few cases in New York and it's likely we will see more. With these situations it's like with the Millennial Bug when we took precautions coming up to the year 2000 with people concerned about computers crashing. We spent a lot of money and when it didn't happen people said 'what a waste of money'! You need to

be prepared, to put the effort in, and then if it doesn't happen, great! People should be concerned, concerned in order to take action and to look after themselves."

Over the next two years I was to write many articles about the pandemic for scientific and lay journals and newspapers. What follows is drawn from some of those, in particular, my monthly 'Podium' contributions for the Journal of the Royal Society of Medicine, articles in the British Medical Journal, and my book, ' Blinded by Corona- How the Pandemic Ruined Britain's Health and Wealth'.

The Diary of a Plague

February 2020.

As the virus arrived in the U.K. Public Health England refused to give the media a breakdown of where people had been tested and where the negative results were recorded. Public Health England (PHE) was even more secretive than China as very few of its own 5,500 staff were given access to these details.

Duncan Selbie, as Chief Executive of PHE, reporting directly to Health Secretary, Matt Hancock, seemed to go along with a hermetic seal on any data that might harm the government; when he had been appointed in 2013, Selbie had joked when accepting the £185,000 a year job that ' you can fit my public health credentials on a postage stamp'.

Commenting on the arrival of the evacuees from Wuhan to Arrowe Park Hospital, newly appointed Chief Medical Officer for England, Professor Chris Whitty, commented that the NHS was ' extremely well-prepared for managing infections and that it was trying to

identify any close contacts of the first two patients to prevent further spread'. This statement at the beginning of February was one of the few that Chris Whitty was allowed to make until mid-February with Health Secretary, Hancock, vying with Transport Secretary, Grant Schapps, Foreign Secretary, Dominic Raab, and Home Secretary, Priti Patel, to own the publicity surrounding the novel event. This was to change dramatically later.

In the second week of February 2020, I was contacted by the private office of HRH Crown Prince Salman of Bahrain with a request to travel to the gulf state and advise him and his newly established task force about the country's response to the threat from the coronavirus, the Crown Prince having seen my SKY tv interview and being anxious to be on top of the issue.

Despite having established the task force on 3rd February, the Prince had decided that he would leave no stone unturned to protect his people. His request was that I should visit Bahrain and forensically examine the task force plans to identify any weaknesses and recommend action to ensure that they were robust and effective. As a result of this invitation I was to make two field visits to Bahrain, from 22-25th February, and again in March and continued to be part of Bahrain's Task Force , remotely by Skype once further travel became impossible.

At the time of my first visit, on 22nd February, there had not yet been any cases in Bahrain, unlike in the UK. However there was growing concern about the situation in nearby Iran and suspicion that the Iranian government was withholding information about the true facts on the ground. A particular worry was the threat posed by Bahraini Shi'ite

pilgrims who were visiting holy sites in Iran; their return via different intermediary routes would pose a test of the arrangements for keeping the virus out of Bahrain.

A 26-person multi-disciplinary team including information analysts, epidemiologists, and public health consultants had been drafted into the War Room on 3rd February, where an information platform was put together that included streamed data from the Johns Hopkins University Coronavirus hub, together with live feeds from local hospitals and clinics and the Baraini national public health laboratory.

From the outset the Taskforce had unfettered access to real-time, raw public health data; precisely the level of information that PHE refused to share with local Directors of Public Health in the U.K. Already, in February, Bahrain's clinical facilities were being reconfigured to provide increased numbers of bio-secure beds to respond safely to the most seriously infectious patients.

Following this visit, and as a result of our close examination of the arrangements in place, these live information feeds were expanded with ever greater granular detail including Corona PCR test capacity, logistic supply-chain information on enzymes, reagents and swabs, Personal Protective Equipment (PPE), reports on the numbers of tests carried out and their results. A dedicated national phone number '444' for suspected cases led to a direct feed to the War Office.

From an early stage direct communication was established with the general public using iPhone technology based on the high levels of iPhone ownership in the country; this

communication initiative included pro-active rebuttal of adverse rumours from an early stage. This impressive initial response created a coherent coordination hub and excellent central support focus against which to explore the system on the ground.

The Crown Prince's brief to myself to leave no stone unturned and to be as critical and meticulous as possible proved to be a refreshing and realistic challenge. The approach I adopted was to walk systematically the passenger and personnel routes through the ports of entry: the airport, seaport, and the causeway linking Bahrain to Saudi Arabia, along which thousands of trucks and cars moved around the region every day. Each of the hospitals and clinics that were to be used for testing and isolating potential cases were inspected along with Bahrain's public health laboratory. Key informants were interviewed and rigorously interrogated, drilling down and forensically exploring for potential weaknesses in the environmental, social, and clinical biosecurity, possible points of vulnerability through which this simple but adaptable virus might gain entry.

The Task Force had moved quickly to increase clinical capacity by freeing up hospital beds, mobilising community clinics for triaging and testing suspected cases and upgrading wards and clinical areas to be able to care safely for patients suffering from serious infectious disease requiring artificial ventilation.

The second visit from 6th march 2020 included two further visits to the War Room, close examination of a new apartment block that had been requisitioned as a dedicated quarantine facility and of a 4,000 person high specification quarantine facility for new arrivals into the country that had been built by the army in 10 days; this facility had three bio-secure, discrete, zones and a range of social facilities including well designed

dormitory and dining areas, play facilities for the children and sports television marquees for adults.

Strengths and weaknesses of the plans and arrangements were identified on each visit and reported back in detail, and in person, to the COVID-19 Task Force, The Bahrain Health Council, and to the Crown Prince in 1:1 briefings, together with extensive recommendations. Although the prompt action of the Crown Prince in convening a Coronavirus Task Force and opening a War room, before there were any cases of infection in the country, had created a sound basis for preparedness, essential adaptations followed even at that early stage.

The key ingredient for Bahrain's success was to be openness to review and the recognition that outside scrutiny was not an unwelcome intrusion but an essential plank of preparedness. It enabled the country, unlike the UK, to turn in a response which would be among the best in the world and would subsequently be highly commended by the Director General of the World Health Organisation.

As a result of this openness an early vulnerability was exposed and immediately rectified in the form of inadequate capacity for virus testing, including PCR machines, reagents, enzymes and swabs. Prompt action enabled more than adequate supplies to be secured well ahead of the time when they would be needed, so much so that extensive testing and tracing of cases became the foundation of effective control. Operational failure to do this at the same stage would underlie UK failure to get to grips with the crisis.

Other weaknesses that were identified during my first visit in February 2020 and acted on promptly included:

* The need for a coherent, rigorously evidence-based narrative to galvanise the joint working of the many different agencies and to inform the strategy of public engagement and communications
* Awareness of weak links in the chain of control of the virus through the many possible environmental, social, and biological and clinical entry points into the country, safe flows of patients through the clinical system, together with robust Standard Operating Procedures with clarity of roles and responsibilities in the many frontline situations. Examples included protocols for case definition, mask wearing and handling the dead
* Specific groups and settings that might be vulnerable and pose a risk to onwards transmission: air passenger and merchant fleets; truck, taxi, and bus drivers; clinical and frontline health service staff; migrant workers living in labour camps; sex workers; prison officers an prisoners; residents of psychiatric and other long-stay facilities
* Collaboration with international partners to ensure that best practice was being followed, systematic logging of daily situation reports, experiences and actions to inform future learning.

As the virus was spreading in the UK the vulnerability arising from the environmental conditions of disadvantaged communities in Bahrain converged with that arising from the behaviors of the privileged and of devout faith communities in placing themselves and their intimates at risk. Action was proposed to test regularly and improve the environmental and living conditions of many of the migrant workers, who at times made

up almost 40% of people living in the kingdom, whose accommodation might make them vulnerable and provide a vehicle for community outbreaks.

This assessment and the prompt action that followed came just in time. On 24th February, the last day of my first field trip, the first case of coronavirus infection was confirmed. The patient was a tour guide for religious pilgrimages to holy sites in Iran and tested positive a week after his return. Normally a school bus driver, the patient had already ferried pupils from three schools on his bus and as a result testing began in earnest.

By my second field visit on 7th March most of the recommendations I had made the previous month had been implemented and there had been no further cases. Not only had the Formula 1 racing Grand Prix been cancelled, but also other large scale social events, mass gatherings and religious pilgrimages, a pro-active approach having been taken by the Crown Prince and the Bahraini Health Council, acting on my advice and that of the COVID Task Force.

Weekly screening of frontline health workers had been put in place and was extended to passengers and crew arriving at the international airport, where triage was now routine and following my visit to the main prison, where overcrowding was identified as a risk, 901 prisoners who were nearing the end of their sentences and were believed to pose no risk to the community, were released; blocks of substandard migrant housing were condemned and replaced. Bahrain's comprehensive and pro-active approach was to pay handsome dividends not only in limiting the health impact of the pandemic but also in protecting the country's economy.

With international anxiety growing and the virus accelerating around the world, pressure was growing on WHO to declare a pandemic. Having the good fortune to be in Bahrain with unencumbered access to all the relevant facts and encouraged be be open in my judgement of the situation it certainly looked like a pandemic as viewed from the War Room in Bahrain. Interviewed from the capital, Manama, on Channel 4 News by Cathy Newman on 24th February I took the opportunity to press for urgent action in Britain, too, asserting that "to all intents and purposes this is a pandemic… It requires the organised efforts of everybody".

Returning to the UK on Wednesday 11th March from my second visit to Bahrain, as WHO was declaring a global pandemic, and digesting the news about the rapidly unfolding public health crisis facing the country, the contrast with how Bahrain was getting a grip on the pandemic was stark. That Monday, Prime Minister, Boris Johnson had thrown caution to the winds and attended a rugby match at Twickenham, thereby sending out a message of false reassurance to the public. This week was going to be tipping point from which there could be no return.

Hundreds of thousands of race goers from around the country and beyond attended a four day race meeting in Cheltenham, beginning on Tuesday 10th March as 3000 Atletico Madrid supporters made their way from a city under COVID siege to Liverpool for a European football competition match. During a fireside chat broadcast on Johnson's Facebook page the same day Deputy Chief Medical Officer, Dr. Jennie Harries explained why Britain was so different: " in this country ", Dr Harries said " we have expert modelers looking at what we think will happen with the virus, big gatherings are not seen as something which is going to have a big effect".

From Monday's rugby match to Tuesday's fireside chat the number of known cases had quintupled and three weeks later distinctive spikes of deaths appeared around Cheltenham and Merseyside ; a physician in Ireland commented that half of his first batch of Corona patients in intensive care had travelled to Cheltenham for the races, by which time the British government had done a complete 180 degree turn and locked down the whole country, closing the stable door once the herd of horses had well and truly bolted , spreading the virus far and wide.

Travelling back to Liverpool from Heathrow airport on the Wednesday I had quickly made the decision not to attend the match at Anfield that evening. With the Johnson cabinet at odds with most governments around the world in its handling of the new pandemic the media was again casting around for public health experts who were not muzzled by political advisers or ministers and could cast light on the confusing messages coming from Whitehall. Speaking to the Daily Telegraph I explained my position that "bringing 3,000 supporters from a very high incidence area was basically just wrong, and the view that open-air events don't pose a threat is really simplistic. I hope I'm wrong but I believe that people were put in harm's way that night".

Having not attended the match at Anfield I found myself the same evening on BBC Television Newsnight where my comments capture my assessment of the situation at that critical moment : " We've got a complacent attitude… we've wasted a month when we should have been engaging with the public…if this now spreads the way it looks as if it's going to spread, there will not be enough hospital beds and people will have to be nursed at home…we should have got a grip on this a month ago…I want to know why we are not

testing, why haven't those people coming back from Italy and are now amongst us? We've got a recipe for community-spread here". (Thousands of families who had been skiing in the high prevalence areas of Italy during the Easter school holidays had been allowed to return home untested for the virus).

Among wall to wall interviews in live and print media that was to continue for months the following evening I found myself on the panel of BBC Question Time from West Bromwich in the Midlands facing government treasury spokesman, Steve Barclay. Fresh back from Bahrain where I had witnessed first-hand, first-class pro-active leadership and a systematic public health approach that was already demonstrating its effectiveness , my sense of frustration at a government unwilling to offer leadership, and a public health system in chaos, was only too apparent. My efforts to be heard were constantly thwarted by the panel Chair, Fiona Bruce, deferring to the minister despite the audience's whole hearted support for what I was trying to say.

By Friday 13th March, the sense of chaos became complete when the government's Chief scientific Adviser, Sir Patrick Vallance seemed to advocate an approach based on achieving 'Herd Immunity', allowing 60% or 40 million people to go down with the virus to interrupt its transmission. The words he used in a BBC interview that "our aim is to reduce the peak (of the epidemic curve), not suppress it completely; also, because the vast majority of people get a mild illness, to build up some kind of herd immunity so more people are immune to this disease and we reduce transmission, at the same time we protect those who are most vulnerable to it ", would come back to haunt him.

The following evening I was invited on Channel 4 NES with, Matt Frei, where I again critiqued the government response, saying that we were in a grave situation, only a couple of weeks behind Italy, that we had failed to test systematically, to engage with the public and to mobilise the community. In response, Dr. Clare Gerada, formerly Chair of the Royal College of General Practitioners, said that she was glad that I was not leading COBRA, (the pandemic steering group), instead of Johnson, that I was ill-informed.

Postscript.

Almost five years on from the beginning of the COVID-19 pandemic and with an Inquiry stretching out into the future, the events of those early days have been covered with competing narratives as those in key positions of responsibility struggle to reframe the storyline. My comments here draw exclusively on my contemporary record from the time and as incorporated into my many publications. As noted in a BMJ blog published on November 2nd 2020 I identified 5 recurrent features of the crisis; they bear reproducing here:

* The failure to get a timely grip
* Too narrow a range of professional advice
* Doing too little too late
* Overpromising and under delivering
* Poor communications based on inadequate intelligence and over centralisation.

It remains to be seen whether the lessons identified will truly be lessons learned.

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"*As a British Army Officer, specialising in health protection, I worked during the COVID 19 emergency to provide SME advice to Nightingale hospitals, COVID 19 testing sites and the use of the military for civilian authority tasks. As a Divisional Staff Officer, I also advised a the General Officer Commanding (a Major General) on the safe deployment of troops worldwide, during lockdown, helping the British Army to maintain its licence to operate and protect UK security. In 2021 I received a Chief of the General Staff commendation in recognition of my commitment to protecting military personnel throughout the emergency*."

The Civil-Military Perspective

During the COVID 19 pandemic the military was asked to support the emergency by manning the original COVID 19 testing centres, working in Nightingale Hospitals, working as additional staff in NHS facilities and in various other Military Assistance to Civilian Authorities (MACA) capacities. The British Army was also required to retain its licence to operate to ensure it could deploy at strength to defend National Security. This licence to operate was only granted when the British Army could validate its formations via formal military Exercises, both in the UK and Overseas. These Exercises necessitate the deployment of troops in a mock fighting environment so that they can demonstrate they can undertake their role proficiently.

The position of SO2 Medical Force Health Protection in the HQ of the 3rd (UK) Division, the only Warfighting Division, was responsible for planning the COVID 19 prevention, management and data collection for the formations deployed on the two largest military exercises during the pandemic. They were also the lead for ensuring the health protection of all 3 (UK) Div troops deployed on MACA tasks. This necessitated extensive liaison with both military and civilian public health networks and clinical leads within NHS and military care settings. The lessons discussed here have been identified as part of this role's work throughout the pandemic.

Lesson 1. Devolved Nations of the UK should seek to unilaterally agree specific Standard Operating Procedures for movements and testing of key workers (including the military) who work across nations during national emergencies.

The military, like many key workers, were required to work across national borders during the pandemic. These roles frequently took them away from their homes for large periods of time. The differing requirements for testing and differing restrictions for movement and households made repatriation to home units for soldiers confusing and difficult. This limited the effectiveness of those restrictions; this was especially apparent where same unit formations were deployed in different areas of the UK and were therefore treated differently. The differences damaged the integrity of the public health advice, reducing he perceived necessity and effectiveness of those interventions.

It is recommended that the public health authorities and Governments of the devolved nations recognise that some groups will have to cross borders during pandemics and agree standard operating procedures for key workers as a contingency matter. The consistency will support effective communicable disease prevention, protect public health

communication perception, the mental health preservation of those subject to restrictions and support resilience for national security.

Lesson 2: The UK public health authorities and Governments should seek to unilaterally agree Standard Operating Procedures with the 5 Eyes Nations[1] for communicable disease testing and public health protection interventions for key workers, including the military, that work internationally during global emergencies.

The first large deployment of troops overseas during the pandemic was for Exercise WARFIGHTER in the USA. This deployment was necessary to validate the effectiveness of our fighting power alongside a partner nation, demonstrating the interoperability of the British and United States Army. One of the limitations for COVID 19 management for the Exercise was that UK soldiers could not be tested in the USA medical facilities due to the requirement to have a US social security number. Of course, UK soldiers did not have these numbers. Although resolved during the Exercise it meant that the initial testing of UK soldiers could not be completed, impacting the immediacy of identifying a COVID 19 free population and starting the collation of valid epidemiological data for onward management. This is an example of where pre pandemic contingency discussions between public health and medical planning personnel may have identified this limitation and have avoided this impact.

Also, the differences in testing regimes and prevention/controls between partner nations meant that UK soldiers could be subject to different COVID 19 exposure levels when operating overseas: be that more or less rigorous than UK requirements. For example, some partner nation soldiers would be released from isolation following a positive test once they tested negative, others would have a set period before leaving isolation. These soldiers would then all mix together due to the nature of the interoperability necessary. This could impact repatriation to the UK of our military and subsequently the exposure to the civilian population of the UK. It is therefore recommended that 5 Eye Nations, have an agreed standard procedure for the movement and testing of key workers required to work across borders to protect all the civilian populations within partner nations. This becomes even more complicated with NATO exercises and deployments where there are potentially even more variations!

Lesson 3: The capacity of the local NHS facilities should be factored into the planning for all military exercises as a routine medical planning mechanism.

Although there were existing strong relationships between local NHS facilities and clinical leads, public health consultants and their military opposites there did not appear to be the same strong links between the medical support officers planning military exercises for Field Army formations. This meant that the planning of major exercises existed in an 'inform' the local NHS, rather than a 'communicate' at the planning stage. The formation of strong links is recommended to ensure that both testing and treatment of military does not overwhelm

[1] '5 Eyes' is shorthand for the intelligence sharing coalition between Australia, Canada, New Zealand, UK and the US.

local capacity or the area, especially when operating in times of National Emergencies related to communicable disease.

Lesson 4: The civilian public health authorities should be familiar with the military exercise activities and timelines, in addition to forming strong relationships with the military commanders and medical planners.

Contingency planning that includes awareness of how the military exercises and operates can prevent delays in decision making in times of national emergencies related to public health. For example, during the first largest UK deployment of soldiers on a validation exercise there was excellent support from the local public health authority, who held primacy for decisions related to the movement or control of the soldiers beyond the exercise boundaries. Whilst roles and timelines were discussed with civilian consultants delays for decisions did exist. If the public health consultants for areas where the military exercised were familiar with the formations and the structure of military exercises and the subsequent risks for example, awareness of signallers working in close proximity, then decision timelines could have been expedited. This was successful in some military regions, Wiltshire and SW England is a strong example, during the 'Swine Flu' outbreak in 2009 and 10 but the good practises from that event and lessons do not appear to have been learned or remembered. Politics and bureaucratic friction are also contributing factors.

Lesson 4: Key worker testing and data collection.

The military testing regime at the start of the pandemic was the same as that of the civilian population, having to be carried out at an official civilian test centre. The test results were sent to the individual and were accessible in the same timelines as for the civilian population. Whilst acknowledging the impact of negating to follow medical confidentiality protection, and the need to avoid preference for various sectors of the population it should be recognised that there are differences between the sectors of the population that may justify alternative management of tests and data including key workers.

Military people are exposed, by the nature of their work, to operating in proximity of each other as are their colleagues in the NHS. The military are also expected to follow certain directions and may be subject to investigation and trial by Military Law if their actions are deemed criminal when these directions or orders are not followed. This means that the military are both more at risk of communicable disease risks due to unavoidable contacts but can also be subject to stricter controls to reduce the risk exposure level. Often troops will also repatriate home to a family unit that will mix with the civilian population without distinction, not acknowledging the fact that one adult has been mixing with a different household whilst in a work setting. This unique situation could justify the recommendation that military tests are processed as a priority to limit onward spread of communicable disease. It may also justify the provision of information to a commander that a soldier is awaiting test results to help them mitigate exposure to their other soldiers.

Whilst undertaking the UK exercises the military would become a distinct subset of population within a civilian population. They would exercise on a camp and be confined to that camp. They would not mix with populations at home or outside of the exercise for a

defined period. The test results for these soldiers would become part of the geographical aligned public health authority area results without distinction. This meant that should an outbreak occur within the military population the civilian population figures would be increased, despite them being kept physically separate. This subsequently could have resulted in additional lock down interventions perceived to be unfair. This was not an intelligent use of the data which created undesirable effect for commanders and their soldiers. It is recommended that key worker tests are identified separately from the civilian population. It is also recommended that where exercising troops are operating in restricted movement areas these tests are treated as distinct to the civilian test results, and surges are investigated separately.

Lesson 5: Force Health Protection Instructions.

One of the success stories within UK military Environmental Health and Public Health Unit was the use of force health protection instructions. These documents had long been used in the military to inform and guide commanders and their troops on how to maximise their health protection during deployments. For example they would inform units and formations on vaccinations requirements alongside additional protective measures such as use of mosquito nets, 'peripel', arms and legs covered, antimalarials plus other advisory or mandatory interventions to avoid diseases specific to the area of the world they operated within.

The COVID 19 Force Health Protection Instruction provided commanders with consistent and thorough guidance on how to operate in the pandemic environment and protect their troops. This document covered a wide range of advice including: vehicle movements of troops, cleaning regimes, disease reporting and notification pathways, safety in smoking areas, ventilation, sleep arrangements including distances between bed spaces and household management guidance dictating cleaning regimes for accommodation, hand washing guidance rae a few examples.

Whilst information was provided on the government website for the civilian population on all the majority of matters covered above, it was covered on different pages and differed between the devolved nations. It is therefore recommended that one succinct, consistent document is provided and accessible across the UK. It is recommended that all workplaces are encouraged to provide information to employees on communicable disease control in this format in the event of outbreaks, especially considering their workplace ventilation and smoking areas. This could then be updated as a 'reissue' allowing the UK population to be updated with every change in advice, guidance, and legislation.

Lesson 6: Air repatriations and Management.

The mechanism and agreement for air repatriations of positive cases of communicable disease should be planned as a contingency matter by senior public health officials and the Government. This should be informed to all public health authorities of the UK, who should be prepared (in advance) to discuss with the logistical leads responsible for implementation in the event of an emergency within their area. There are well rehearsed standard operating procedures that the RAF, other single Services and NHS jointly train with for other very high

BioSafety Level communicable diseases but COVID 19 was deemed by government to be 'something different' and possibly 'more dangerous', demanding that new rules had to be created which only added to complications, inefficiencies and potential mission failure.

Early in the pandemic non symptomatic government employees were repatriated to the UK and held in a secure, guarded location. This repatriation was logistically supported by the military. Much criticism ensued following the photographs of a bus driver not wearing a mask or any PPE. Additionally, the failure to agree to repatriation of soldiers early in the pandemic, from operational theatres exacerbated mental health risks amongst deployed populations and risked ongoing exposure to communicable disease risk for partner nations that were rotating.

Early planning for various logistics management of movements would prevent confusion and delay.

Lesson 7: Behavioural specialists.

It is recommended that behavioural specialists are included throughout the contingency planning for both public health emergencies and their advice is shared with key workers and their employers.

During the military exercises several individual soldiers continued operating, despite exhibiting and suffering from early symptoms of the disease. When asked the soldiers said they didn't want to let the colleagues down or were concerned about the impact of not having a positive performance report post the exercise. The use of a behavioural specialist to predict and guide how to manage these situations would have been highly beneficial to those managing the control of cases. This is a scenario that was seen amongst the civilian population were individuals didn't want to let someone down or leave work due to financial situations or conversely when individuals were signed off sick were castigated by their coworkers.

Professor Maggie Rae CBE

FFPH, FRCP (Hon), FRCP Edin, FRCPath (Hon), FFSRH (Hon), FFOM (Hon), FRSPH , FFPM (Hon)

"*Maggie Rae is currently President of the Epidemiological and Public Health Section of the Royal Society of Medicine. She has interests in health inequalities, sustainable development, workforce, education and standards setting for Public Health. The COVID Pandemic was the fourth pandemic in her career. Maggie recently demitted as President of the Faculty of Public Health and worked closely with the Academy of Royal Medical Colleges, Local Government Association and a wide range of partners who have interests in Public Health. Maggie is committed to working with all 4 Nations of the UK and public health colleagues across the world to tackle poverty and inequalities*."

Covid Reflections

Introduction

Working in public health, we understand that pandemics are always a question of 'when, not if'. Those of us who have worked in public health long enough will have been involved in responses to SARS, H1N1, Ebola, Zika and of course HIV/AIDS – pandemics are something that public health professionals are trained to prepare for and respond to.

Despite this, no one – public health professional of otherwise – could have predicted the scale of the challenge that we were about to face when reports of Novel Coronavirus were made in Wuhan in December of 2019. In the coming months and years, nations across the world grappled with the pandemic as first infection rates, then deaths began to rise globally.

I took over Presidency of the UK Faculty of Public Health in July of 2019, and though the Faculty made achievements on climate change, anti-racism, tackling health inequalities, and many other areas during my three-year term; my time as President was necessarily, and rightly, dominated by the COVID-19 pandemic.

The following is an account of the UK response to the COVID-19 pandemic, and of the Faculty of Public Health and our members work to protect health for populations across the UK and internationally during a two-year period from March 2020 – March 2022.

A core part of this work was both advising and holding Government to account on decisions made during this time period. Delivering under immense pressure as they responded to the pandemic, Faculty members were not always supported by sound decision-making from Government. The decision to disband Public Health England in

the middle of the pandemic response, and failure to properly invest in local public health stand out as two particular examples here.

I remain immensely proud of the work delivered by Faculty members in response to COVID-19, and hope that if there is one lesson Government learns from the pandemic, it is that investing in a properly resourced and well-trained public health workforce is necessary to protect and improve the health and wellbeing of the nation.

March 2020

Faculty members were dealing with a torrent of advice on how public services should cope with what was still widely referred to as Novel Coronavirus. Sources of information included government departments, Public Health England, chief medical officer Chris Whitty and his colleagues across the four nations.

Public health teams were analysing and interpreting advice which was evolving rapidly, inevitably incomplete and sometimes contradictory, as different parts of the system struggled to understand what we were all facing and make their best efforts to shape the response.

Council public health teams needed to interpret the advice and explain it to a huge range of people. Inside the local authority this included the leader, chief executive, councillors, senior managers and teams covering services as varied as adult social care, education and trading standards.

The scale and variety of people we needed to advise in our local communities was astonishing. As well as those running shops, factories and offices we needed to advise people such as hairdressers, head teachers, religious leaders, fire officers, tattooists, massage therapists, delivery staff, takeaway owners and tailors.

Among the scores of issues we were trying to understand and address were how to handle suspected cases of Covid-19 infection in care homes, what advice to give people who were returning from countries with high infection rates, how to manage risk assessments for domiciliary care visits, advising people working on construction sites, deciding what to do about weddings and civil partnership ceremonies and working with public transport operators to try to keep services safe. We also had to think about mortuary capacity.

Across local government and the public sector, organisations were setting up their ‘gold, silver, bronze’ command structure for dealing with emergencies while increasingly operating through remote working and videoconferencing. From the beginning there was a palpable sense of collaboration and unity of purpose between teams and organisations as decisions that might have taken months in normal times were taken in minutes.

As lockdown hit on 23 March and the shocking scale of infections, hospitalisations and deaths we were facing became clear, everyone was trying to distinguish the urgent from the important as they struggled to get on top of the growing crisis and prioritise their work.

Incessant demands from government for information sometimes felt like an avoidable additional pressure, but we knew that our civil service colleagues were simply trying to understand the shape and scale of the problems and anticipate what was going to happen.

Faculty members felt it was important to speak out for those at the sharp end of the health inequalities that were being further widened by the pandemic. Towards the end of March the Faculty played a leading role in pressing government to support telemedical abortion services. We pointed out to health and social care secretary Matt Hancock that in the coming 13 weeks, as the pandemic was predicted to reach its peak, at least 44,000 women would have to leave their homes needlessly to access early medical abortion care. At that time the government was repeatedly refusing to follow advice from scientific and professional bodies to enable telemedicine for early medical abortion, but it agreed to change its policy.

April 2020

By the beginning of April Faculty members were focused on helping protect rough sleepers by preparing plans for local authorities to "get everyone in". The commitment came from government but the delivery came from councils.

The priority was getting hold of hotels and other accommodation to bring people in off the streets, and then ensure they and the staff caring for them could live and work safely. This was a huge undertaking, involving intensive work with charities, volunteers, the NHS and the private sector to set up systems for triage, assessment and care. Apart from meeting an urgent need, it gave public health staff a unique opportunity to build relationships with many more rough sleepers and to help them access support services for issues such as mental health and drug and alcohol dependency.

The whole project had to be managed carefully and sensitively, such as finding ways to ensure people with significant drug and alcohol difficulties could be supported separately. The 'everyone in' initiative was also one of the early tussles with ministers about meeting local councils' costs for Covid-19.

Mental health was already becoming a wider public health issue. The Faculty began sharing insight on how lockdown and illness would affect people at different stages of their lives, from the boredom and isolation of teenagers to the financial stresses of working age adults. We were also offering our own members advice on dealing with the pressures of having to work while self-isolating.

As the scale and breadth of the public health response grew it was impossible to ignore the impact of 10 years of austerity. Council management teams were severely stretched, with few support staff, while shortages of key workers such as school nurses meant it was a constant struggle to meet rapidly growing demand.

At government level, organisations such as the Faculty and the Association of Directors of Public Health (ADPH) were pushing ministers to understand how the virus was playing out in local areas and the impact of different pieces of guidance and legislation. But there

were too many occasions when the government seemed more interested in issuing instructions than listening to expert advice.

In an interview with the Telegraph I said: "While the injection of £3.2 billion of new cash to support local governments through this current crisis was welcome, further efforts are needed to give local structures the resources and mandate to enable the country to release the current lockdown measures and restore the economy without risking an uncontrolled second wave epidemic."

Recognising the pressures on the public health workforce, the Faculty announced we would be postponing examinations scheduled for early summer.

May 2020

By May there was palpable frustration at the failures in the supply of personal protective equipment (PPE) to frontline staff. The Faculty was among many professional organisations pushing for government to sort out the supply of PPE and the guidance around its use.

Keeping care home residents and staff safe was one of the biggest worries. Our members worked with care home managers and staff to address issues such as infection control, shielding for the most vulnerable, stopping communal activities and restricting non-essential visiting.

Supporting care homes was one of the hardest areas of work emotionally, because public health teams knew the immense toll that isolation would take on the mental well-being of many residents, particularly those suffering from dementia. Keeping loved ones apart even to the point of people dying alone was difficult for everybody.

Meanwhile there were signs that government was beginning to grasp the importance of local flexibility in the pandemic response. The Faculty was now part of the National Contact Tracing Design Group for the Test and Trace programme, but getting the local voice heard – particularly in the design and delivery of Test and Trace and getting timely access to detailed data on who had infections – was a constant battle.

Towards the end of the month I was trying to damp down the idea that the government's contact tracing app – then being trialled on the Isle of Wight – would be our saviour from Covid-19. In a joint statement with David McCoy, public health professor at Queen Mary University, we urged people to understand that the app could never be more than an "add-on" to a robust, locally-based contact tracing system.

Ramadan underscored how successful public health work is built on strong community relationships. Across the country public health teams worked with imams and community leaders to help Muslims adapt to the pandemic, such as through virtual iftars (the evening meal to break the fast).

June 2020

By June the UK was beginning to open up. A phased reopening of schools began, and non-essential shops reopened. Our members worked alongside everyone from the police to environmental health officers to help the public, businesses and organisations understand the new rules, such as enforcing the two-metre social distancing rule, wearing masks and taking precautions such as using screens on shop tills.

As this new wave of work built, the Faculty again focused on the growing mental health pressures we were seeing in communities. Demand that would have been expected in normal times but which had been hidden from view by lockdown now began to emerge, alongside new demand connected to the pandemic such as bereavement, domestic violence, isolation and substance abuse. Faculty members came together with GPs, mental health trusts and many others to try to quantify this demand and influence the planning of the recovery phase of mental health care by the NHS, local authorities and charities.

July 2020

Leicester and parts of Leicestershire became the first area to face a government-imposed local lockdown following a surge in cases. It was announced on 29 June and came into force on 4 July, just as pubs, restaurants and hairdressers were opening up in other parts of England.

The lower rates of Covid-19 infection over the summer months gave the Faculty a chance to analyse the response so far and press for action to prepare for future waves. I joined my colleagues in several other medical colleges in calling for a rapid review of the UK's preparedness for a second wave. In particular, we called for a review of parliamentary scrutiny, involvement of regional and local structures and political leaders, procurement of goods and services, improved coordination of disease control, examination of the pandemic's disproportionate impact on Black, Asian and Minority Ethnic individuals and communities, and greater international collaboration.

August 2020

As chancellor Rishi Sunak's Eat Out to Help Out scheme was grabbing the headlines, the Faculty was concentrating on the wellbeing of the workforce leading the pandemic response. We joined forces with the Academy of Medical Royal Colleges, BMA, NHS Confederation, NHS Providers, RCN and Unison to call for sustained support for the mental health and wellbeing of "weary and traumatised" staff, including better working conditions and a plan to boost recruitment and retention.

On 18 August we heard – via a story leaked to the Telegraph – the news that the government was abolishing Public Health England partway through a pandemic. It seemed barely conceivable that ministers would decide to destabilise and demoralise one of the pillars of the pandemic response at such a crucial time.

Our response stressed that the collaboration of Public Health England staff with local government public health teams had been the most successful part of the widely criticised Test and Trace system, vastly outperforming the national operation in tracing infection contacts.

Alongside the ADPH and Royal Society of Public Health we said: "Throughout the current pandemic, the public health workforce have acted with upmost professionalism; committed to protecting the health of the populations they serve at national, regional and local level, delivering exceptional work in the most pressurised of circumstances.

"With a huge strain already placed upon the public health system by Covid-19, this decision and the nature of its announcement will cause further stress and uncertainty to the public health workforce in England and across the UK."

September 2020

The hard-won gains of the summer began to unravel as infection rates began to rise rapidly again. The 'rule of six' restricting both indoor and outdoor gatherings in England was introduced, quickly followed by a return to homeworking and a curfew for the hospitality sector.

October 2020

As a three-tier system of restrictions was introduced in England we continued to listen to our members' frustration and anger about the abolition of Public Health England. Staff at the agency told us of their pride in the work they had done, how they felt their contribution had been downplayed compared with the work of NHS staff, and their concerns that the plan to replace the agency with a new national body which would only be responsible for health protection issues – with responsibility for wider public health priorities such as obesity passing to an as yet unidentified destination – risked fragmenting vital services.

There was also fear that the agency's abolition marked the demise of one of the few parts of government which understood how local public health systems worked.

Our submission to the government's spending review called for the restoration of £1 billion of public health funding, £3 billion investment in public health prevention and an increase in public health training places.

November 2020

The second national lockdown came into force as infections rose sharply. The big priority for the month was supporting local public health teams in developing Test and Trace operations in their communities, and pushing government to provide adequate funding.

It took many months to get the government to understand that local intelligence was key to controlling outbreaks. I had the chance to put our case on Newsnight in an interview with Emily Maitlis, arguing for a targeted approach to testing, a Covid-19 response led by

local intelligence and more capacity for public health teams in ensuring a successful rollout of the imminent vaccines.

Part of our argument around targeted testing was aimed at getting away from the idea encouraged by the government that testing was simply a numbers game – the more you do the greater the impact – and instead prioritise communities and settings where the virus was likely to spread quickest or harm the most vulnerable.

On 25 November we were stunned to learn that the chancellor had found not one penny of additional funding for the local public health grant in the 2020 spending review. It needed a substantial increase simply to recover the ground lost through cuts, and a multi-year settlement to enable long-term planning. But the chancellor decided that the greatest public health crisis in a century did not justify this investment.

With the Faculty's examination programme being essential in assuring the highest possible standards in UK public health practise I was pleased that the Faculty successfully held its first online examinations over three days in November 2020. That they went ahead with so few problems was thanks to a monumental effort by our staff and many members.

Among my speaking engagements for the month was the opportunity to address the Royal College of Physicians and Surgeons of Glasgow about tackling homelessness. While the 'everybody in' drive had provided some short-term relief for around 15,000 rough sleepers across the UK, it was increasingly apparent that many people who had lost their jobs already, or who faced losing them at the end of the furlough scheme, would be unable to afford accommodation. Around 600,000 tenants were already in rent debt, while in Scotland the death rate of homeless people per million population was double that of England.

December 2020

As infections surged throughout the month there was little time for reflection on a tumultuous year. The big question was the extent to which people would be allowed to mix over Christmas, and the wisdom of doing so.

Throughout the constant swerves in government policy – from announcing a significant Christmas relaxation on 24 November, to urging people not to do what the government was allowing them to do on 15 December, to a formal tightening of the rules on 19 December long after many families had finalised their Christmas arrangements – the Faculty stuck to its message of avoiding mixing indoors.

I got the chance to put our message across on Sky News, warning that the consequences of mixing on Christmas Day would be seen in the first two weeks of January, and urging people to protect their relatives by not spending time together.

Meanwhile, the second lockdown ended at the beginning of the month to be replaced in England by the tiered system, which was itself strengthened 17 days later. But at last the first vaccines began to be administered.

January 2021

As the seven-day rolling average of confirmed new cases peaked at 60,000 and the UK began its third lockdown, local public health teams were mobilising to support the accelerating vaccine rollout. Across the country, public health directors worked with community leaders in mosques, churches, temples, synagogues and community centres to ensure high take-up of the jab among the people who needed it most.

After so many dark months it was uplifting to see respected people such as imams playing a key role in getting the message out about the safety and effectiveness of the vaccines, including opening up their facilities as vaccine centres and being photographed and interviewed about being vaccinated themselves. It was a great example of how the trusting relationships built over many years are crucial to implementing successful public health strategies. Addressing health inequalities is a core value of the Faculty, and that shaped our response to the vaccine programme.

History repeated itself with another round of difficulties getting hold of vital local data. This time it was persuading the government to give us detailed information on who had, and had not, taken up the offer of a vaccine.

Meanwhile the Faculty in Wales reported that the country's Test Trace Protect service, which was embedded in local authorities, was working well.

February 2021

As the lockdown succeeded in rapidly driving down new infections, the government released its white paper on reforming the structure of the NHS to promote local service integration. We were pleased that ministers had listened to the arguments of the Faculty and many others that public health needed to remain part of local government, but took the opportunity to call yet again for a £1 billion increase in the public health budget and a multi-year funding settlement.

A year after the first Covid-19 infection was reported in the UK, we announced a survey of our members to identify the different ways the pandemic had affected their mental and physical health, training, and career aspirations.

With public concern shifting to the risk of mutations undermining the vaccine programme, I wrote an opinion piece for the BMJ outlining that an effective early warning system was essential, saying: "It is worrying to see how the results of Imperial College London's REACT study and the Office for National Statistic's infection survey still do not tally with the data we have coming out of Test and Trace. To enable public health teams to take effective action to prevent infection rates rising, we need to fix these problems. Public health teams need fast access to accurate, granular data – as opposed to the delayed access to inaccurate data that they currently receive – so that they can quickly spot where localised outbreaks are taking place and mount an appropriate response."

During the virtual British International Doctors' Association conference I again highlighted the way the pandemic had exacerbated existing problems such as stalling life

expectancy and widening health inequalities, as well as discussing the need for effective international collaboration to ensure global access to Covid-19 vaccines.

Among the month's meetings, I was particularly pleased to join Prof Chris Whitty for a discussion with BAME health professionals, focused on removing barriers to vaccine uptake among disadvantaged and minority ethnic communities.

March 2021

As the number of confirmed cases continued to fall from the January peak and plateau, the government activated Steps 1 and 2 of removing Covid restrictions in England. On 8 March schools in England reopened for primary and secondary school pupils, while from 29 March outdoor gatherings of either six people or two households were permitted, including in people's gardens. The 'stay at home' order ended, but people were encouraged to stay local.

The government revealed more details about the reorganisation of public health bodies. Its paper 'Transforming the Public Health System' published at the end of the month said the health protection capabilities of Public Health England would be combined with NHS Test and Trace to form the UK Health Security Agency. The health improvement and prevention functions were due to transfer to a new Office for Health Promotion, but it was still far from clear whether these vital roles would get the profile and resources they deserved. Important details on where responsibilities for services such as screening and immunisation and dental health would sit were absent. We also wanted to see clearer support for public health staff such as school nurses and health visitors.

Throughout the consultation process we stressed the importance of local and regional directors of public health, who had played a vital role in connecting local public health teams with the centre as the pandemic built, and in mobilising resources and expertise in the face of major outbreaks.

But the paper did show that FPH and ADPH lobbying had led to the recognition of the leadership role for directors of public health in the new integrated care systems (ICSs).

The government's focus on structural change at the centre seemed a long way from the urgent local priorities, such as the incontrovertible link between poverty and the impact of Covid-19, and the ever-growing racial disparities in health outcomes.

A key priority in tackling inequalities was – and remains – equitable access to vaccination, both in the UK and globally. I had a chance to talk with our Sudan Special Interest Group, led by Dr. Mayada Abu Affan, about their work with the World Association for Sustainable Development to ensure vaccine access for all.

Among work beyond the pandemic, the Committee of the Faculty of Public Health in Scotland published a briefing for prospective MSPs ahead of the Scottish Parliamentary

election in May, highlighting how much work still needed to be done to tackle health inequalities in Scotland, despite progress on issues such as smoking and alcohol.

The UK government's announcement that £3.3 billion had been allocated to public health funding for councils for 2021-22 – just 1.4% up on last year's budget – was nowhere near adequate to respond to the challenges ahead. It stood in sharp contrast with the vast amounts given to programmes such as NHS Test and Trace.

April 2021

Whilst UK rates of infection remained relatively low, India recorded a huge rise in confirmed cases and deaths. Against this backdrop, the Faculty again pressed our government to do more to ensure global access to Covid-19 vaccines, stressing that safety at home ultimately depended on vaccine coverage in all countries.

It was clear that while the UK had the infrastructure and supplies to vaccinate low risk adults, the global vaccination consortium Covax was struggling to secure and distribute supplies. The UK had already bought enough doses to vaccinate the adult population four times over. We called on the government to release 30% of its pre-purchased vaccinations to countries least able to secure supplies, and to support the scaling up of local manufacturing capacity in low and middle income countries.

May 2021

Infection rates were still low but there was a notable increase among 13-17-year-olds, and rates in Yorkshire and the Humber was higher than other regions. Covid restrictions began to loosen. From 17 May, those in England were allowed to meet in groups of up to 30 outdoors, as well as groups of six indoors or two households, as the government declared the country had reached Step 3 of the roadmap out of Covid restrictions. But people were advised to continue working from home if they could. Mass events outdoors were allowed to restart for up to 10,000.

My engagements for the month had a strong international feel, including a regional meeting of the World Health Organization's (WHO's) working group on health and climate change, where we discussed how the health community could support an equitable approach to recovering from the pandemic and addressing climate policy. I was also pleased to address the launch event of the UK Chapter of Women in Global Health.

We were also working hard on the continuing fallout of the plan to abolish Public Health England, which meant some of our members faced an uncertain future. We continued to talk to government about our concerns that public health services would become fragmented.

At the end of the month there was a worrying increase in confirmed Covid-19 cases.

June 2021

The relatively low rates of Covid-19 infection during April and May gave way to a rapid rise in cases as the more transmissible Delta variant became established as the dominant strain in the UK, accounting for 90% of cases. The surge in infections forced the government to delay the further lifting of restrictions planned for 21 June until mid-July.

On 28 June, in an article in the BMJ, I again presented the Faculty's argument that the government needed to replace its "eye-wateringly expensive mass testing strategy" with targeted testing led by local intelligence from council public health teams, and prioritise groups and settings where the virus could spread quickly such as schools, universities, hospitals, care homes and workplaces. We had been arguing for months that it was a mistake to see the test and trace strategy as simply a centrally-driven numbers game.

Three days earlier, the National Audit Office (NAO) reported that NHS Test and Trace had spent £13.5 billion in 2020-21. It highlighted significant difficulties with its operations and impact, including continuing failures to provide local authority public health teams with the data they needed when they needed it.

July 2021

After peaking mid-July, confirmed cases fell back a little towards the end of the month. Deaths crept up again as the Delta variant made its mark, but the success of the vaccination programme in containing serious illness and deaths was clear.

The government pressed ahead with Step 4 of the roadmap, removing most legal restrictions on social contact in England and reopening the final closed sectors of the economy, such as nightclubs.

In a joint response with the ADPH, we stressed that the pandemic was far from over and that handwashing, ventilation, testing, isolation and face coverings in high-risk settings remained vital tools to help prevent further transmission of the virus.

August 2021

The summer holidays and warmer weather helped keep new infections in check. They rose a little during the month but stayed markedly below the July peak. Deaths within 28 days of a positive test continued to creep upwards, but at a much lower rate than in Europe as a whole.

A major focus of our work over the summer was lobbying around the Comprehensive Spending Review expected in the autumn. We worked closely with the Local Government Association (LGA), ADPH, Royal Society for Public Health and others to lobby government for adequate public health funding.

In a talk to the Institute of Government and Public Policy, I pointed out that the public health grant was around £3.3 billion a year, compared with £140 billion for the NHS, and that spending on public health would lead to a huge return on investment.

September 2021

Deaths across the UK continued to rise slowly, while new infections broadly held steady. Concerns about a surge in winter infections were palpable, with the government outlining potential Plan B measures such face masks to be used if the NHS came under unsustainable pressure.

I gave evidence to the House of Commons' committee considering the Health and Care Bill – which put ICSs on a sound legal footing – alongside Councillor James Jamieson, chair of the Local Government Association.

My message to MPs was the need to prioritise health inequalities as we recover from Covid-19. I argued that a key reason why the UK was losing so many lives the virus was that we had one of the most unhealthy populations in Europe. To justify yet another upheaval of NHS structures, these new organisations need to be focused not simply on treating disease but on managing population health. That means working with local government and its public health directors to understand the evidence about the distribution and causes of ill health in each area and taking firm action to reduce health inequalities.

Parliament remained at the forefront of my mind during the month as we continued our lobbying in the run-up to the Comprehensive Spending Review to restore adequate funding of public health.

The critical role of public health directors in the pandemic response was underscored by a report from the King's Fund on their contribution. Its report A Year Like No Other explained their leadership in meeting a wide range of health protection activities, from community testing to supporting the vaccination programme and providing everything from food to emotional support for local people.

October 2021

New cases rose to levels not seen since mid-January before abating a little towards the end of the month. Daily deaths climbed to a rate not seen since mid-March.

In response the Faculty join forces with the LGA, Royal Society for Public Health, Chartered Institute for Environmental Health, the British Medical Association and senior local government officers' body SOLACE to call for strong, urgent government action to contain the spread, such as by discouraging travel and strengthening the vaccination drive in communities with poor uptake. We warned that without decisive intervention we risked seeing exponential increases in deaths over the winter months.

One of the worst health crises in a century was not enough to secure adequate funding for public health in the chancellor's spending review. We accused the government of a dereliction of duty in failing to honour commitments to address health inequalities and take robust action to prevent ill health. The government had now cut the public health budget by 24% in real terms since 2015/16.

November 2021

Confirmed cases continue to decline over the first week of November before beginning what became a relentless two-month rise. Deaths continued to fall, but we knew it would not last.

On 26 November the WHO designated the variant B.1.1.529 – Omicron – as a variant of concern. Evidence from South Africa, where it was first identified, hinted at far higher transmissibility compared with earlier variants. It was already in the UK by the middle of the month. Still the government did not act.

The Faculty's observer status at the United Nations' COP26 conference in Glasgow on climate change gave us a platform to encourage policymakers to make the connection between global warming and harm to health. With more than 20 organisations from across the world, we called for immediate and large-scale changes to energy and finance systems to protect health by limiting global warming, alongside work to help communities become more resilient to the climate crisis. Global warming and its impact is a central priority for Faculty.

At the Local Government Chronicle Awards a special presentation was made to honour the contribution of the country's public health directors to protecting their communities during the pandemic.

December 2021

New cases rocketed towards 200,000 a day – far exceeding earlier waves – as Omicron gripped the country and replaced Delta as the dominant variant. Hospital admissions and deaths began to climb again as the new year approached, but at a far lower rate than the previous winter thanks to the vaccinations and better treatments. The extraordinary prevalence of the Omicron variant complicated the figures, because of the significant numbers of people in hospital with it rather than for it.

On 8 December the government finally moved, announcing Plan B measures in England. Two days later, facemasks became compulsory in most indoor public venues and the NHS Covid Pass became mandatory in places such as nightclubs.

Yet again I used platforms such as the BMJ to push our message that unless the government took firm action at home and did more to support global access to the vaccine, there would always be a serious risk of the NHS coming under unsustainable pressure.

Analysis of the results of our members' well-being survey, which attracted almost 800 responses, highlighted the toll the pandemic had taken on public health staff. Around half said they felt emotionally exhausted, overwhelmed or frustrated, with most respondents reporting feelings of depression, anxiety or isolation.

The impact was felt most keenly outside the workplace, with significant deterioration in family time, sleep, leisure activities and general life satisfaction. The main causes of poor

mental health and wellbeing were work stress, unmanageable workloads, social isolation, frustration at the government's response to the pandemic, uncertainty about the future and feeling unable to influence events. Around one in six had accessed formal mental health and well-being support.

One of the toughest challenges for healthcare workers the world over during the pandemic has been 'moral distress' – experiencing unease and anxiety because they feel constrained in their ability to do what they believe to be ethically correct. So we began a new study among our members to measure the scale and impact of moral distress, identify situations that caused it and promote strategies to cope with it.

January 2022

The year began with the pandemic reaching another unwelcome landmark, with confirmed cases across the UK peaking at over 200,000 in one day, before more than halving by the end of the month. Confirmed deaths stayed stubbornly high, averaging well over 200 a day for most of the month. Public services were hit by high absenteeism as staff self-isolated.

Throughout the pandemic, local public health teams had been concerned about the disproportionate impact on BAME communities, and since the beginning of the vaccine rollout had been working hard to build trust with them and give them the confidence to be vaccinated. Among the most striking interventions had been the role that BAME healthcare professional networks played in forming a bridge between their communities and the healthcare system.

In January the Faculty began planning an evaluation of these interventions, to assess their impact, understand whether they were a feasible and appropriate way of reaching minority ethnic groups for health and care purposes and explore the role of BAME professionals as trusted community agents.

The BMJ was immensely supportive of the Faculty in promoting our message to fellow healthcare professionals and government throughout the twists and turns of the first two years of the pandemic. On 19 January, with several hospitals declaring critical incidents, they published an article by me which argued that "it is profoundly unhelpful that the government has not updated its official – and now outdated – list of symptoms", leaving us lagging behind the WHO, US Centers for Disease Control and Prevention and many other agencies internationally.

One of the more welcome priorities for the coming year was celebrating the Faculty of Public Health's 50th anniversary, at a time when a home and a voice for public health professionals have never been more important. One of the highlights we were able to announce in January was that we would be joining the Royal Society of Medicine in hosting the four UK chief medical officers for the annual DARE Lecture in May, which celebrates the contribution of the public health workforce and discusses its future role.

February 2022

The deaths finally began to subside as the number of confirmed new cases continued to fall – although an uptick at the end of the month proved a precursor to another steady climb. This followed the announcement by Boris Johnson on 9 February that all Covid regulations – including the requirement to self isolate after testing positive – would be abolished on 24 February, a month earlier than Downing Street had indicated in January.

I made clear my anger, writing in the BMJ, "Throughout the covid-19 pandemic we have seen a chronic failure from the government to deliver clear public health messaging in support of an effective, long term strategy to combat Covid-19… The latest ill-conceived decision to scrap free Covid-19 testing and end Covid-19 restrictions represents a dangerous knee-jerk reaction."

Whatever the pandemic looked like from Downing Street – still immersed in the Partygate affair about its own lockdown breaches – public health staff could see in their local areas that it was far from over. For us, finding a way to 'live with Covid' did not mean giving the impression that it's all over and we could drop our guard. It meant finding ways to get on with our lives while making sensible, proportionate adjustments to keep each other safe and enable health agencies to maintain effective monitoring to guard against developments such as further variants.

I was particularly infuriated by the announcement that access to free tests would be abolished. It was obvious this would hit the most vulnerable and widen health inequalities even further, because people with low income would be unable to afford to pay for test kits. Government was now moving from vastly expensive and indiscriminate testing to effectively abolishing it for the communities who needed it most. I also feared that giving the impression it was all over would significantly weaken the vaccination drive.

The government should have focused on saving lives by getting the protection measures right instead of abolishing them altogether. We needed a free testing system which targeted high risk populations to quickly identify infection spikes and new variants. We also needed to do even more to address issues of vaccine equity, with people in the most deprived areas twice as likely to be unvaccinated as in the least deprived. Most important of all, we needed to learn the public health lessons from the pandemic and have a plan across central and local government and the NHS to address the causes and effects of health inequalities.

The end of Covid restrictions came four months before the completion of my three-year term of office as president of the Faculty of Public Health. As the pandemic unfolded the eight elected officers of the Faculty and our small team of staff had done our best to give the expertise and insights of public health professionals a voice in public debate and government decision-making. It took many months for ministers to accept that local government public health teams had a critical role to play in providing intelligence about how the pandemic was developing and being in the frontline of the community response to the virus.

Any success we had as a Faculty was down to the dedication of our local members and officers. However difficult the pandemic became, it was always uplifting to see the determination of public health teams to keep their communities safe, despite the shortages of money and staff and the difficulties in getting the right information from government.

Partnership working was at the heart of each response, from colleagues on the council to schools, care providers, businesses and community leaders. There is now far greater understanding of the importance of public health policy and practice, and the relationships from the pandemic will strengthen our work for years to come. I'm so proud of everything that the Public Health Services in the UK and around the world achieved.

Iain Stainton

Principal Lecturer, Policing Criminology and Law, University of Cumbria.

"Iain is a Principal Lecturer in University of Cumbria's School of Justice, bringing over 30 years of operational policing experience to this academic position. From originating one of the first Police - Academic collaborations in 2010, to designing, delivering and managing a series of Policing oriented higher education programmes. Iain prides himself on combining practitioners' views with an academic approach to his team's learning material. This content originates from a wealth of personal and professional experiences and conversations. Always enthusiastic to speak about policing matters Iain can be contacted at: iain.stainton@cumbria.ac.uk"

POLICING COVID

I was looking forward to Thursday 19th March 2020. A Civil Contingencies exercise had been planned for my students providing an opportunity to bring real word emphasis to their studies. Testing real time decision making and introducing dynamic demands to these professionals of the future. The materials had been created and everything put in place, final checks were interrupted by a colleague who recommended I check my messages. Thus Covid 19 arrived in my professional world.

Three decades as a police officer prepared me to dynamically respond to most occurrences, drawing on policy, guidance tried and trusted plans, referring to experiences, accessing and analysing my own internal databases to react professionally to most matters. A move to higher education introduced decision making drawing on theory and analysis of past events and responses to provide solutions for future actions.

The unique challenges of Policing Covid 19 in turn challenged all these tried and trusted techniques officers rely on to support their practice.

The 1829 '*Peelian*' foundations of Policing, summarised as the public being the Police and Police being the public establishes the situation where the police are the guardians of our society's security. Effectively being the section of society charged with the full-time role of preserving the peace to be found in the aged social contract establishing the foundations of this arrangement across both society and its guardians. Consider then the challenges and uncertainty that officers and Police staff faced in addressing the situation professionally when at the same time they were replicating the actions of many of us, drawing their families and loved ones into a protective cocoon whilst embracing their duty to protect all of society in a duality of protector and protected. Giving rise to a set of considerations it would be difficult to explain to those who have never experienced such contrasts.

Fielding (2005) explains that Policing often operates at the heart of social conflict, addressing an eclectic range of behaviours ergo at first sight policing was well prepared for the forthcoming challenges. Much comment and opinion is currently ventured as to trust in Police. The transparency and fairness of many policing actions is built upon a realisation that laws represent matters society does not approve of and a realisation that policing is charged with addressing transgressions on our behalf, thus providing an acceptability of actions that would not otherwise be tolerated. Such was the speed of developments during lockdown with little foundation in matters we are familiar with, which coupled with the evolving safety messages the result of which seemed to be to instil fear, that the unjustness of restrictions and associated police actions became prevalent, amplified by the ability of all citizens to be journalists in our digital age.

Those who work with risk are rarely described to be risk seekers. Risk professionals mitigate risky environments to achieve an acceptable threshold. Considering this alongside the Peelian principles helps to recognise that during the constantly developing risk scenarios of Covid 19, when guidance to isolate, socially distance and remain in tightly controlled groups were being reenforced by constantly evolving warnings as to the dangers of not doing so; the position of police officers and staff who were balancing these restrictions on their own personal and family life against the duty to police as closely to normal as the far from normal circumstances permitted; a situation which would verge on the untenable to the non-policing public.

Police officers are leaders in many demanding situations, it is recognised that police arrival at a scene is often accompanied by a transition of control that has more to do with a uniform than any perceived seniority. This situation has become part of our society's norms over lengthy periods when police officers were recognised as experts in their field. Issuing and receiving direction, and guidance in the early stages of any challenging environment has more to do with the perceived legitimacy of those issuing the direction than specific expertise a matter police training as long recognised. When combined with the realisation that initial responders are apt to be the least experienced, the importance of society's trust in the legitimacy of policing is paramount.

As an emergency service it is expected that policing is at the forefront of any crisis situation, such as with Covid 19 when officers were charged with policing the wider determinants of public health such as travel, residence, social distancing and public gatherings all of which in less demanding times would be regarded as overly intrusive. The legitimacy of intrusive practice is commonly legislated for providing a necessity balance between benefit and detriment. The evolutionary manner in which law mirrors social norms is reflected in the emergency powers provisions of Civil Contingencies Act 2004 (CCA) which provided foundations for emergency planning such becoming law. The chosen path of Coronovirus Act 2000 (CA) as legislation introducing legal obligations introduced a challenge to the perceptions of Police as informed arbiters of law and the powers it bestows. Emergency situations allow no preparation opportunities, whilst general planning under the terms of CCA was invaluable, CA provisions detail was being provided to the public in the same time frame and detail as to the Police further eroding the expert status.

The College of Policing 4 E guidance to Engage, Explain, Encourage before considering Enforcement may be interpreted as defining a policing approach which has been found to work since the adoption of the modern police in 1829. The role of policing societal restrictions during lockdown tends to introduce a barrier between police and public. Personally, I experienced a nervousness on noticing a police vehicle, mentally preparing a reason for being at a place at a time whereas in more normal times I would barely register a policing presence. Anecdotally I learned of a plethora of calls to police accusing neighbours of lockdown transgression each requiring attention, the result of which had a tendency to introduce a Panopticism based siege mentality within communities

Whilst the Covid 19 Policing role is comparable to that of National Health Service workers, the public perception seems different. One of the tenets of Policing is protecting the balance of freedoms alongside preserving the peace and protecting society from harm or injury. In customary periods the use of law and associated powers granted to the office of constable are acceptable to the majority, and restrictions provided in law and ramifications for breaching them accepted as a 'price worth paying'. Public support has the ability to lessen the demands of the most trying situations. However, the visibility of support for health workers did not seem to be mirrored to policing. It is not possible to calculate if this affected officers' perceptions of how the public related to their actions but if there was an effect it must have been negative.

The majority of us are not legal scholars but do understand we should not assault fellow citizens, steal, speed or insult amongst a myriad of other laws. We understand the reason for and value of societal rules. The chosen regulatory path of Coronavirus Act 2020 and Health Protection (Coronavirus Restrictions) Regulations introduced hitherto unknown laws to govern society's actions and was given to the Police to enforce. Policing an era of uncertainty through uncertain powers and laws created a cocktail of insecurity which feeds suspicion and disdain. Communications strategies employed during lockdown were accompanied by commentary and opinion, the traditional era of expert guidance being replaced by the speed and coverage of the digital era bringing a previously unencountered opportunities for expert and pseudo expert contributions, impinging on a public's understanding of a barely understood, rapidly developing phenomenon. The unconscious understanding of not necessarily agreeing but accepting how and why restrictions and laws are enforced with the United Kingdom could not necessarily be applied to this era.

It seems that the lasting impact of nationwide events such as 1980's miners strike on police and public relations has not occurred, although this may be disguised by a number of other influences for instance the conviction of Wayne Couzins. Covid 19 represented the ultimate global influence on local events, the realisation that trust in our police has a multiplicity of influential factors both within and outside the ability of policing to affect reflects an increased importance in each officer's realisation that their actions always have the potential for far reaching implications, positive as well as negative.

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Ann Wylie Biography:

I have been a Medical and health educator and researcher for three decades, specialising in health promotion, public health, global health and primary care mainly based in public health and King's College London Medical School.

I led in Health Promotion curricula design for both UK and internationally, conducting educational research, updating and evaluating programmes.

During the pandemic I planned and implemented revised core health promotion and public health curricula and assessment modalities for online cohorts.

Revising Health promotion courses linked to reflections from Covid-19.

This paper explores my critical reflections of the function/s of Health promotion courses in the light of the Covid Pandemic of 12th March 2020 to Sept 2022.

I have constructed it in to five sections.

1 Health Promotion Principles of Practice

2 Health Promotion skill sets for Community Intervention

3 Populations: politics, policy making and the media

4 World Health: what Covid taught us.

5 Action and Policy Making for the Future

Introduction

Health promotion (HP) is a complex synergy of many paradigms and inevitability some professionals will be specialist in a few paradigm areas but not all. HP is an integral component of public health (PH) and global public health, with many overlaps and complementary epistemologies. There are many HP definitions each with limitations (Kirtchuk 2021). However, the factors that specifically differentiate HP from PH are as follows:

- The research paradigms are associated with intervention approaches and outcomes.
- The fundamental questions are on causes of health rather than disease.
- HP can be relevant to individuals, communities, and populations.
- The focus is identifying the modifiable determinants of health and evidenced based interventions enabling these modifiable determinants of health to be addressed within people centred and ethical frameworks, cognisant of the four main pillars of ethical linked to decision making, namely beneficence; non-maleficence; justice; and autonomy. (Cribb 2002, Duncan 2007)

As such HP courses and programmes are adapted for variable needs of the participants and professional roles (Wylie and Holt 2010). There are some courses with long standing regulated providers offering accreditation and qualifications.

- Short practical courses aimed at skilling community health professionals in behaviour change skills to integrate into their work, including patient centred advice and information for decision making.

- Specific components for health professional career pathways such as Medicine, Occupational health, Dental professionals, Nursing, Physiotherapy, Dietetics and Nutrition, Teaching, Community Pharmacy, Environmental professional, Youth Workers, Police, and interpreters.
- Modules for Public Health trainees
- Level 5-7 courses for Health Promotion professionals – for intervention development, strategic and policy development, evaluation, planning, resourcing, researching, and accountability.
- Skills in debating and forming informed argument, based on complex multi-source evidence, cognisant of ethical issues and wider contexts - usually for academic HP professionals.

Looking back at the period 2020-2023, a time of global upheaval, we need to consider how well prepared the HP workforce were and what needs to adapt and improve as we move towards 2030, the end point of Sustainable Development Goals (SDGs). (Nations 2015)

Leading up to the pandemic the UK health and social care, and specifically PH, were poorly resourced following government policy changes since 2010. Noticeable declines were reported in health, increased levels of morbidity, poverty, obesity, sub-optimal physical activity and widening inequality gap.(Marmot 2010, Marmot, Allen et al. 2012)

Despite many advances in medicine and human development, the situation globally and nationally at the start of the pandemic were probably contributors to the vulnerability of governments and populations.

In the UK the Government had a plan. https://www.gov.uk/government/publications/uk-pandemic-preparedness/uk-pandemic-preparedness. But plans need to be resourced, implemented, and amended rather than file fodder and policy statements. Future HP courses must include critical reviews of such plans and how relevant and pragmatic to the local context, as well as how they link with WHO/UN agreement and plans that are pragmatic. https://www.who.int/news/item/25-10-2023-new-infodemic-management-tools-to-support-pandemic-planning-and-preparedness-for-pandemic-influenza-and-respiratory-pathogen-disease-events

Health and politics are intrinsically linked. HP courses should enable participants to engage with topical political discussions and have a sound awareness of the health care systems, the funding, and the different arrangements within the four UK nations but all part of the NHS, as well as how the UK compares to other health care systems with similar economies. How ethics and values impact on health care and related services such as social care. The health challenges faced by all countries during the pandemic need to be debated and explored, and the issues around data, indices for health outcomes and access to resources should be integral to HP courses.

In the UK the ongoing Hallett inquiry https://covid19.public-inquiry.uk/about/ will need to be explored by HP course participants (and similar reports from other countries.) for lessons learned.

Ethical issues, resourcing, communication, impact on different members of society, what support would be available and pragmatic, logistics, and of course political

leadership are all part of the agenda for discussion and planning better for the future.

Public health and HP specialists, such as behavioural scientists were given a voice but ultimately many people were isolated, vulnerable to abuse and mental ill-health, weight gain, increased use of alcohol and tobacco, lack of physical activity and increased anxieties. Whilst others had to do frontline work with greater risks of exposure to the virus and infection, and for many their homes were not suitable for the "stay at home" regulations. There were challenges on accessing food and medicines, other essentials and financial worries.

Rationale

Many challenges facing our health and well-being nationally and globally need to be identified and acknowledged. The priorities and focus of health promotion will inevitably change and the need to adapt is essential. However, the generic principles and theories of HP that have evolved since 1987, still arguably apply to professional education and training programmes. And an appropriate staring point is the Ottawa Charter https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

Section 1 Principles, epistemology, theories, and intervention ethics and methodologies.

- The Ottawa Charter and the relevance in the 21st Century
- Synthesis of paradigms informing current practice – what needs revisioning?
- Frameworks, processes, and pragmatics – strengths and limitations

The Ottawa Charter provides the basics and principles of the field, the practice, the research and the academic role for HP.(World Health) . The five key areas being:

- Building healthy public policy
- Creating supportive environments and societies
- Strengthening community action
- Developing personal skills
- Reorienting health services

The links between poverty, deprivation and inequality are explicit. The pandemic experiences as well as the climate change crisis suggest these principles published more than of 3 decades ago remain essential, relevant, and more urgent than ever.

The challenges are complex and challenging. However, the established process involved in HP practice remain a good base for refining, updating, and modifying HP practice and research, drawing on the synthesis on many variable paradigms that can inform practice.

HP professionals in the UK at all levels were facing many dilemmas at the onset of the pandemic, and these continue with insufficient funding and resource, little or no ongoing training and workforce development, and a lack of skilled and competent workforce. Priorities changed.

Lockdown risks and benefits; social distancing; vaccine uptake challenges; physical inactivity; mental and emotional distress; education; relationships and bereavement. The list could be extended but those with limited resource, space and poor or no internet access were disadvantaged. HP professionals were limited in what they

could do and or how to help and support. They themselves were also facing personal issues and options.

Conspirator theories and misinformation proliferated and hampered efforts to provide balanced and well-informed information and trust in professionals and politicians waned. This erosion of trust has persisted to some extent which becomes a limitation to designing and developing proactive interventions.

Campaigns to curtail the spread of the virus met with various levels of resistance and acceptance. As the restrictions eased, what could the HPs do? In the UK initially there was a need to explore "the damage done", what type of need assessment could be undertaken? Ethical questions needed to be explored.

Section 2 Skills sets for community intervention planning.

- Complexity of systems-based interventions – bottom up/top-down.
- Complex and contested evidence for practice – adaption but with fidelity
- Evaluation and action research – integrity and ethical issues
- Targeted or universal approaches
- Inequalities and social determinants of health

Vaccination hesitancy; vaccination availability, shielding citizens, access to GPs and other health and social care, access to family and friends, availability of food and necessities including medications, poor transport, increased morbidity, both physical and mental, late presentations with symptoms, harmful self-medication to cope, missed education from pre-school to graduate study with missed socialization opportunities, some potentially toxic behaviour and misinformation online are all contributors to the health of the nation

Financially there were unique dilemmas with the more affluent having managed well, often with increased disposable income, linked to lack of travel enabling spending on home exercise equipment, extra devices, and online shopping. Whilst those with low or insecure income became worst off hence widening the inequalities gaps.

Each programme should engage in these issues of health and research the approaches to local interventions:

- How were needs assessments conducted, if they were?
- What was possible given the restraints, local context and government funding and directives?
- What skill sets were needed and available?
- What evidence if any informed planning and practice?
- Were interventions targeted, universal or a mix of both?
- What evaluation/action research e.g. RE-AIM, (referring to: reach, effectiveness, adoption, implementation and maintenance) https://www.frontiersin.org/articles/10.3389/frhs.2022.959565/full or other monitoring processes were in place?
- What ethical situations were considered/encountered?

Critically reviewing interventions, strategies, and links, if any, to policy and government directives is an essential aspect of courses and programmes.

HP modules and Public Health modules for PH trainees would additionally explore these issues within complexity of systems-based interventions complex and contested evidence.

The interventions may have explicitly aimed to address and reduce inequalities, either way such issues need to be consider as in some cases they could increase inequalities.

Factors that may limit or worsen inequalities include accessibility, language barriers and limited health literacy. Major ethical issues could be explored using debate formats. (Cribb 2002) (Duncan 2007)

Section 3 Population issues, current affairs, politics, policy, and media

What is topical and gaining attention varies but in essence, programmes need to encourage participants to debate the issues, identify the ethical complexities and the contested aspects, both broadly speaking and in a local and professional context. These experiences should aim to be transferable as a new topical issue arises whether through popular media, public health campaigns, or social media.

The vaccination hesitancy that rapidly progressed in 2021-22 for example, could have been anticipated in such areas as:

- Resistance to MMR vaccine since the Lancet publication 1998.
- Concerns about measles outbreaks in some areas where populations were not meeting herd immunity levels.

The above became fodder for conspirators, media, political discussion as public funding was significant to promote and implement mass vaccination. Creating doubts at a time of heighten uncertainty. Looking back over the last ten years similar concerns regards infectious disease had gained medical coverage - Ebola, Zika, Sars

and ongoing endemics such as HIV and malaria as well as annual seasonal influenza. This provides programme directors and curricula developers opportunities to critically review planning, managing, and implementing campaigns as well as evaluation impacts.

It has been highlighted during the pandemic that we need to and can support our neighbours and strangers, and if we fail to do so we harm others. Organisations such as Age UK https://www.ageuk.org.uk/ and all-inclusive welcoming activities, such as Parkrun https://www.parkrun.org.uk/, are community organisations that HP professional can work with to enhance the gains. Parkrun is now a social prescribing activity that all UK GPs can refer to. https://www.rcgp.org.uk/Blog/The-power-of-parkrun and https://www.gov.uk/government/case-studies/the-parkrun-practice-initiat

Section 4 The global picture - are we healthier, can we live with increased morbidity?

HP programmes need to ensure participants are aware of the various ways in which health is "measured", the pros and cons and limitations of the data available. Whilst the global burden of disease is dominate in the Public Health area and literature, regularly reported in The Lancet, and may complement how health is measured. However for HP the focus on measuring health is imperative.

The COVID-19 pandemic and Climate changes data are seen as contentious and confusing with many flaws and limitations. But the Health Foundation https://www.health.org.uk/what-we-do/a-healthier-uk-population. provides some

insights in to health which HP courses and programmes can draw on for debates, discussions, action research activities, intervention planning and grant applications.

Life expectancy and infant mortality data dominates for many global HP planning https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years) https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/infant-mortality

Section 5 Activism and pragmatism

- The Ottawa Charter
- The changing roles and priorities of WHO and UN

The Ottawa Charter remains the best guide to the ideals and aspirations of health promotion as an academic discipline, a focus for research, a guide to the field of practice and interventions. These five key areas Building healthy public policy; Creating supportive environments and societies; Strengthening community action; Developing personal skills; and Reorienting health services require action.

- Building healthy public policy - to prevent, prepare and respond to pandemics; to regulate notification information regards infectious diseases (IDs) and support appropriate interventions to reduce risk and manage IDs, to prevent where possible climate catastrophes, to mitigate and plan for climate changes especially for vulnerable populations in Middle and Lower Income countries (MICs and LICs), to create structures that could reduce migration and lesson risk associated with migration, and to support refugees

and provide appropriate health care. This list is not exhaustive enabling each course or programme to focus on aspects that are contextually relevant. Participants need to be supported in critically reviewing current affairs information and opportunities for action, lobbying, and arguing for healthy public policy development and implementation, cognisant of the potential challenges and limitations.

- Creating supportive environments and societies - https://unstats.un.org/sdgs/report/2023/ the SDGs latest reports are an invaluable source of information and progress and course participants could be encouraged to look in depth at 3 or 4 of their choice and link to context of their areas of work. Whilst these are global goals, examples of local activism in the UK includes "Surfers against sewage"; WWTs (Waste Water Treatment Solutions) at local level; RSPB, MIND, Liberty, Amnesty and many more. The important aspects of activism, especially if your students are public servants is to focus on facts, well-informed argument, and various potential intended consequences, know the counter arguments and avoid party politics. There will be dilemmas and ethical issues, but the skills are about navigating these, listening and being civil.
- Strengthening community action – local populations are often aware of the local issue and needs, they are part of the solution and will welcome collaboration when it is in partnership but not top down. Examples could be identifying funding for their project ideas and supporting the application process. Also promoting local schemes already started and established such as NCT, http://www.breastfeedingtogether.co.uk/, Home Start

https://www.home-start.org.uk/ Link visiting scheme https://www.linkvisiting.org/ There will be many very local groups and well as national organisations. The Parkrun is supported by the Royal College of GPs and events are across the UK - students could explore their local Parkrun, identify what local benefits are visible and consider who is missing out. What options are there to be more inclusive? https://www.parkrun.org.uk

- Developing personal skills - Health Literacy is the key focus for this area of the Ottawa Charter https://www.who.int/teams/health-promotion/enhanced-wellbeing/seventh-global-conference/health-literacy and there is a wealth academic literature in this field. The needs of local populations vary so needs assessments need to be considered and more recently being digitally aware. Since the pandemic we have become more reliant on online information and whilst that has enormous benefits, going paperless etc and reaching out, there are many that are disadvantaged by these formats and of course potentially to be misinformed, with bogus and false information. The UK statistics on literacy levels can be discussed at both a national level and in the local context where students are working to reflect on the implications such as poor antenatal care, suboptimal vaccination uptake, compliance with medication, limited translation services (https://www.languageline.com/en-gb/), claiming benefits. What interventions are in place and what is their role in strengthening and supporting these? https://literacytrust.org.uk/parents-and-families/adult-literacy/
- Reorienting health services – the UK National Health Service, like many health care systems is basically a service for people who are sick. Rapid changes

took place during the pandemic with much of the routine elective work cancelled and people had to learn how to manage telephone consultations and or video consultations. Whilst certain health facilities remained open there were many caveats, such as social distancing, stay at home, if possible, limited pharmacy options and supplies. As people adjusted some of the fall out was late presentations, resulting in poorer prognosis. Health staff became ill and many experienced "burn out". The health service in the UK like others experienced a public health emergency yet it was the public health services that had been depleted for 10 plus years. Obesity, sub optimal mental health, physical inactivity and an increasing level of morbidity and increased inequality gap were significant. The health service was challenged and unable to address these issues but must deal with the consequences. It is argued that Primary Care and health promotion should now be a priority.

As Marmot asks, "why treat people and send them back to the conditions that made them sick?'. I conclude with a suggestion to revisit SDGs and consider what could be done locally to improve health such as the role of social and exercise prescribing; better local public transport and air quality, improving access to Primary Care and community pharmacists, recreation and green spaces; and support for families are just a few health promotion areas that could reduce morbidity if planned, resourced and implemented well. Plenty of project work for students.

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