Witness Name: William Roberts,
Royal Society for Public Health
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Exhibits:
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF William Roberts, Royal Society for Public Health

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I, William Roberts will say as follows: -

About RSPH (ROYAL SOCIETY FOR PUBLIC HEALTH) and me

Established in 1856, Royal Society for Public Health (RSPH) is an independent health education and campaigning charity, committed to improving and protecting the public's health and wellbeing. The world's longest-established public health body with over 5000 members, RSPH is committed to supporting the public's health, activities include providing qualifications and running public health programmes, alongside campaigning on issues to support better health and wellbeing for the public. RSPH works across the four UK nations and is a Royal Charter company.

RSPH is a membership organisation and represents the voice of those who deliver public health. These range from addiction support officers and food safety trainers to community health champions and school nurses, and from academics to vaccinators. RSPH focuses on three key areas: i) tackling the drivers of inequalities, ii) supporting the public health workforce and ii) ensuring that public health and prevention is everyone's responsibility, from governments and businesses to communities. We do this through our public health training and programmes, membership offer, qualifications, convening the sector and policy development and influencing.

I am the CEO of RSPH, having joined in 2022. I am a registered nurse with a clinical background in communicable and infectious diseases, I hold a Masters degree in Public Health, worked as a lecturer in Public Health and have been the responsible director for EPRR in a Clinical Commissioning Group. Prior to the pandemic I led national work in the NHS on integration and care homes and have worked in the field of inequalities for over twenty years. During the early stage of the pandemic, I returned to the NHS, working clinically in a community services provider supporting community based Covid planning

and delivery. I have worked at all levels of the NHS both clinically and managerially as well as working in national policy.

Pre-pandemic EPRR (Emergency Preparedness, Resilience and Response) plans and the state of preparedness

The UK had a good set of pandemic plans in place [WR/1-INQ000180268, WR/2-INQ000180269, WR/3-INQ000180270, WR/4-INQ000180271]. These had been tested, used and reviewed in the Swine Flu pandemic [WR/15-INQ000180282]. The starting point for the pandemic from an emergency planning perspective, should have been strong. However, the plans that had performed well in Swine flu, had not been revisited or tested on a regular basis outside of those heavily involved in emergency planning. It would be possible to critique the plans saying that the overly focused on pandemic flu and that Covid was a different type of pathogen, and whilst this has some validity, the processes and systems hold up to scrutiny and should have been fit for purpose. Our emergency planners were ready but the systems in which they worked were not, be that core health and care systems, communities, or business [WR/13-INQ000180280].

Whether we were prepared for a pandemic is a difficult question to answer, certainly it appeared in all the national risk registers, but the scale and speed of the pandemic did appear to take many by surprise [WR/13-INQ000180280, WR/17-INQ000180284], though the information coming out of Italy should have prepared us to some extent. Public health teams have endured significant reductions in resources over the years and have spent a huge amount of their time dealing with non-communicable diseases [WR/18-INQ000180285]. Alongside this the NHS had extremely limited capability and capacity around public health meaning that the capability to respond sat within local authorities and the initial response was driven through the NHS. This meant that in the years leading up to the pandemic there was not a huge amount of time spent preparing for a pandemic or a significant crisis. The intensity, duration, and scale of the Covid pandemic does appear to have been something that we were not prepared for as a nation [WR/17-INQ000180284].

We also know that despite having good systems in place, the services that needed to enact those systems were struggling at the time of the pandemic. Whether this is viewed through the lens of staffing levels, waiting lists or spare capacity within the system, our public services in the UK were stretched and tired with little or no surge capacity available [WR/5-INQ000180272]. The capacity of the NHS, local government and other statutory services to respond was severely limited as a result of both governmental choices around funding and local choices around priorities and cuts including to local public health services [WR/5-INQ000180272, WR/13-INQ000180280, WR/16-INQ000180283), WR/17-INQ000180284].

In short, the written plans were fine, the reality of those plans being enacted, preparedness and resilience simply were not.

Inequalities and vulnerabilities of different groups in society entering the pandemic

We would not be able to comment on the extent to which the UK's emergency and pandemic planning and preparedness adequately took into account pre-existing inequalities and vulnerabilities of different groups in society as we were not part of those discussions. We can however comment on the potential impact of those pre-existing inequalities and vulnerabilities of different groups in society in the period leading up to the pandemic.

It is a matter of fact that in the decade leading up to the pandemic, there was a significant reduction in the levels of public sector funding outside of the NHS. We also know that whilst NHS funding was increased, demand for the services far out stripped the funding increases. This effectively meant that on entering the pandemic, the NHS was tired, experiencing significant delays in treating people and had little or no surge capacity coming out of winter 2019 into the spring of 2020 [WR/5-INQ000180272].

It is also a matter of fact that those who had the highest levels of need and experienced the greatest inequalities were disproportionately impacted by austerity [WR/5-INQ000180272].

We also know that in the period between 2010 and 2020 inequalities increased in the UK [WR/6-INQ000180273, WR/7-INQ000180274, WR/8-INQ000180275, WR/9-INQ000180276, WR/10-INQ000180277, WR/11-INQ000180278].

Going into the pandemic there were a range of people who experienced inequalities, had seen many of their safety nets removed and were in poor health both physically and mentally. If you pick almost any health indicator in that period it is clear that those with inequalities had worse outcomes, poorer access and less agency to improve their health (WR/10-INQ000180277, WR/11-INQ000180278). A number of research papers, health commentators and experts had demonstrated that focusing on reducing inequalities was essential to having a healthy and strong nation [WR/11-INQ000180278, WR/8-INQ000180275, WR/9-INQ000180276, WR/10-INQ000180277, WR/11-INQ000180278].

Therefore, this group of people along with those who were most vulnerable should have been priorities for any intervention or support, as their reliance and risk of both their ill health and the likely burden on the NHS would be greater.

If sufficient thought had been given to taking these issues into account, the contemporaneous documents should demonstrate a clear plan for how to protect the most vulnerable and those experiencing the greatest inequalities. If these do not exist, then we would take the view that insufficient attention was given to this. Based on my professional and clinical expertise I would take the view that insufficient thought was given to supporting the most vulnerable in society and there was limited nuance in the plans to ensure that it was both possible to identify and support the most vulnerable. If we consider the decision to discharge those with Covid from Hospital to Care and Nursing homes, the historic evidence of the impact of seasonal flu which has simpler interventions to prevent transmission than Covid-19, should have been sufficient to make the government question

the wisdom of sending infectious individuals with an airborne respiratory pathogen into a setting for vulnerable people. Similarly, the low paid workers going to work throughout the pandemic in jobs that required face to face work were more likely to be in less good health and at greater risk, again there is little evidence of planning for this [WR/14-INQ000180281, WR/17-INQ00180284].

The shielding group were identified but that looked at specific clinical characteristics, required you to be diagnosed and took little or no account of inequalities in the assessment.

Positives going into the pandemic

In the decade leading up to the pandemic, public health experts repeatedly raised the importance of tackling inequalities and the risk of removal of statutory funding. Prevention takes years to impact and cannot be easily ramped up in an emergency. That this was identified and championed was a positive [WR/7-INQ000180274, WR/8-INQ000180275, WR/9-INQ000180276, WR/10-INQ000180277, WR/11-INQ000180278].

We also know that at a local level public health teams and emergency planners worked hard, and within the budgetary constraints that they had, to develop the networks, relationships and processes to support a local response. Many of these local systems had been developed and retested through local crises such as flood, fire, and terrorism. The role of local public health teams in developing community-based responses, contact tracing and in partnership with Primary Care (especially GPs), identifying the vulnerable was a positive thing.

The emergency planning systems were strong in the UK, they worked, we possibly did not enact them when the pandemic started and instead developed a range of new systems and approaches. Whilst not at a local level, it appeared that way at a national level.

The local freedoms experienced later in the pandemic and the local flexibilities afforded by statutory bodies appear to have been both a sensible and pragmatic choice.

What we at RSPH believe could have been done better in relation to the UK's emergency and pandemic planning, preparedness and resilience.

Investment in a wider set of emergency planning capability- not just training emergency planners but building the capability and capacity in the wider business and statutory organisations. This is something that still is required as recent shortages and pressures have shown. Pandemic and wider emergency planning need to be better distributed across the country. We see a clear role for businesses, supply chain and others in this work [WR/13-INQ000180280, WR/16-INQ000180283]. One of the most obvious examples during the pandemic weas that the same equipment was required by many (not just PPE) and therefore it became very hard to order supplies as everyone was ordering the same products (examples include beds, oxygen). Similarly, schools, universities and businesses

did not have the plans to switch to different ways of working in a short space of time. Some of this could have been mitigated [WR/13-INQ000180280, WR/16-INQ000180283].

Understand the importance of a range of smaller charities and organisations in supporting the vulnerable and those experiencing inequalities. Many organisations stepped up and stepped in during the pandemic. They did this because they needed to, not because they were asked to. They are all struggling financially, and the charity and voluntary sector is undervalued, underfunded and over relied upon. The impact of the pandemic would have been far worse if they had not been able to step in. From big charities like the British Red Cross to small local charities. They deliver their work at a fraction of the cost of state or private companies yet have little or no long-term financial support [WR/16-INQ000180283, WR/17-INQ00180284].

Plan whole systems resilience with specific plans for those that are likely to be worst affected. Plans need to take account of both the global resilience issues required but also the need for support to specific populations. We know that in any situation there will be people who are worse impacted, and we do not always ensure that this level of planning occurs. For example, in heatwave we consider the needs of the elderly, but this is not then replicated for pandemic planning where the assumption is all risk is equal, the pandemic has shown quite clearly that this is not the case [WR/13-INQ000180280, WR/14-INQ000180281, WR/15-INQ000180282, WR/16-INQ000180283, WR/17-INQ00180284].

Our engagement with the UK government around this

RSPH has undergone personnel changes since January 2020 and the information that we have is from records. However, we do know that RSPH, prior to Jan 2020 worked alongside what was then Public Health England to develop a level 4 qualification in health emergency preparedness, resilience, and response. Whilst this did not have a focus on viral pandemics the content did have an overlap. RSPH was not called upon to adapt or deliver this training wider to provide additional support during the pandemic. An opportunity missed. This award is now provided through UKHSA (UK Health Security Agency) at Porton Down. We are developing a range of EPRR training offers as we can see a clear need for this in the wider system.

RSPH has had little or no direct engagement with the government post January 2020. There was no attempt to see if the qualification for health emergency preparedness could be adapted for the pandemic or even to deliver key aspects of the training where there was overlap. Both areas of expertise for the organisation. Despite this RSPH did develop a covid Hub providing signposting for the public to government advice and the latest information regarding vaccinations. In response to the hesitancy and doubts that were growing around the Covid Vaccines, RSPH developed and launched the Level 2 award encouraging vaccine uptake. This was used to support leaders in communities with high Covid vaccine hesitancy to support increased uptake. It has had positive feedback and evaluation. Information regarding the course, including a mini evaluation showing positive outcomes and an increase in uptake, was provided to the Public Health Minister in October

2021 following their attendance at the RSPH Awards [WR/19-INQ000180287]. However, we received no communications from the office following this to look at how it could be rolled out wider or adapted to support and increase uptake in key communities. There has also been no contact from other areas of Government to explore how either qualification (Health Emergency Preparedness or Vaccine Hesitancy) [WR/20-INQ000180286] or a new qualification could be developed to support response or future preparedness. A missed opportunity given RSPH expertise and reach through membership and networks.

RSPH did not receive any engagement from the government on any of the qualifications and tools it was offering and how they could be rolled out more widely to support the response. Aside from guidance and documentation that was available to all the RSPH received no additional information or advance copy to provide input and expertise. This was a missed opportunity given the wider public health workforce membership and our ability to adapt, develop and run evidence-based qualifications and courses to support pandemic response.

As mentioned above there has been a personnel change at the RSPH since the pandemic however the record and conversations that we have had at the organisation reflect that outside of the training mentioned earlier, there was no communication with us regarding pandemic planning or preparedness and at no point were our opinions or views sought on this area despite our access to the wider public health workforce or being the oldest public health organisation in the world.

Despite RSPH developing key qualifications to support vaccine uptake and a report that highlighted public attitudes to the Covid vaccine, the government has not engaged with the RSPH on pandemic related areas since 21 January 2020. This is despite our membership consisting of over 5,000 people from the wider public health workforce who could have been communicated with and used to provide key intelligence and support to the pandemic response [WR/19-INQ000180287].

<u>What we think could have been different</u>

With hindsight, a decade of austerity looks both short sighted and unnecessary. It almost certainly eroded public services, many people's safety net and left our services stretched and depleted as we entered the pandemic. If we want a strong nation we must invest in the health of populations who have been most impacted by austerity to support people to build their health and resilience.

Given the fiscal impact of both Brexit and the Pandemic, the savings seem ideological rather than essential. If we want a strong and prosperous nation, we need to invest in our population health in the way we would for any major infrastructure, consistently, fairly and over a prolonged period of time.

As previously mentioned, we had good systems, we did not appear to enact them early enough and that with hindsight could be seen as a mistake and the government did not get the messaging to the public right or consistent enough.

Learning for the future and future pandemics

If we were to recommend a range of learning to take forward from the pandemic, we see several potential areas of learning.

Build resilience into systems in advance rather than trying to ramp up capacity in a pandemic. That local services responded was heroic and fortuitous but not through design. We have now a choice and chance to build upon this and support those sectors, industries and communities.

Spread emergency planning capability wider than the NHS and Local Authorities. We think that each statutory organisation should have EPRR capability and that many businesses and critical industries would benefit from this. There is a small window in which these organisations may be receptive to this, the further we move from the pandemic the more this recedes.

Draw on public health teams in local government as your experts. They were not used well enough or early enough and despite their best efforts were sometimes ignored and always underfunded. Restoring the funding to 2010 levels for the public health grant would be a good place to start.

Listen to communities and support the voluntary and charity sectors better as they have many of the answers to the problems.

Statement of Truth

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: 14/04/23