Faculty of Public Health Statement on COVID-19

19 June 2020

The following statement has been produced by the Faculty of Public Health (FPH) Board in relation to the UK's response to the COVID-19 pandemic. It builds on the rich source of information and articles that we have on the FPH website. The statement draws on the experiences across the UK and highlights the key areas on how best to tackle COVID-19 and save lives. These key areas – which are identified below – should be urgently considered by Government.

The Faculty of Public Health is a membership organisation for nearly 4,000 public health professionals across the UK and around the world. We are also a registered charity. Our primary role is to set standards for training and education for public health specialists and to work with our members to improve the health and wellbeing of local communities and national populations.

The COVID-19 pandemic is the biggest single threat to the health of populations since World War II, with over 40,000 deaths in the UK directly attributable to COVID-19 as at 6 June 2020. The UK has the highest absolute excess of deaths in Europe, with over 63,000 more deaths in the UK than usual for the time of year by the week ending 29 May 2020. The Faculty's members worldwide, within many different settings and organisations have been working tirelessly to protect the public. The breadth of their expertise and experience allows us to provide a unique professional perspective of the public health system.

To date, the Faculty has used our extensive networks and connections, collaborating with others to influence the development of the response to the pandemic. As it becomes clearer that inadequate preparation and systems errors have impeded an effective response to COVID-19, we hope that the publication of this statement will provide an additional impetus to the debate.

FPH helped develop the Quality Framework for the public health system, published by the Public Health System Group in March 2019 that sets out the characteristics of a high performing public health system; namely that it is co-produced with communities; focused on equity; evidence-informed and standards-driven; delivered by qualified and well-trained staff; timely and responsive to the needs of the population; and prioritised in a planned way within available resources. These are essential features that need to characterize the system response to COVID-19.

The Faculty will continue to work through our members to protect the health of the public. We acknowledge the contribution of the World Health Organisation and colleagues who advise governments in the UK and across the world in their endeavours to bring the pandemic under control.

There is an urgent and critical need to ensure that the new resources going into the pandemic, and the renewed links with social care are used to restore, re-invigorate, and strengthen the public health system at local, regional and national levels. The pandemic has highlighted the need to strengthen the public health specialist presence within NHS settings in future arrangements.

Key areas on how best to tackle COVID-19 and save lives
This statement sets out the key areas of good public health practice that urgently need to be embedded within the current response. Whilst we recognise that work is already underway in a number of these key areas, as indicated in the opening paragraph of this statement we need to strengthen the current response.

1) **Leadership & integration -** An effective national, regional and local system where local leadership, ownership and involvement is prioritised. Clarity of responsibilities, relationships between bodies and agencies with clear lines of accountability and communication is essential.

2) **Data & Surveillance -** Transparency and openness in data availability and reporting to those in the System who need it and this must include local PH Teams.

3) **Testing & Contact Tracing** - A test and trace strategy that has clarity of purpose and quality standards and that is effective in managing outbreaks, suppressing the virus and preventing further spread.

4) **Community Engagement -** Consistent and targeted public messages about COVID-19 related risks and how to mitigate and manage these is required.

5) **Health Inequalities -** COVID-19 is having a disproportionate effect on disadvantaged communities.

6) **Workforce & Training -** Every member of the workforce undertaking key public health roles including contact tracing and testing must be appropriately trained and supported to undertake this role. Minimum training standards must be developed for new and/or temporary workers.

7) **Ethics & Law -** There must be a sound ethical underpinning to legal and policy interventions.

8) **Sustainability -** The pandemic has highlighted the importance of access to green space in our urban environments. It has also reduced travel and the emissions of CO2 – we want to ensure that these benefits are sustained in the future.

Further detail is given below.

Leadership and integration
A fully integrated public health system with clear leadership and overall accountability at national, regional and local level is required to effectively manage a pandemic at every stage.

Public health is a critical strategic component of a national health service and not simply a partner. The power, local accountability, flexibility and knowledge of locally based public health teams and their links to local government must be fully utilised. Whilst the detailed arrangements in the devolved nations of the UK vary significantly, these principles are applicable throughout the UK.

Local Directors of Public Health and their teams are a critical part of pandemic control and must be fully informed of all cases, contacts and outbreaks within their populations. National testing programmes must be integrated with local public health teams, with local delivery and ownership. Directors of Public Health must be actively involved in developing and implementing local outbreak

plans in partnership with other stakeholders, including national and local government, health services, public health agencies and others. Local action requires local leadership and involvement.

General practitioners and primary care systems must be provided with individual level data on all laboratory diagnosed positive cases so that they can support patients, their families and communities.

The importance of strong public health research and academia to the management of the epidemic is self-evident. Mechanisms to facilitate links between academia, services and elected officials need to be reviewed. It is important that scientific and medical experts can speak truth to power and that the public has valid, comprehensive information on public health issues. Such information must be based on fact, not supposition, and be clear and unambiguous. Investment in public health research and infrastructure, embedded within services, is needed on a secure and ongoing basis to generate live and actionable evidence for improving the health of the public.

The NHS has a huge responsibility to respond to unmet healthcare need and health inequalities, which have been exacerbated by the crisis. Particularly in the recovery phase, technical public health skills are needed to identify action to reduce these health inequalities, develop risk stratification and advise on prioritisation as the NHS remodels and resumes clinical activity. We urge a wider adoption of public health consultants based in the NHS to lead and advise locally on specific NHS roles tailored to local recovery, but also future efficient and effective services, and wider preventative work going forwards.

Please see the joint statement on Guiding Principles for Effective Management of COVID-19 at a Local Level.

Data & Surveillance

The fractures between national policy and local delivery, and between the NHS and local government, are evident in the repeated failures to share information during the pandemic.

Surveillance data must be meaningful, timely and of appropriate granularity to support decision making at every level.

Data must be presented as rates in addition to crude numbers, age-sex standardised as appropriate, and place-based data must include positive COVID-19 test results from all sectors in that locality.

Agencies must adopt a proactive approach to sharing information by default, in line with the Instructions of the Secretary of State, the Statement of the Information Commissioner on COVID-19 and the Civil Contingencies Act, all available here.

There must be clear processes for data sharing with appropriate safeguards for data protection and confidentiality between different parts of the system, so that a comprehensive picture of the spread of COVID-19 is available at national, regional and local levels. Agencies must agree data flows, pathways and information sharing protocols.

Testing & Tracing

A test and trace strategy that has clarity of purpose and quality standards and that is effective in managing outbreaks, suppressing the virus and preventing further spread.

A clear, overarching strategy is needed for testing that ensures effective, equitable access and efficient use of this (scarce) resource. This must recognise that testing may serve a number of different purposes, and has a role in a number of different processes including diagnosis for symptomatic individuals, surveillance, research, prevention of transmission, protection of others, case finding and contact tracing. A report and discussion paper produced by the Royal College of Pathologists is helpful in highlighting some of these needs.

Clarity is needed as to the purpose, processes and populations that are being tested in all of the above situations. Specific examples include routine screening of NHS patients prior to admission and discharge; health and care workers; processes for infection control in institutions such as prisons and detention centres; port of entry testing; return to work of infected staff; workplaces; follow up of contacts of cases to control the epidemic and prevent a second wave of infection.

GPs and primary care staff must be able to order testing as part of routine clinical care and receive the results of all testing for their patients.

All individuals with symptoms suggestive of COVID-19 must be encouraged to have diagnostic testing as soon as possible in all care pathways.

Transparent and meaningful reporting statistics for demonstrating progress in delivering the testing strategy are required. Fast turnaround for test results i.e. within two days maximum, is essential for effective contact tracing and performance should be monitored.

The limitations of testing should be acknowledged; the risk of a false negative test result means that repeat testing should be available where there is a high prior probability of infection, with advice given to people with characteristic symptoms to self-isolate until a second negative test is received. However, in most cases - when prevalence is low - the negative predictive value of a single negative test result remains over 99 per cent and is therefore reliable.

As it is difficult to ascertain all asymptomatic and pre-symptomatic cases through testing and contact tracing there is a continued need to maintain adherence to hand washing and social distancing and face coverings as appropriate.

Contact tracing

Comprehensive contract tracing systems must be fully integrated with local public health teams, local communities, NHS and primary care systems. Local public health teams, including community nurses and environmental health practitioners, have long experience of contact tracing and this expertise must be maximized. A strong place-based approach is essential for the long-term control and suppression of COVID-19.

There must be a transparent and clear systems map available in the public domain that shows how different agencies and organisations work together and how information flows between them.

Quality standards for contract tracing systems must be explicit and reported on. This must include as a minimum, the proportion of cases contacted, the average time taken to contact cases, the average number of contacts identified and the proportion of contacts successfully traced. Information should be provided on the number and proportion of cases linked to institutions such as healthcare providers, care homes, schools, places of worship or other workplaces. Regular monitoring of the quality of advice given should be undertaken.

Support must be provided for those who are required to isolate and shield. This should include practical issues such as grocery shopping and prescriptions, alongside financial, mental health and social support. Local primary and community services and the voluntary and community sector have an important role to play in providing this.

Advice on self-isolation must be evidence-based and must be clear and easy for the public and professionals to follow.

Community engagement

Consistent and targeted public messages about COVID-19 related risks and how to mitigate and manage these is required. This should be based on evidence about the risks of exposure of different activities and the balance of harms and benefits to individuals.

The importance of hand hygiene, social distancing and self-isolation of individuals and their households if symptomatic needs to continue as a key public health message.

Local communities must be engaged in prevention of COVID-19 and be provided with appropriate information to do this. This may require materials in different languages and community support workers. Local public health teams have a key role in communicating with vulnerable and excluded groups at place level.

Recognition, engagement, and financial and practical support for the voluntary and third sector organisations who have risen to the challenge of providing much-needed services is required especially homeless charities, foodbanks and addiction services

Health inequalities

COVID-19 is having a disproportionate effect on disadvantaged communities, with a higher incidence and mortality rate in minority ethnic groups and socio-economically deprived communities. Targeted support is required in these communities. This must include ensuring communication is appropriate, providing material and social support, health promotion support for behaviour change such as weight loss and smoking cessation to mitigate risks, and investment in infrastructure, particularly green spaces. Research is urgently needed to explore the underlying reasons for the disproportionate impact on minority ethnic groups in order that interventions may be targeted most effectively.

The Faculty of Public Health has issued this statement on racism and inequalities, with COVID-19 once again shining a light on the widening inequalities faced by minority ethnic groups.

Over 95 per cent of deaths from COVID-19 occur in persons aged over 60 years of age in the UK. A successful strategy to prevent loss of life must recognise that increasing age is the most important single risk factor and must seek to protect this age group. More thought is required around the advice given to this age group and the positive discrimination that should be instituted to minimise risk.

Targeted support for vulnerable children not in school is required, and we welcome the Government's recent u-turn on free school meals during the summer in England, as already the case in Scotland and Wales. Northern Ireland have not declared a position yet.

It is also becoming clear that certain occupations are at increased risk of exposure to COVID-19, and we see that these groups are also disproportionately low paid and from minority ethnic communities, further increasing their risk. Targeted support is needed for these high-risk groups, particularly as they are often providing essential services such as public transport.

The suspension of established pathways of health care has prevented individuals at risk of other health conditions, most notably cancer, from accessing interventions that are proven to improve outcomes. At an individual level this imposes a risk to health and wellbeing which may outweigh the risk from COVID-19. Restoration of services based on stratified risk assessments needs to be addressed as a priority.

Workforce and training

Every member of the workforce undertaking key public health roles including contact tracing and testing must be appropriately trained and supported to undertake this role. Minimum training standards must be developed for new and/or temporary workers.

Consideration should be given as to how surge capacity is managed, including the use of local public health and community staff, volunteers and recently retired public health professionals. FPH also wants to acknowledge the contribution of public health professionals working within the NHS and recognises this important public health input.

Public Health Specialty Registrars have been exemplary in their response to the pandemic and have provided a much needed and welcome resource.

Ethics and Law

The pandemic has highlighted and exacerbated existing health inequalities and demonstrated that health is a shared good and a shared responsibility. Law and policy are essential measures in interventions to pandemic responses, and there must be a sound ethical underpinning to legal and policy interventions, paying attention to basic democratic principles, fairness, and social justice.

Sustainability

The pandemic has highlighted the inequitable access to green space in our urban environments. It has revealed that a large proportion of the population are living without access to outdoor space and has demonstrated the importance of access to nature and green space for good mental and physical health.

It has made clear that large reductions in traffic-related emissions are possible in a short time, and that these reductions are associated with substantial improvements in air quality. Many people have walked and cycled in local areas in a way they have never previously done. During the period of recovery it is essential that actions taken to green our urban environments, reduce air pollution and carbon emissions, and increase active travel are sustained and built on.

The use of re-usable cloth face covering should be encouraged, and disposal arrangements made for the substantial and increasing volume of waste from PPE as use by the public becomes routine.

Reference documents

Public Health Standards: a high quality public health system (March 2019): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/809305/Quality_in_public_health_shared_responsibility_2019.pdf

Royal College of Pathologists: COVID-19 testing, a national strategy (June 2020): https://www.rcpath.org/profession/on-the-agenda/covid-19-testing-a-national-strategy.html

Association of Directors of Public Health, Faculty of Public Health, UK Chief Environmental Health Officers Group, Public Health England, Local Government Association, Solace: Public Health Leadership, Multi-Agency Capability: Guiding Principles for Effective Management of COVID-19 at a Local Level (June 2020): https://www.adph.org.uk/wp-content/uploads/2020/06/Guiding-Principles-for-Making-Outbreak-Management-Work-Final.pdf

Public Health Medicine Consultative Committee: Statement on the easing of lockdown and on test and trace (18 June 2020): https://www.bma.org.uk/news-and-opinion/statement-on-the-easing-of-lockdown-and-on-test-and-trace

We recognise that our members who are at the forefront of tackling this pandemic will have invaluable feedback on the UK's response. We are keen to gather evidence and concerns which will be reviewed post COVID-19, and you can submit your comments through our dedicated webpage here.