Witness Name:
Statement No.:
Exhibits:
Dated:

# UK COVID-19 INQUIRY

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## WITNESS STATEMENT OF PROFESSOR KEVIN FENTON

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1. I, Professor Kevin Fenton, President of the UK Faculty of Public Health, will say as follows:

**About the UK Faculty of Public Health**

2. The UK Faculty of Public Health (FPH) is the professional standards body for public health specialists and practitioners. The Faculty has around 4,000 members in the four nations of the United Kingdom and overseas. We define public health as the science and art of preventing disease, prolonging life and promoting health and wellbeing, through the organised efforts of society.

3. The Faculty of Public Health was borne out of changing approaches to public health (or 'community medicine'), and specifically a Royal Commission on Medical Education (1965 - 1968), which published a landmark report recommending the creation of an organisation to assume '…a major role in the training of those who practice in the field of community medicine'. The inaugural meeting of what was then called the Faculty of Community Medicine was held on 15 March 1972, with a membership of just over 1,000 Members and Fellows. Changes in the structure and delivery of NHS services, and public health/community medicine over the following decades led to changes in the name of the Faculty, and shifts in focus, though addressing health inequalities and the wider determinants of health remains central to the Faculty's work.

4. FPH is a registered charity and a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). Its charity number is

263894. Although it is an integral part of the three colleges, it has its own officers, manages its own affairs through a trustee board and is financially independent. The FPH Trustee Board is democratically elected and is the ultimate decision-making body within the organisation. Much of its business is conducted through a structure of committees and sub-committees.

5. Our Charitable Objects are to promote for the public benefit the advancement of knowledge in the field of public health; to develop public health with a view to maintaining the highest possible standards of professional competence and practice; and to act as an authoritative body for the purpose of consultation and advocacy in matters of education or public interest concerning public health.

6. FPH is a membership organisation for those working in or interested in public health. There are several classes of membership available within the Faculty, ranging from the most senior public health figures from the UK and overseas to students starting their careers. There are approximately 1,300 consultants / specialists / directors of public health (DPH) in the UK (the equivalent to a consultant doctor in other medical specialties) and this group makes up a critical core component of the Faculty's membership body.

7. The work of the Faculty is centered around three core strands: education and training (setting the training curriculum, examinations and other standards for training in public health); setting standards for practice in public health (through continuing professional development (CPD), revalidation and oversight of appointments to consultant and DPH posts across the UK; and advocacy and policy (working collaboratively with our 4,000 members to encourage them to share, discuss, and develop various projects and elements of policy and best practice). Much of the Faculty's advocacy work is guided by our special interest groups, collectives of members interested in specific policy areas that are overseen by formal policy committees.

8. The work of the Faculty and public health contributes to reducing the causes of ill-health and improving people's health and wellbeing through: health protection (action for clean air, water and food, infectious disease control, protection against environmental health hazards, chemical incidents and emergency response); health improvement (action to improve health and wellbeing and to reduce health inequalities (for example by helping people quit smoking or improving their living conditions); and

healthcare public health (ensuring that health services are the most effective, most efficient and equally accessible). These three core strands of public health are underpinned by public health intelligence (surveillance, monitoring and assessment), academic public health (promoting evidence, knowledge and research) and workforce development.

**Our views on the UK's readiness for the COVID-19 pandemic**

9. Throughout the planning and response to the pandemic there was a lack of executive awareness across responder organisations around the level of societal risk from pandemic events. This may have been due in part to the limited opportunity for multiagency response exercises outside of the workforce who directly work in health protection, public health and emergency planning. This is further exacerbated by a legislative framework for health protection (including port and border health) which is complex, archaic and not fit for purpose to address current and future hazards and threats. National pandemic planning was focused almost solely on a novel influenza virus and there was little consideration for other potential organisms and required capabilities.

10. The way health protection was delivered in local areas in England changed significantly following the enactment of the Health and Social Care Act 2012, with the transfer of public health from the NHS into local government and the creation of Public Health England (PHE). Health protection functions in local government public health teams moved largely to an assurance role without specific funding or assurance within the ring-fenced grant as a mandated service. There was also a lack of clarity and specificity on the statutory role of the director of public health for health protection in the 2012 reforms as they pertained to England.

11. Health protection teams, which moved from the Health Protection Agency (HPA) to PHE (in England), saw successive reductions in funding and capacity over the pre-pandemic years and a lack of investment in regional emergency preparedness, response and resilience (EPRR) teams. A direct result of these changes was a reduction in the amount of professional exposure that the public health specialist generalist workforce had to health protection duties and continuing professional development outside of PHE. There was also a reduction in the exposure that NHS staff in general had to important public health issues associated with health protection,

especially in community settings. This is likely to have contributed to a poor understanding of the role of the wider public health agenda around pandemic preparedness, and more specifically the role of local authority public health teams and wider system partners in pandemic preparedness and response. Community infection prevention and control (IPC) is a key element of pandemic planning and local health protection more generally, but guidance is unclear on commissioning responsibilities, funding streams, and standards for high-performing local integrated services. It is largely understood that provision for community IPC was a significant casualty of the 2012 reforms and the Faculty considers the creation of Integrated Care Systems, with local authority Directors of Public Health and UKHSA as key partners, an opportunity to rectify the current problems. The use of Contain Outbreak Management Funding (COMF) during the pandemic to temporarily increase IPC capability in many systems provides proof of concept of what can be achieved through concerted effort and funding enhancements.

12. Additionally, in England the nine Government Offices of the Regions had a statutory duty under the Civil Contingencies Act 2004 to run regional resilience forums chaired a by a regional director of resilience. Their purpose was to plan and support local resilience forums in their region for emergencies, coordinate all regional-based services (blue light services, armed services, utilities, business, the voluntary and community sector, with public health services and the NHS) and liaise with Whitehall. This was key to successfully managing swine flu in 2009 as well as other emergencies such as exceptional weather events, terrorism and strikes etc. Their abolition in 2010 led to the loss of this important part of the national resilience infra-structure for planning and response to the pandemic.

13. The net result of these changes was a lack of capacity for pandemic preparedness and response at regional and local levels within and across public health organisations working to improve and protect the health of the population.

14. At the time of the pandemic, the national guidance was widely acknowledged as being outdated and did not relate to contemporary structures, roles and responsibilities. For example, the Civil Contingency Act 2004 predates the Health and Social Care Act 2012 and the amends made since do not capture the full scope of emergency preparedness, response and resilience. The national strategy and guidance did not

cover the range of public health interventions that were utilised during the pandemic response – particularly absent were references to non-pharmaceutical interventions (NPIs) such as social distancing measures, population level test-and-trace programmes, the use of face-coverings in public, school closures or wider societal lockdowns. A draft Pandemic Flu Bill had been drafted centrally and without stakeholder engagement and co-design; this resulted in a legislative approach and planning assumptions which were not well understood across public health and wider system partners and could not be tested in advance.

15. Generalist specialists in public health, particularly those working in health protection at regional and local levels, have been under-represented in the development of national pandemic policy, strategy and guidance and there is opportunity for this to be addressed in the future through the UKHSA-hosted Centre for Pandemic Preparedness. There was a significant missed opportunity for broader engagement in planning across local resilience forums and local health resilience partnerships which require closer working and mainstreaming of planning, training and exercising of pandemic response arrangements.

**Inequalities and pandemic planning**

16. For the most part, local multi-agency planning (including pandemic planning) will have included provisions for the identification of vulnerable groups and those who may be disproportionately impacted by an incident or major emergency. This is collated and used to maintain the provision of services during a period of disruption. Although the UK National Pandemic Flu Strategy was supported by an ethical framework, this considered equality, fairness and equity, but not specifically health and social inequalities and disparities in impact.

17. Due to the nature and scale of the COVID-19 pandemic and the centralised coordination of the response, interventions were largely universal and there is a lack of evidence that health inequalities in impact and outcome were key considerations. An Equality Impact Assessment was published in 2011 as part of the UK Pandemic Preparedness Strategy. However, as population level non-pharmaceutical interventions (NPIs) employed for COVID-19 were not included in the scope of pandemic influenza plans, socioeconomic determinants and risks were considered in relation to the planned interventions only (e.g., National Pandemic Flu Service). This

limited consideration of the impact, based on age, deprivation and ethnicity, became major areas of disproportionately poorer outcomes that services and response processes were ill-equipped to mitigate. Identifying and addressing health inequalities and disparities in outcome is a key element of the science and art of public health and must remain central to health protection and security in the future.

**What was done adequately in planning for the pandemic?**

18. With the benefit of hindsight, and with reference to the responses provided above, the Faculty of Public Health finds it difficult to identify specific examples of emergency and pandemic planning preparedness and resilience which can be considered 'adequate' in relation to the COVID-19 pandemic response. In no small part, the existing pandemic plans did not reflect the actual response – in part, because pandemic planning focused on influenza rather than considering 'disease X' scenarios for other candidate pathogens. The plans did not consider the full range of interventions that were available to ministers during the response. Whilst the hard work of all those involved in emergency preparedness across the UK will have offered some benefit through awareness raising and capability development, it is hard to assess against any clear benchmark or standards.

19. The national and international response to the 2009 swine-flu pandemic may have created a false sense of security in relation to the required levels of planning, preparedness and resilience required for a subsequent pandemic event – particularly one not caused by influenza. National, regional and local assurance exercises did not examine response capabilities in sufficient breadth or depth. The outdated strategy and guidance meant that roles and responsibilities of leaders and responders across national, regional and local systems were poorly understood and could not be assured effectively. The Faculty wishes to highlight that major system and organisational changes intrinsically impact on resilience and preparedness and emergency preparedness and response should be a central consideration.

**What could have been done better in planning for the pandemic?**

20. The Faculty is of the view that there needed to be purposeful updating and rationalisation of national policy and strategy built on a stronger foundation of evidence-based risk assessment and planning assumptions and there was a missed

opportunity to do this in the years prior to the pandemic. This should have included a review of the health protection legislative framework, including port and border health provisions. Multi-agency, multi-disciplinary approaches to planning – engaging generalist specialists in public health and system partners in co-design and co-production of policy, strategy and guidance – would have likely resulted in greater preparedness, increased resilience and effective response. A wider ranging public discourse around pandemic planning, alongside other hazards and threats, would help to develop community resilience and participation.

21. The public health specialist and practitioner workforce is key in this area and specific consideration should be given to the coordinating role of local Directors of Public Health as system leaders, working alongside national agencies and their teams as health protection specialists. The contribution of public health generalist specialists and practitioners in preparing for and responding to the COVID-19 pandemic is significant, largely unseen and often underappreciated.

22. In addition to the local authority Directors of Public Health, large NHS organisations need to be more systematically encouraged to work on behalf of their community resident catchments to support the wider system DPH role which includes, but is not limited to, health protection issues. At the present time, many DPHs have little direct influence on the NHS.

**FPH engagement with the Government before and during the pandemic**

23. Prior to 21 January 2020, the Faculty of Public Health had limited communication with Government on the state of the UK's emergency and pandemic planning, preparedness and resilience.

24. In our response to the 2011 consultation on the UK Influenza Pandemic Preparedness **[KF001] [INQ000108768]** strategy we commented on the importance of sharing scientific information between countries, the cruciality of independent advice from public health professionals working outside of Government, the need for properly functioning technical infrastructure to report data, and importance of increasing surge capacity for local public health services as they respond to the outbreak.

25. After 21 January 2020, The Faculty of Public Health clearly and consistently communicated its views to Government on the UK's emergency and pandemic planning, preparedness and resilience and lessons learned. These views were communicated through public and private communications, in journal articles, through official statements, and letters to Government **[KF002 – KF021] [INQ000108769], [INQ000108770], [INQ000108771], [INQ000108772], [INQ000108773], [INQ000108774], [INQ000108775], [INQ000108776], [INQ000108777], [INQ000108778], [INQ000108779], [INQ000108780], [INQ000108781], [INQ000108758], [INQ000108765], [INQ000108762], [INQ000108759], [INQ000108766], [INQ000108760], [INQ000108763].**

26. In these communications we explained, amongst many other points mentioned in this response, the need for transparent and consistent public health messaging, an effective and targeted test and trace system, a vaccination programme which ensured equity of access, adequate and realistic funding for the public health system, and long-term support for communities as they recover from the impacts of the pandemic.

**Our views on the UK Government's engagement with FPH**

27. The introduction to this witness submission sets out the role and purpose of the Faculty of Public Health as a membership body directly serving the needs of its members and primarily ensuring their wellbeing throughout the pandemic. Within this context, the Faculty had limited direct engagement with the government around pandemic preparedness.

28. Within the governance structure of the FPH, the Health Protection Committee (HPC) reports to the Advocacy and Policy Committee (APC) which in turn reports to the Faculty's Board. Largely due to the operational pressures of the pandemic response on members, the HPC was not sitting in the period immediately up to the pandemic response but was reinvigorated in October 2021 after the dissolution of PHE and transfer of English health protection functions to UKHSA.

29. As a member organisation of the Academy of Medical Royal Colleges, Officers of the Faculty met with DHSC and NHS England colleagues during the pandemic to discuss response arrangements and agree joint policy positions.

**What could have been done differently?**

30. Earlier recognition of the limited existing capacity for health protection at regional and local levels would have enabled a more rapid, proportionate and sustainable scaling up of capacity in the early weeks of the pandemic across public health, health and social care. There was a clear lack of awareness of structures, roles, responsibilities and capabilities by decision-makers and an unfamiliarity with the work of public health leaders, generalist specialists and practitioners in this respect. The generalist specialist workforce which includes consultants in public health and health protection were central to the response and much in demand, although the workforce demands far outstripped supply. Generalist specialist training, recruitment and retention should be reviewed in light of lessons learnt from the COVID-19 pandemic.

31. In the early weeks of the pandemic, local public health teams under directors of public health put in place structures key to containing infectious disease such as contact tracing. As numbers increased, this was taken away and put onto a national digital platform which was inconsistent, leading to ambiguity and individual decision making. As this was scaled up there was a lack of public health specialists involved in large scale test and trace operations.

32. Port and border control restrictions were not put in place in a timely way and there were complications in the implementation of guidance. Guidance on this and other key aspects essential in the containment phase were limited or delayed, this included restrictions on large scale events, this saw several large events take place in the days leading up to lockdown.

33. Given the rapidity of the emergence and spread of the COVID-19 pandemic and its disproportionate impact on Black, Asian and minority ethnic communities, it was important for the COVID-19 response to understand and respond to the emerging inequalities in a far more agile and urgent way. Although many colleagues, especially those working at local and regional levels, called for more community-centred approaches to the pandemic response, it was clear that nationally focused leadership and responses were prioritised, and especially so in the first pandemic wave. The net impact of this prioritised national leadership (at the expense of both local and community centred responses) was an inability to use all the tools available to the

government at that time to manage the pandemic response and a failure to build trust and deeper engagement with communities.

34. Failure to adequately engage and mobilise communities had a material impact on the ways in which communities expressed their trust and confidence in national messaging, access to and uptake of COVID-19 health and care services, COVID-19 testing and contact tracing, and more recently the uptake of the COVID-19 vaccine. Many of the challenges of community engagement were best managed at the local level and required significant investment by local authority partners working with voluntary and community sector partners. These local partnerships were shown to be effective in helping to rebuild trust and promote greater engagement in COVID-19 preventive and intervention measures, including the uptake of COVID-19 testing and vaccination.

35. The introduction of the Coronavirus Act 2020 (based on the unpublished draft Pandemic Flu Bill) granted wide-ranging powers of extra-judicial detention Schedule 21 for designated Public Health Officers (PHOs) who were designated by the Secretary of State from a small pool of PHE/UKHSA Consultants. The powers were delegated without prior engagement, little guidance and insufficient training to generalist specialists who may have had limited experience of instigating statutory proceedings for public health outside of providing evidence to Justice of the Peace in the local authority-led processes under the Health Protection (Part 2A Orders) Regulations 2010. The Faculty holds that where generalist specialists in public health are required to undertake significant new statutory functions, these should be consulted on in advance and with an opportunity for appropriate legal training. This further supports the need for an urgent review of the public health and health protection legislative framework covering both pandemic and all hazards preparedness and response.

**What lesson can be learned?**

36. The Faculty is of the opinion that whilst lessons can be identified through debriefing and inquiry, they cannot be considered ‘learnt’ until implemented through changes to policy, strategy, guidance and operational response.

37. Public health interventions employed during the COVID-19 pandemic should be robustly evaluated with consideration to their overall impact, clinical effectiveness, cost effectiveness, adverse incidents and synergies with other areas of policy - particularly those which were not included in the scope of the UK Pandemic Flu Strategy, and even more so for those with little or no existing evidence base. Consideration should be given to the degree to which interventions were monitored and evaluated in close to real time to help steer decision-making at all levels. Public health generalist specialists and academics across the UK remain well placed to lead and support such interventions and should be consulted on future proposals for preparedness and response.

38. The COVID-19 pandemic shone a light on long standing health inequalities and exacerbated emerging inequalities as the pandemic progressed. Key among these inequalities was the disproportionate impact of the infection on Black, Asian and minority ethnic groups, older individuals, and those living in socially and economically disadvantaged parts of the country. A key lesson learned through the pandemic has been the importance of robust engagement with potentially disproportionately affected populations both in the planning and preparedness as well as in the design, delivery and evaluation of public health interventions instilled as part of a pandemic response. The need for culturally competent prevention and engagement methods as well as tools to guarantee a community-centric approach to pandemic preparedness and response was also clearly demonstrated in COVID-19 and must be a key recommendation and legacy arising from this experience. Associated with this is the importance of ensuring that health equity considerations are seen as a core part of the planning and preparedness and response to emergencies and threats and not seen as an afterthought or a secondary consideration. With regards to inequalities in the pandemic preparedness, protocols could have mitigated a number of the impacts of COVID-19, especially in the first year of the pandemic.

39. Whilst the UK Pandemic Flu Strategy made reference to an ethical framework, this was limited in scope to the range of interventions considered – furthermore, the ethical positions and reasoning underpinning the COVID-19 pandemic response were not always as clear and transparent as they might have been. FPH advocates for greater inclusion of public health ethicists as part of multidisciplinary decision-making.

40. The role and contribution of the public health profession, particularly generalist specialists in public health and sub-specialists in health protection, has not been well recognised in the national discourse. This highly skilled, agile and regulated workforce has been central to the response providing professional, clinical and system leadership across a range of programmes and functions. It is imperative that the generalist specialist public health workforce is maintained with sufficient capacity and capability to respond effectively to future pandemics and other threats to population health. While we do not have fully comparable figures over time, the number of specialists across the UK has fallen from 22.2 per million in 2004 to 18.6 per million in 2020. This contrasts with the pattern in most other specialties where consultant numbers have risen over the same period. There is also significant regional variation in the workforce provision in public health; the Faculty has long advocated for a workforce of 30 public health specialists per million of the population as a reasonable and realistic provision.

41. Recognition also needs to be made of the important contribution made by academic public health specialists as part of authoritative advice on COVID-19, including the population modelling of the pandemic. The need for better population disease modelling was clear, including the development of models which could examine the impact of policy issues on wider health implications rather than just narrow health consequences.

42. Despite very early concerns regarding the disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities, the move to understand the nature of these disparities which resulted in the publication of the Public Health England COVID-19 reports on disproportionality in risks and outcomes of COVID-19, helped to shine a light on the emerging inequalities, and inform areas for improving the response following the first wave of the pandemic. The subsequent investment in culturally competent interventions, better data, better community engagement and more funding for community centred responses was both welcomed, although the nature of the investment and the sustainability of this investment may mean that ability to extract the benefits of this investment may wane overtime.

43. Across the country the community-centred responses which have emerged from the pandemic have again shone a light on the importance of engaging our communities

as part of emergency planning, preparedness, resilience and response efforts. They are an essential part of any effective response both, for future pandemics as well as other emerging threats such as climate change. A key lesson therefore arising from this experience must be to strengthen the community-centred approaches to emergency planning and to ensure that local authority and local health and care system partners have the tools, resources, and training required to undertake community-centred responses to emerging threats.

44. Whilst the national public health agencies employ much of the health protection specialist capacity in the UK, the same recognition needs to be made for directors of public health and local teams in leading local systems and coordinating local response, local intelligence, managing local relationships, drawing on their understanding of local population and services. Roles and responsibilities for health protection and security across national, regional and local levels, should apply principles of subsidiarity in both preparedness and response. Public health must continue to focus on people and the places they live in, with responses coordinated locally, supported regionally and enabled nationally.

45. There must be greater opportunity to codesign and coproduce future pandemic response arrangements, taking a holistic approach to public health to support the societal efforts to minimise the impacts of a pandemic. Whilst countries cannot effectively legislate their way out of any pandemic, well-designed, robust and proportionate public health legislation does have a major part to play in securing the health of the population. FPH supports a holistic review of statutory duties and powers for health protection within the wider health legislation.

46. Wholesale reorganisation of the English public health, health protection and health security architecture in the middle of pandemic response, however well intentioned, may have been ill-advised. Risks and opportunity costs for response and wider mitigation of secondary and tertiary impacts were inevitable. Fragmenting the domains of public health across different public sector organisations also introduced additional challenges in sharing information, intelligence and data across a changing landscape.

47. Recovery remains the most challenging and overlooked area of the COVID-19 pandemic response. Whilst this is mentioned in the context of finding approaches to reinstate services such as screening and elective surgery and 'business as usual' in

local GP surgeries, the reality on the ground is different. Inside waiting rooms, the numbers are increasing and services and limitations on the workforce cannot meet the demand. There is little mention of recovery outside of healthcare and the economy. Recovery is needed across the public health system as we begin a collective journey towards a new normal and an as yet undefined 'business as usual'. Recovery needs to consider the impact across society and the work required to address this, as well as address the time lost from proactive, preventive programmes to focus on pandemic response. It is likely that there will be a loss of capacity, capability, skills, knowledge and experience from within the public health profession following the response phase of the pandemic – this may be due to the sad loss of colleagues to COVID-19 and other concurrent infections, leaving work due to mental and emotional impacts such as burnout, taking early retirement or moves into other professions.

**Additional documentation**

48. A list of key articles, reports and statements is provided along with this submission **[KF001 - KF021], [INQ000108768], [INQ000108769], [INQ000108770], [INQ000108771], [INQ000108772], [INQ000108773], [INQ000108774], [INQ000108775], [INQ000108776], [INQ000108777], [INQ000108778], [INQ000108779], [INQ000108780], [INQ000108781], [INQ000108758], [INQ000108765], [INQ000108762], [INQ000108759], [INQ000108766], [INQ000108760], [INQ000108763].**

**Statement of Truth**

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

**Signed:** Personal Data

**Dated:** 13 April 2023