Thursday, 13 July 2023

(10.00 am)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: Good morning, my Lady. May I please call Marcus Bell.

MR MARCUS BELL (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: Mr Bell, may I begin by thanking you for the assistance you've so far given to the Inquiry. I know that you have made witness statements both in relation to this module and also Module 2.

We can see on screen the witness statement that's most referable to this module. Can you confirm, please, that it's true to the best of your knowledge and belief?

A. I can.

Q. Thank you. We can see that on page 6 it has been signed by you on 20 April of this year.

Thank you, we can take that down.

Mr Bell, you joined the Cabinet Office in 2016, you became director of the Race Disparity Unit and also the Disability Unit, and from September of 2020 you have been director of the government Equality Hub, which is based in the Cabinet Office and is focused on disability policy, ethnic disparities, gender equality, LGBT rights and the overall framework of equality legislation for

the United Kingdom. Is that right?

A. That's correct.

Q. Thank you.

The Equality Hub was created in September of 2020, so in fact it postdates the end of the Module 1 time period, but I will during the course of my questioning this morning ask you about your experience within the hub.

I want to begin, however, by seeking your assistance in describing the three units that made up the hub that were joined together in September of 2020, starting off with the Race Disparity Unit.

So from your experience in it, can you describe to the Inquiry what that unit did, what was its remit?

A. Right, so the Race Disparity Unit focuses on ethnicity disparities, so that's differences of treatment or outcome affecting people from different ethnic minority backgrounds, and as you said it was set up in 2016.

Q. Mr Bell, can I just ask you slow down a little bit, please. You speak rather quickly.

A. So sorry.

As you said, it was set up in 2016, following an initiative by the then Prime Minister, and it was actually originally intended to be a time-limited project, it was only supposed to last for a year, but

the decision was taken to keep it on.

So it had its origins as effectively a statistical unit focused on ethnicity data, and the Race Disparity Unit collects and publishes a very large amount of ethnicity data on its website, ethnicity facts and figures, which we still maintain. But after an initial phase focused on data, the Race Disparity Unit grew a policy function on top, because if you publish data about ethnic disparities, the public expects the government to tackle them, and so the Race Disparity Unit became both a policy and a statistical unit focused on collecting and publishing high quality data about ethnicity but also trying to influence public policy on that supporting ministers. So that was and is its function.

Q. Thank you.

What about the Disability Unit?

A. So the Disability Unit was created in late 2019, so November 2019, and the idea there was to bring more of a strategic focus to disability policy at the heart of government, so that's been the Disability Unit's focus: to try and improve the quality of cross-cutting policy on disability from the Cabinet Office.

Q. Finally, the Government Equalities Office, or the GEO.

A. Right, so GEO is more long-standing than either of those

other two units, so it's been around since 2007, and its focus, again as you said in your opening remarks, is on gender equality, LGBT rights and the framework of law and guidance around equality.

Q. What is the Social Mobility Commission and where does that currently sit?

A. So the Social Mobility Commission is an independent arm's length body, so it's an independent commission though it's appointed by ministers. Its focus is on improving social mobility and its secretariat, so the staff who support it, are part of the Equality Hub. So that's the join with the other things we've been describing.

Q. Right. What was the rationale in combining the three units which you've described?

A. I think the rationale was two-fold. So one was that there are connections between the different issues that the different units focus on, so people can experience discrimination based on race and gender at the same time, and so it was thought to be a good idea to bring the units together for that reason.

I think there was also an efficiency argument, because the different units had teams focused -- separate teams focused on, for example, communications and analysis and other issues, and it was thought to be

more efficient to bring them together within a single organisation.

Q. As we've said, the knitting together of the three units took place in September of 2020, so, as this module is well aware, that was during the outbreak of Covid-19. Is that a decision and the rationale that you've just set out, was that something which had been thought of before the onset of Covid-19, or was it something that happened as a result of Covid-19 perhaps?

A. I don't think it primarily happened as a result of Covid-19. So I think that there was -- before September 2020 there was informal collaboration between the different units, both on Covid and on other issues. I think it was -- it was felt by the Secretary of State at the time, Liz Truss, that the work would be done better if it was managed together, so I think that was the main reason, but I don't think it was particularly driven by Covid, even though obviously that was going on at the time.

Q. So that was just a coincidence in terms of the timing that it came together?

A. I think so. And it's worth saying that the -- of the different units that you've been describing, the Race Disparity Unit and the Disability Unit were very heavily engaged in Covid work in 2020. I think the Government

Equalities Office was engaged but less so.

Q. Right, thank you.

Is it right that the Equality Hub has three key areas of responsibility? The first is policies that are solely the responsibility of the Equality Hub, for example legislating to ban conversion practices. Second, policies and pilot programmes that are developed within the Equality Hub and then handed over to other government departments to lead, such as the LGBT bullying plan, which is now the responsibility of the Department for Education. And, third, advising and supporting other government departments to deliver policies drawing upon the experience that's held within the Equality Hub.

A. I think that's correct, and I think the easiest way of explaining this is that every single public policy issue has an equality dimension to it.

Q. I'm sorry, I'm going to have to ask you to slow down. The stenographer has to follow what you're saying and you are very quickly spoken.

A. I'm sorry. I will try and slow it down.

Q. Thank you.

A. So I think the best way of explaining that is that every single public policy issue has an equality dimension to it --

Q. Right.

A. -- whether that's in education or health or the armed forces or benefits, and there's no way that all of that can be managed properly by a small unit in the centre of government, so inevitably we have to prioritise. So for the most part we look to individual government departments to manage their own equality issues. We provide guidance from time to time to departments from the centre, and we also focus at any one time on a limited number of issues that are a particular priority for ministers.

Q. Going back in time to the ten years leading up to the onset of Covid-19, and bearing in mind the dates at which you have explained to the Inquiry that the separate three units were set up, are you able to help us in terms of the level of consideration, consultation and involvement that the Race Disparity Unit, the Disability Unit and the Government Equalities Office had in pandemic planning with other government departments?

A. Yeah, so I know from my own experience in the Race Disparity Unit and the Disability Unit, which I was leading at the time, that we had no involvement in pre-pandemic preparedness within government. I understand from GEO colleagues -- so I wasn't the director of GEO at the time, but I understand from GEO

colleagues that they did not have any involvement either.

Q. With your role as director of the Race Disparity Unit and the Disability Unit, was pandemic preparedness on your radar at all?

A. I would say it wasn't. Perhaps if I just say a brief word about what was on our radar and why.

So we agreed a set of priorities in the Race Disparity Unit with ministers, and that came from two sources. So one was data. So, as I said, we collect a very large volume of data about ethnic disparities, so one source was data showing where disparities were greatest, the other was a kind of judgement call from ministers about what were the issues that they particularly wanted us to focus on.

So among the issues that we were --

LADY HALLETT: Please slow down.

A. I'm so sorry.

LADY HALLETT: It's not just our brave stenographers, I also try to make a note. So it was a judgement call by ministers -- sorry, I interrupted.

A. A combination of data and a judgement call by ministers. So among the issues that we were focused on, they included school exclusions, adoption, mental health and university entrance, because those are all issues where

there was a significant ethnic disparity from the data, but also some willingness from ministers to address them.

MS BLACKWELL: Thank you.

I'd like to display, please, the strategy from 2011, the United Kingdom pandemic preparedness strategy, and in particular the analysis of impact on equality which accompanied the strategy. Thank you very much.

If we could have a look at page 1, please. Thank you.

Just to remind ourselves of this document, which has been mentioned to my Lord before today.

"The Equality Act 2010 mandates a duty within the public sector to:

"- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;

"- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

"- foster good relations between persons who share a relevant protected characteristic and those who do not share it."

Then the next paragraph sets out a definition of what protected characteristics are, and says:

"The Department of Health's ... Analysis of Impact on Equality ... process is a key element of demonstrating how it is meeting the duty. It also considers other groups that may experience disadvantage and barriers to accessing services as well as poorer experience and outcomes."

So, just pausing there, please, did you have any impact or involvement in the preparation of the Department of Health's analysis of impact on equality at any point?

A. Well, in relation to mental health issues, as I said, we were working on that in 2019, yes. In relation to the issues covered by this document, no, not in 2019, but also, of course, this document was prepared in 2011, when neither the Race Disparity Unit nor the Disability Unit existed.

Q. No, of course, and the Inquiry has heard that there were plans afoot to update it but matters did not come to fruition prior to Covid-19 hitting the United Kingdom.

But in preparation for its update, did you, in either the Race Disparity Unit or the Disability Unit, have any contact from those who were charged with updating this document to make contact with you and to seek your views as to any assistance you could give in provision of information for the updated document?

A. I believe we didn't, no.

Q. Right.

Since Covid-19 and the improvements -- given the impact that it's had on the country, the improvements to this and other documents and -- both in terms of preparedness and the resilience of the country, has there been contact with the Equality Hub, as it now is, to seek its consultation in terms of the preparation of documents and plans going forwards?

A. Well, we were very heavily engaged on Covid work specifically from, I think, the sort of early months of 2020 onwards. So, I mean, I think particularly from May 2020 onwards. And my minister, Kemi Badenoch, made a statement to Parliament in June 2020 about the work that we were then going to do, and I think we had a very extensive involvement with the Department of Health and its various agencies over the two years which followed.

Q. Is the Equality Hub expecting to provide, for instance, guidance to the Cabinet Office groups who are now charged with the responsibility of taking forwards pandemic preparedness and resilience matters?

A. We're very happy to, and we did publish recommendations about some key lessons learned from the pandemic from an equality perspective in the report that we published in December 2021.

Q. Well, I'm going to come to those in a moment, Mr Bell. Before I do, you will be aware that Professors Marmot and Bambra have provided both a written report and evidence to the Inquiry in terms of health inequalities, and part of the evidence that they've given to my Lady was that, in their opinion, in terms of this document and the analysis of impact on equality report, the analysis undertaken was fairly limited in terms of identifying the multiple issues faced by different social groups, and that there is little in this document provided on what action should be taken to mitigate any differential impacts. Do you agree with that assessment?

A. I think those are fair comments, yes, and perhaps it might be helpful if I said a little bit about what I would expect to see in equality impact assessments.

Q. That was going to be my next question, so yes, please.

A. Right, okay.

So clearly it's primarily the responsibility of lead departments, as I said, to prepare equality impact assessments, so we see quite a lot of them, and sometimes they're done well and sometimes they're done less well. But I think the three things that I would particularly expect to see in a good equality impact assessment are clarity about the outcomes that the

department is seeking to achieve or prevent, so I think that's the first thing. I think the second thing is an analysis of the maintain protected characteristics that might be impacted. And third is good data about how far different protected characteristics are impacted by whatever the department is seeking to achieve.

So I think those are three things that I would expect to see in a good equality impact assessment.

Q. Has the Equality Hub provided that opinion and guidance to any of the lead government departments?

A. So the Equality and Human Rights Commission, who I think you're seeing later on, they publish guidance about equality impact assessments. We write to departments from time to time about what an effective approach is to equality impact assessments, and I believe the most recent time was in 2021 when Kemi Badenoch wrote to ministers about equality impact assessments.

I think it's worth saying that we also have a more informal arrangement called the PSED Network --

Q. The what, sorry?

A. PSED Network, the Public Sector Equality Duty Network, which is a network of officials dealing with equality issues around government, who we -- from time to time we meet them and discuss what an effective approach is and what works and what works less as well.

Q. In your answer to that question, you've set out how the Equality Hub can reach out to other government departments and the reasons why the Equality Hub would do that, but it's a two-way street, isn't it? The Equality Hub is a visible unit which lead government departments in relation to any aspect of risk planning would know about, and know how to get hold of you.

Do you also agree, Mr Bell, that there is a level of responsibility on those within other government departments to reach out to the Equality Hub and to seek guidance and assistance in areas where that is appreciated to be a need?

A. Yes, I would agree with that, and it's worth saying that there is quite a lot of expertise now in departments in conducting equality impact assessments, and quite a lot of experience in doing them, so we wouldn't automatically expect that people would consult us when conducting this work, but obviously, you know, they do from time to time and we're happy to help where we can.

Q. Thank you.

Let's then look at the summary of Equality Hub Covid-19 lessons learned session, and this report is at INQ000101263. Thank you.

We can see from the document that this is the report of the session that took place on 18 November -- of

which year?

A. I think 2021.

Q. Thank you. It contains a summary of the points raised in the session. I'm going to read through them and ask you some questions about them, Mr Bell.

"Redeploying staff externally.

"- The first staff to be redeployed were the analysts working on the COVID-19 dashboard, which became the single source of truth and informed the early government daily briefings. This happened quickly and easily and the dashboard made a real difference.

"- [Equality Hub] staff made a good impression on other departments. Almost all of the gender team that were redeployed moved on to new roles."

Just pausing there, was there a significant movement of staff during the course of the Covid-19 outbreak?

A. There was, yes. So initially particularly from the Government Equalities Office and the Race Disparity Unit, because at the beginning of the pandemic there were -- lots of new roles were needed almost immediately around government, and so a large number of staff were redeployed, particularly from those two units.

So Disability Unit was to some extent protected during that period, but a lot of staff were redeployed, including myself, for a limited period, yes, and that

was because of a view by senior people in government that there were some new priorities, it was a national emergency and people needed to move quickly.

Q. Yes.

Just moving down to the penultimate bullet point in this paragraph:

"- Issues around access to IT ... meant that some people experienced delays in getting up to speed in other departments."

And:

"- It was felt that Cabinet Office over-egged the redeployment process and redeployed too many people overall. Some people were told they were going on emergency redeployment but then had little or nothing to do after they had moved."

Whilst appreciating that we're now straying, really, into Module 2 issues, I want to ask you where this level of redeployment left the Equality Hub: was the work of the hub effectively put on hold from the moment that Covid hit and the redeployment process began to take effect?

A. I think the impact was actually very limited, despite what's said here, because Race Disparity Unit and Disability Unit were both declared -- I forget exactly what the phrase was, but kind of critical business units

in Cabinet Office terms, so the general notion was if you're a critical business unit you weren't expected to redeploy staff anywhere else because what you were doing was a critical function.

So RDU and DU were both designated as critical functions, I -- from memory I think in about June of that year, I think when it became obvious that disability and ethnicity were going to become -- were going to be really important issues in the pandemic. So I think -- I think when we're talking about redeployment of people elsewhere, that really happened in the first couple of months of the pandemic and very little after that, except in the case of Government Equalities Office, where I think a number of people were redeployed later in the year, and that probably did have an impact on that unit.

Q. Can you give the Inquiry an idea of the size of the three units and also whether or not there has been a reduction in staff since the Equality Hub has been created?

A. Right, so, in round terms, Disability Unit is about 20 staff, Race Disparity Unit is about 20 staff, Government Equalities Office is rather bigger and is about 130. So that's about 170 staff overall. And it remained pretty much at that level until current year

when, because of wider changes in the Cabinet Office, we have had to make some staffing reductions of around about 30, but that's certainly something that's only happened in the past few months.

Q. So putting the Government Equalities Office to one side, given what you've said about the redeployment of staff within that unit, and bearing in mind that the sum total of staff in the other two units is about 40, how many staff do you say were redeployed in the beginning months of the Covid-19 pandemic?

A. Right, so I'd have to check the numbers, so this is from memory, but in the case of Disability Unit I think it was literally one or two.

Q. Right.

A. So hardly any. In the case of Race Disparity Unit I think it was probably three or four, including me. So, as I say, I was redeployed, but most of the team stayed in place.

Q. So there were significant numbers still running those units and carrying on the business as usual?

A. Yes.

Q. Thank you.

May we just move down this document, please, and go to the final paragraph:

"Experience of working with the centre

"- There was too big a focus on presenteeism in the early days of the pandemic regardless of the risks. This meant a number of key people all became infected at the same time.

"Conversely, this approach excluded the No. 10 disability SpAd from key decisions. As a result, mistakes were made - eg not having a BSL interpreter at the daily briefings.

"- It was felt that equalities interests weren't properly represented in early meetings."

And:

"- There were mixed views on working with the CO Covid-19 Taskforce."

LADY HALLETT: I'm sorry, Ms Blackwell, I'm not following why this isn't just Module 2.

MS BLACKWELL: Well, I just wanted to finally bring this all together and to see whether, in terms of going forwards with the Equality Hub, what were the lessons learned from the very early days of Covid. I appreciate that our timescale finishes in January, but ...

In your position as director, Mr Bell, were there lessons to be learned in terms of the time at which Covid hit and the timescale running up to January of 2020?

A. Well, so we published in December 2021 some

recommendations about dealing with equalities issues arising from the pandemic, so if I just sort of briefly summarise what we said there, and how that relates to some of the issues you have been --

Q. Yes, please.

A. -- talking about.

So I think the key things that we said in terms of future approaches to pandemics was, it was essential to have really effective communications with different groups which were tailored to them and actually cut through to who you wanted to communicate with. So that was one point.

I think the second was that maintaining trust with all groups is really important, and -- sorry, maintaining it or building it where it does not exist, because effective communication, effective action with, particularly, disadvantaged groups strongly depends on trust, so I think that's the second point.

I think the third one is about the absolutely critical importance of high quality data about, you know, particularly, because we're talking about a pandemic, mortality, but also a number of other impacts on people, so that the government was in a place to act swiftly with issues as they were emerging.

So I think those issues around trust, communication

and really good quality data, particularly about disadvantaged groups, I think those are the main things that we said, and there's quite a lot of detail in the recommendations about how we thought it needed to be taken forward.

Q. Yes. In terms of communications we can see that the bullet point 5 in this particular paragraph of experience relates to communication from the taskforce, so communications between the departments themselves.

Was that in itself a recommendation, improvement in communication between the groups within government, or do you mean communication outwith government and between the Equality Hub and those that are its subject matter?

A. I think what we were thinking of primarily was communication with the public about public health matters, and about the pandemic and vaccines and Covid. So that's primarily what we were thinking about. Though, I mean, communication with government in the early stages of the pandemic in particular could also have been better, as you probably heard from others.

Q. Yes, all right.

In terms of the recommendations that have been made and the time that has elapsed since those recommendations have been set out by the Equality Hub and today's date, what progress has been made in terms

of the actions that were raised?

A. I can't give you a really clear view about that at the moment I'm afraid. I mean, as I say, we made a number of recommendations back in 2021 about this but our direct involvement with Covid and pandemic planning is, you know, obviously less than it was at the time, so I can't give you a really clear view about that today.

MS BLACKWELL: All right.

Unless my Lady has any questions, that completes my examination of Mr Bell, and there are no questions from any of the core participants.

LADY HALLETT: Thank you very much for your help, Mr Bell.

THE WITNESS: My Lady.

(The witness withdrew)

MS BLACKWELL: My Lady, may I call Melanie Field, please.

MS MELANIE FIELD (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: Is your full name Melanie Field?

A. It is, yes.

Q. Is it Miss Field?

A. Ms.

Q. Ms Field, thank you.

You are the chief strategy and policy officer of the Equality and Human Rights Commission?

A. That's right.

Q. A position that you have held since 2015, and you have previously been overall -- I'm so sorry, been -- acted asset joint CEO between July and September of 2021 but in fact have worked at the commission since 2014; is that right?

A. Yes.

Q. You have overall responsibility for strategy and policy at the EHRC and you report directly to the chief executive officer?

A. That's right.

Q. You have been kind enough to make a witness statement in the course of the preparation for the Inquiry hearings. We can see it on screen now. Please can you confirm, Ms Field, that the statement is true to the best of your knowledge and belief?

A. I can confirm that, yes.

Q. Thank you very much.

Thank you for the assistance that you've given, we can see that the statement was signed on 5 May, and thank you for coming to give evidence today.

I want to begin, please, by inviting you to explain to the Inquiry what the Equality and Human Rights Commission is and what it does.

A. Yes, the Equality and Human Rights Commission is a statutory non-departmental public body, so it operates

at arm's length from government. It was established by the Equality Act 2006 and set up in 2007. It replaced predecessor equality commissions, the Commission for Racial Equality, Equal Opportunities Commission and Disability Rights Commission, and it has responsibility for protecting and promoting equality and human rights, including enforcing the Equality Act 2010.

Q. Is one of its roles to promote understanding and engagement with equality and human rights issues?

A. Yes, it is, yeah.

Q. Is it accountable to Parliament through the Minister for Women and Equalities and the Women and Equalities Committee?

A. Yes, it is.

Q. And is funding provided by the Government Equalities Office?

A. It is, yes.

Q. Thank you.

You tell us at paragraph 9 in your witness statement that the commission adopts a "three nations approach". What do you mean by that?

A. So our statutory remit covers England, Scotland and Wales. In relation to Scotland, our human rights remit extends only to matters reserved to the UK Parliament; the Scottish Human Rights Commission has responsibility

for devolved matters. But obviously working across three nations we're working in the context of three different governments of three different political colours, and different social and economic conditions in those nations. So we try to take a corporate approach, but also one that is responsive to the circumstances in the different nations in which we work.

Q. In terms of pandemic planning and emergency preparedness, and the timescale with which this module is interested, was there any contact from any of the governments to the commission to provide its assistance in terms of pandemic planning and emergency preparedness?

A. I'm not aware of any, and a search of our systems has not revealed any such contact.

Q. It's Britain's main equality organisation, is it not?

A. Yes.

Q. Given what has been aired during the course of this Inquiry so far, and what you now know about the manner in which preparedness planning went forwards in various nations, are you surprised that there was no contact, apparently no contact, over the course of time for the commission to provide its assistance?

A. I am -- yes, I am surprised.

Q. What level of assistance is the commission able to give

in terms of pandemic planning and preparedness, in the knowledge that it's been suggested to my Lady that there should be a high level of consideration of those who are likely to be affected the most by a pandemic hitting?

A. I mean, I think it's fair to say that the issue was not on the commission's radar either. So it was not something that we were actively looking at or looking at engaging in, and in fact during the period in question, before the pandemic, our strategic plan, which sets out our strategic priorities, did not include a focus on health and social care, because we had taken the view that the issues in that sector that needed to be resolved were ones that our powers were not best shaped to address, in that they were around kind of funding issues predominantly.

Sorry, can you take me back to the core of your question?

Q. Yes, of course. I was asking whether or not you were surprised -- or, given what you know now --

A. Yes.

Q. -- about what's been aired during the course of the Inquiry, whether or not there is significant assistance that the commission can give and perhaps should have been asked to give in the terms of identifying those who are most likely to be affected by a pandemic hitting?

A. Yes, well, I mean, a key part of the commission's role is supporting duty holders under the legislation that we regulate to comply with that -- their obligations well, and a key part of that would be the public sector equality duty which applies to all public bodies. That's at section 149 of the Equality Act 2010. And that's the mechanism, really the legislative driver for public bodies to consider equality issues when performing their functions.

Q. Yes.

A. So that's the mechanism through which I think we could have engaged in terms of providing support about how to comply with that duty well.

Q. One of the ways in which that duty is complied with is in the creation or carrying out of an equality impact assessment, isn't it?

A. There's no requirement to carry out an equality impact assessment. The duty requires the duty holder to have due regard to a number of matters, the elimination of discrimination, the advancement of equality of opportunity and the fostering of good relations when carrying out their functions. There are specific duties to publish equality objectives and to publish information about -- so I'm referring here to the duties that apply to the United Kingdom Government, the

English-specific duties -- and to publish information demonstrating how the public body has complied with the duty. But an equality impact assessment I would say is a good practice mechanism for evidencing that due consideration has been given to these matters.

Q. So there's no duty to actually carry out the assessment, but it is good practice in complying with the duty to have due regard?

A. So there's no duty to publish a document --

Q. Publish the document.

A. -- but there is a duty to have the consideration, so the process of assessing is what is in the duty.

Q. What makes an effective equality impact assessment?

A. Well, I would say what constitutes good compliance with the duty is an appreciation of what the purpose of the function is that's being carried out, and a consideration of the evidence of how the performance of that duty might impact differently on people with different protected characteristics under the Equality Act -- there are nine protected characteristics under the Equality Act -- for example, race, sex, disability.

So an engagement with: what's the purpose -- what's the purpose you're seeking to achieve? How might what you're proposing to do impact differently or be

experienced differently by different groups? Then, are there mitigations that you need to put in place, first of all to make sure that what you're doing doesn't adversely impact particular groups, which might be unlawful discrimination; and, secondly, are there opportunities to alleviate inequalities in performing that function?

Q. So the results of that assessment and the publication of that data, it seems, could help in two regards: firstly in relation to preparedness for those who are most likely to be affected by a pandemic, but also in relation to resilience, so improving the plight of those with protected characteristics; is that right?

A. Exactly so. I mean, I think on reviewing the evidence that was sent to me as part of this process, it seemed to me that there was an inadequate consideration both of the existing health and other inequalities that might mean that people going into an emergency situation would not be on a level footing, and secondly that they might need different responses in order to come out of -- you know, have equal outcomes.

Q. Yes. So going forwards, what involvement and impact can the commission have in assisting in terms of pandemic preparedness and also resilience?

A. Well, the commission itself does already provide quite

a lot of guidance for public bodies about how to comply with the duty well, and I referred to some of those in my witness statement.

So we do give pointers to public bodies, but we also occasionally work with public bodies. So we might offer to look at an equality impact assessment and comment on it. We might be able to draw on our own stakeholder engagement and evidence about the inequalities that exist, and feed those -- that thinking into the assessment process.

We also conduct our own analysis of inequalities in Britain, so we publish a statutory report at least every five years which sets out some of the issues that I think perhaps could have been or should have been considered in the planning process.

We are also able to assist public bodies with putting them in touch with representative groups of different communities who might also be able to feed into thinking.

Q. Dr Halima Begum, who is chief executive officer of the Runnymede Trust, has provided a witness statement to the Inquiry in which she states that:

"The United Kingdom governments must ensure the country is better prepared to manage a future pandemic in a way that considers the impact on inequalities,

including ensuring systems can quickly and effectively identify those who are clinically vulnerable through further investment in high quality linked data."

Do you agree with that remark?

A. I do agree with that. One of the key ways of understanding that there is a problem is to have data on the problem. If you don't have the data, then you won't know what's happening. But I think in the health and social care space there isn't consistency of approach to data collection or comprehensive data collection around people's protected characteristics. So we would always advocate for collecting comprehensive data that is disaggregated so that you can analyse the different situations of different population groups.

I mean, one of the things that came out of the pandemic, I think, quite early on was the inability to evidence indications that there were disproportionate deaths among certain ethnic minority communities because of the inability to link data on ethnicity to death certification. So there's something about, you know, collecting that data but also being able to join that data up between different systems so that you can get a proper picture of what's going on, and that's important both for predicting what might happen but also, in real time, monitoring what is happening and

then being able to respond to it.

Q. Thank you.

I'd now like to turn to the lessons learned for the future and what you say about this in your witness statement, beginning at paragraph 24. You say that, as an organisation, you recommend that:

"... the government [going forward] should routinely seek views on the likely different impacts of proposals on different groups, where pressure of time allows, and ensure that impacts are monitored and steps are taken to mitigate any adverse impacts on particular groups."

Now, is that something that should be, in your view, embedded into the government's planning process?

A. Yeah, I mean, I think that the lesson for everyone is that in a crisis that's not the best time to try and get everything right.

So, I mean, I was struck, looking at the impact assessment of the 2011 pandemic preparedness strategy, that there appeared to have been -- well, there's no note of any engagement with any groups representing ethnic minorities, or, indeed, any reference to existing information about health inequalities, for example Professor Marmot's review, or any engagement with the Government Equalities Office or ourselves. I think what we have all learned is that you need to have those

systems and mechanisms in place and you need to have relationships and understanding of those communities before you -- before you're trying to respond in an emergency situation, so that you have those relationships then that you can draw on.

Q. Indeed Professor Kevin Fenton, who has given evidence to the Inquiry, has told my Lady about the importance of co-production, so not just obtaining the data and the information, but the government actively seeking the assistance of groups and units in order to prepare the necessary documentation together, if you like.

A. Yeah, I think obviously if you're going to communicate effectively or prepare effective responses for different communities, then those need to be informed by the needs of those communities.

I mean, the other thing that I would say is that that is important -- I mean, another thing that came out of reviewing the documentation was that there seemed to be an expectation that these issues would be sort of picked up as the pandemic played out at local level, and that it wasn't really possible to predict or make assessments at the national level. But of course we know that there are inequalities that play out nationally.

Q. Yes.

A. I think it is -- it's also important to remember the public sector equality duty is not delegable. So wherever you are in the system, you need to comply with it, as it relates to the functions that you are performing as a public body.

Q. In terms of the practicalities of obtaining data and seeking an effective consultation, at paragraph 28 in your witness statement you talk about the Welsh Government during the pandemic -- so I'm straying beyond the timescale of Module 1 for a moment, but just to use this as an example -- using online platforms to enable ministers and officials to seek the views of and learn directly from the experiences of groups with particular protected characteristics.

Now, that is an example of a process that can be used outside of a pandemic, you know, hitting, isn't it? That platform process, that connection between ministers and those with protected characteristics, can be used at any time?

A. Indeed, and of course during the pandemic, as a result of the pandemic, we've all learnt to do that kind of online engagement much better, so there is an opportunity here to build on that and ensure that that becomes sort of part and parcel of how public bodies make policy in a much more collaborative way in

future.

Q. Finally, I just want to ask you, Ms Field, about the human rights lens that you identify within the course of your witness statement.

A. Yeah.

Q. You identify that there is a gap in routine consideration of policy decisions being seen through a human rights lens. What do you mean by that, and how might that affect pandemic policies and pandemic planning?

A. Well, I mean, in the same way as the public sector equality duty requires consideration of inequalities and equality issues in the performance of public functions, the Human Rights Act makes it unlawful for public bodies to act incompatibly with the rights set out in the European Convention on Human Rights, and there are also other international human rights treaties that the UK has signed up to, and those -- those treaties contain rights that are highly relevant to an emergency situation. So, you know, the right to life, the right to respect for private and family life, the right to association, the right to education, and there is a requirement that those rights are enjoyed without discrimination. So the state has a responsibility to make sure that people are not kind of disadvantaged in

their enjoyment of those rights.

The human rights framework provides a sort of legal and, in a way, ethical framework for considering some of these difficult decisions about how these rights are balanced. So how do you strike the right balance between the right to private and family life, you know, for example, for a person in a care home to have contact with their family against the right to life? How do you balance the rights of individuals against the kind of broader public good?

So that framework, you know, obviously, as the Equality and Human Rights Commission, I would say should be absolutely guiding both the planning and the response to any emergency situation.

Q. Going forwards, as guidance and policy is updated and the experience of Covid-19 is taken into account, the Human Rights Act and the protections that that provides to people should underpin the guidance and policies, and, as you've just explained, there is a balancing exercise that needs to be undertaken in order to be able to have proper consideration and arrive at the right place?

A. That's right, yeah.

MS BLACKWELL: All right, thank you very much.

My Lady, unless you have any questions, that

completes Ms Field's evidence.
LADY HALLETT: Thank you very much indeed for your help, Ms Field.
THE WITNESS: Thank you.
(The witness withdrew)
LADY HALLETT: I've been encouraged to take an early break.
MS BLACKWELL: Right.
LADY HALLETT: Nods. So I shall return at 11.10.
MS BLACKWELL: Thank you, my Lady.
(10.54 am)
(A short break)
(11.10 am)
MR KEITH: My Lady, the next witness is Nigel Edwards of the Nuffield Trust.
MR NIGEL EDWARDS (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY
MR KEITH: Could you give the Inquiry your full name, please.
A. My name is Nigel Charles Michael Edwards.
Q. Mr Edwards, whilst you give evidence, could you please remember to speak up and to speak as slowly as you are capable of doing. Thank you.
Thank you very much for providing a statement, which you have, it's INQ000148416, and you have provided a signature and a declaration of truth at the conclusion

of that.
Mr Edwards, your statement will be published and the Inquiry has read and considered it, and it will be the subject of further consideration in due course.
I want, therefore, to ask you some questions in a very broad sense about the state of resilience of the NHS and the social care sector in the United Kingdom, but primarily England, because that's the focus of the Nuffield Trust, but not, whilst you do so, to delve into the detail operationally or otherwise of our NHS and social care structures, because they're for later modules.
In essence, I want you to focus, please, on the extent to which the Nuffield Trust believes that those structures were capable and envisaged to be capable of responding to the severe demands of a pandemic.
What does the Nuffield Trust do?
A. We are a charitable foundation and we do research into health policy and healthcare delivery, largely with a focus on the UK, and we do that by using our own researchers, and working with published data.
Q. Are you the chief executive of the trust?
A. I am. I have been the chief executive for about nine and a half years.
Q. Is the trust a charity?

A. We are a charity. We have an endowment, which is the bequest of the late William Morris.
Q. Does it follow that you are, therefore, registered with the Charity Commission?
A. We are.
Q. I'm not going to go through the charitable objects one by one, but in essence does the Nuffield Trust carry out a number of important functions? You make available an evidence base, material, detailed information, that allows you and others to better understand the care structures in the United Kingdom, you provide expert commentary, analysis and scrutiny, and do you also bring together, for seminars, symposia and so on, policymakers and decision-makers in order to try to identify better ways forward and solutions for the problems that you identify?
A. That's a very good summary of what we do.
Q. Now, in the years before January 2020, was pandemic planning or preparedness for pandemics something that the trust looked at specifically?
A. We didn't look at this area specifically, for two main reasons. One is that we did not have the internal expertise or knowledge to really do that effectively, and secondly, from a number of sources it did appear that the UK's general level of preparedness was

satisfactory.
Q. Is infectious disease, being a form of health emergency, something in fact that the Nuffield Trust historically has looked at?
A. Not specifically.
Q. But presumably you would and you did nevertheless continuously look at the state of resilience of the system, that is to say the extent to which the systems would be able to deal with the sort of shock that a health emergency or a pandemic might bring about?
A. Yes, indeed. One of our main areas of focus over the years has been the ability of the NHS to deal with winter, which is a period where the NHS has historically come under a great deal of pressure, and indeed is something of a bellwether about the overall resilience and capability of the system, and this has been a focus of our research and -- a significant focus of our research and commentary over the time that I have been at the trust.
Q. Does it form an important part of the trust's functions to raise concerns where you discover there are problems or you discover there are systemic flaws in the system? So in relation to, for example, the ability of the NHS to cope with a severe winter, do you raise your concerns the government and with policymakers and so on?

A. Yes, we both raise concerns but also monitor the situation and try and make predictions about the future response and understand some of the underlying reasons why the NHS has historically struggled with dealing with even a relatively routine winter.

Q. Although the trust didn't look specifically at preparedness or pandemic planning, did you after 2020 carry out some pieces of work which did happen to look at lessons which could be drawn from the pandemic in the particular context of infection prevention and building design in terms of the NHS and the social care structure?

A. Yes, indeed we did. We undertook two pieces of work, one funded by the Department of Health's New Hospital Programme, and one that we funded ourself internally, the latter looking at the response of small hospitals, the former looking at what we should learn from the way that hospitals were designed and operated to make them more resilient in future, particularly as new hospitals are being constructed.

Q. Maintaining the focus on planning or lack of planning or preparedness or lack of preparedness, what did you find was the position in relation to the existence of pre-existing plans, pre-pandemic plans, designed, on the hospital front, to deal with the possibility of

a sustained pandemic?

A. So the hospitals that we spoke to, and this was a sample, I should emphasise, had plans in place for dealing with influenza but not, we found, for dealing with a long-term sustained pandemic.

Q. Without going into the operational aspects of the hospital estate, and again focusing just on the degree of pre-planning that there was, was there a particular area, the supply of oxygen, in fact, in relation to which there appeared to be a marked absence of planning?

A. The requirement for high flow oxygen as a method for treating Covid-19 certainly came as a surprise, both clinically and also to state departments, who discovered that, in a number of cases, both the size of the pipework to supply oxygen and the machinery that's used to condense oxygen to keep the supply going were inadequate for the scale of the task that was -- that they were required to respond to.

They responded very well, but they had to make very major engineering and structural changes to be able to accommodate that.

Q. Does the fact that those changes had to be made of itself indicate that there had been an absence of planning for that eventuality?

A. I think it probably indicates a broader issue about the

way that hospitals in the -- in many parts of the UK have been designed and built over the years, which is to really strip out any kind of redundancy, to compress the spaces that are available, to save money where that is possible by reducing to the lowest tolerance that sits within the guidance.

Q. That would appear to be more of an operational aspect of the state of affairs in the NHS. Can you say whether or not you reached a view as to whether or not there had been an adequate or proper degree of planning, guidance and policy documents, drawn up to cater for that possibility?

A. I think, on the basis of what we saw, we can conclude that those plans were not adequate, and that partly reflects the nature of the treatment regime that was then required.

Q. All right.

Turning to social care and the social care sector, following the pandemic, did you -- and do you continue to -- carry out a study jointly with the London School of Economics, I think funded by the National Institute for Health and Care Research, as part of which you've looked at how well prepared the social care sector was for a pandemic?

A. Yes, indeed.

Q. In relation to three or four factors or three or four features of that study, firstly, the Inquiry has heard a considerable amount of evidence about the existence of what are called standards, assessments or tests, if you like, to validate the performance of the various bodies in the government structures. Is there a difference or did you find there to be a difference in the availability or existence of standards for the NHS to operate against as opposed to the social care sector?

A. The NHS typically has a much clearer set of standards defined than the social care sector.

I think it's fair to say that we haven't done a detailed examination of the standards, but the general principle of what you are saying is correct.

Q. You are aware, and of course the Nuffield Trust is aware of the fact that there were over the years a number of exercises carried out in the United Kingdom, dealing with a wide range of possible eventualities and different possibilities which might eventuate. Were you able to get an understanding of the degree to which the outcomes of the various exercises were implemented in the social care sector?

A. It's not been an easy trail to follow. So-called Exercise Alice, which looked at the challenges associated with the MERS, Middle East respiratory

disease, only covered health. The later Exercise Cygnus did look at social care. Our researchers did not find -- were not able to find a great deal of evidence that the lessons from that were incorporated into social care, and the -- in relation to the previous question that you asked, you know, that -- this general lower level of requirement standards in social care continued after that, there did not seem to be a significant change in advice given to the sector.

Q. It is obvious, and the evidence plainly establishes, that such preparedness as there was was focused on the possibility of an influenza pandemic as opposed to a different type of catastrophic pathogenic outbreak. To what extent did your researchers see the consequences of that focus as they looked at the general state of health of the social care sector? Did they see evidence that non-influenza outbreak had been planned for to any degree at all?

A. No. Most of the focus had been on planning for an influenza-type outbreak, and the significance of that was that a number of the proposals for how to deal with that did not take into account the airborne nature of transmission for Covid-19.

Q. Did some of the employees and the managers in the social care sector to whom your researchers spoke

express any view on the extent to which, both pre and post pandemic, the United Kingdom had availed itself sufficiently of learning or knowledge or experience from other countries who had had to deal with pandemic outbreaks in earlier times?

A. We couldn't find direct evidence for that.

Q. All right.

The Member of Parliament Matt Hancock gave evidence to this Inquiry about the difficulties encountered by the Department of Health and Social Care during the early days of the pandemic in understanding the sheer number of social care providers, as well as the number of persons receiving care in the social care sector, as well as, I should say, the number of persons who required care but were not receiving care in the social care sector.

Is there, in the NHS, the means to identify centrally the numbers of persons receiving healthcare?

A. At a broad level, yes.

Q. Is there a comparable mechanism in the social care sector? Do they have comparable mechanisms for understanding how many people are being treated and how many people are receiving care?

A. No, and in fact the overall oversight of the sector in terms of even who is employed and who is providing care

is also -- the information on this is also patchy or poor.

Q. Is that because the majority of the providers of social care are local providers, instructed or paid by local authorities to provide care for their purposes, and therefore there are a very large number of individual fragmented providers?

A. That is correct, although the Care Quality Commission would have a register of all registered social care providers, but that's a regulatory function rather than a managerial one.

Q. Now turning to resilience, which forms the majority of your statement. In the context of looking at the state of health of a health system or a social care system, why does resilience matter when it comes to examining the potential impact of a health emergency or a pandemic? Why can't it just be assumed that a system of care will suck up whatever a health emergency presents it with?

A. One of the reasons for that is that some of the nature of health emergencies means that there is a very large surge in demand, many percentage points greater than the baseline level, and many health systems but the UK in particular has traditionally run with very low margins of spare capacity, which means that having a plan for

how to deal with a sudden surge or emergency is very important, but it also of course limits the scope of that plan because the level of spare capacity in the system is relatively low.

Q. Do different considerations apply to whether or not a system is capable of recovering from a shock as opposed to dealing with the initial shock of a pandemic?

A. Our research internationally suggests that the ability to recover from a shock is very closely related to the overall level of capacity and pre-existing resilience in the system, so those countries which had higher levels of beds and staffing, more hospitals, better provided home care services, have recovered significantly better than those, like the UK, that do not.

Q. Was the Nuffield Trust -- or is it able to reach a view as to general levels of resilience, firstly in the NHS and secondly in the social care sector, over the years preceding the pandemic? Is there a chart or a line or a broad degree of progress that you can identify?

A. If we start with bed capacity and the demand associated with that, the number of beds in the NHS has remained relatively static during the period leading up to the pandemic. The NHS has a very low number of beds per capita compared with other high income countries. It tends to run them at a much higher rate of occupancy,

which of course means that its ability to absorb shocks or increases in demand is much lower. And although the number of beds has remained static, the population has both grown and aged over this period. So while demand has been going up by 2% a year, the beds have remained static, and the number of nurses have gone up by 0.2% over this period, which means that the system -- the hospital system is highly constrained.

Q. So that's beds and nurses. What about the state of resilience in terms of the workforce generally in the NHS over, for example, five years preceding the pandemic?

A. So the workforce has been growing, but the level of -- so too has the number of vacancies, and there have been shifts in the way that people work for the NHS, more people working on temporary contracts and through the use of bank and agency-type staff, which, again, does affect the ability of the NHS to provide services that respond to these growing levels of demand.

In community services we have a much less clear view of what the capacity of the system is. There does not appear to be a very reliable way of quantifying that, but we do know that there has not been a growth in community services to compensate for, again, this growth in the age of the population and its high level of need,

and as a consequence -- I mentioned earlier winter, which I think is quite a good indicator of the resilience of the system. So, for example, in 2018, NHS England instructed hospitals to cancel all of their planned work to make space for emergencies in January of that year.

Q. What are community services? You referred twice to community services --

A. Yes.

Q. -- by contrast to hospital services?

A. That is a much more complicated question than it might at first appear, but it would include some types of community hospitals, so hospitals which don't --

Q. Slow down, please.

A. Sorry, I do apologise.

Q. It's quite all right.

A. Hospitals which don't manage emergency care --

Q. Right.

A. -- maybe used for rehabilitation or for aftercare following a hospital visit.

Nurses and other clinical staff who provide care for people in their own homes, support patients with long-term chronic -- with chronic conditions, manage their care and provide rehabilitation and aftercare in a home care setting.

Q. So you've touched upon, now, general workforce levels, general bed capacity. This is all in the NHS and non-social care. Again, without going into the detail and certainly not the operational side, what was the state of resilience in January 2020 of the capital infrastructure of the NHS, that is to say the buildings, the capital assets, the equipment, the hospitals, the wards?

A. As part of the approach to trying to keep NHS funding, at least keeping up a little bit with changes in costs, the capital budget had been reduced and turned to revenue, and one of the consequences of -- so it's an accounting shift, but the implication of it is that money that should have been spent on new equipment, on repairing -- on repairs and maintenance, was shifted to keeping everyday operations going, and as a consequence the backlog maintenance bill of the NHS has grown very substantially over this period, which is another indicator of a problem because it means that a significant amount of the estate is really not fit for purpose.

Q. So in other words, and forgive me for oversimplifying it, there is a certain amount of money that goes into the NHS pot, money that might have been used to improve the infrastructure was used instead for its current

account, that is to say for its trading, for keeping the system ticking over?

A. That's correct.

Q. And that means that we've fallen behind in terms of the maintenance of our infrastructure and our capital expenditure?

A. That is correct.

Q. All right.

That's the NHS. Could you give us, by reference to, firstly, places, then the general workforce numbers, and then, again, the capital infrastructure, the analogous position for the care home sector?

A. It's not so easy to do this for social care. We can talk generally about what had happened to funding over this period.

Q. Yes?

A. So funding comes from councils, as you mentioned, and many of them had a significant reduction in their -- the grants that they were receiving from central government, so they had -- the spending in 2019 in real terms was actually less than it was -- it was only just at 2010/11 levels, but the demand for social care and the need for it had significantly increased over that period, with the consequence that many local authorities were reducing the -- what is called the eligibility criteria,

so how much care -- how much do you need to demonstrate a need for care to be able to be entitled to receive it from local authorities. So we've seen a constriction in the number of people offered care and the level of care that was available.

In the nursing home care sector, the consequence of that squeeze was that many nursing homes were having financial difficulties. Those with a strong self-paying component, so -- were using that to subsidise the local authority residents who they were often housing at a loss. So there was --

Q. Can you just pause there?

A. Yeah.

Q. By that do you mean that, in order to balance their books, because obviously care has to be paid for and money needs to be paid to care home providers to provide the service, persons who pay privately get charged more to make up the deficit because the councils are paying relatively little to the care home providers to provide the service for their local authority care home residents? Is that the nub of it?

A. That's absolutely correct. And one of the consequences of the financial squeeze is -- although this is harder to quantify, is that this sector was also reporting that its investment in physical infrastructure, technology

and other improvements had been severely limited over this period.

LADY HALLETT: Can I just check, you started off by talking about nursing homes; are you using nursing homes and care homes interchangeably?

A. I am, yes.

MR KEITH: There are different types of --

A. Yes.

Q. -- social care homes, are there not?

A. Yeah, they have --

Q. What are the broad groups?

A. They have two. There are those that provide an element of nursing care and which some of the care is provided -- is paid for by the NHS, and the hotel component either by the individual or by local authorities, and then there are care homes which do not have a nursing -- a healthcare component and are more, you know, sometimes called residential homes.

Q. That's very clear, thank you.

Can we now look at data. So, as I said, Mr Hancock referred to the very real difficulties that the Department of Health and Social Care had had in trying to get on top of the numbers in the social care sector, and my Lady has received evidence from Professor Woolhouse, who spoke of difficulties in trying

to get access to data for the purposes of legitimate and important research that he was conducting.

Is the NHS's ability to collate and provide data relatively good in the opinion of the Nuffield Trust?

A. Broadly. I mentioned a concern about the data on community, these community services, which are an important component of care, but for hospital services the availability of data is pretty good.

Q. Does the Nuffield Trust have a view as to the extent to which concerns about data protection and privacy have prevented the proper utilisation and dissemination of data?

A. The problem of privacy are more relevant to the use of data, for example, to identify people at risk or to -- and sometimes to do planning. Most local authorities have found ways to work with other agencies to do that, but there are some bureaucratic hurdles which the current legal framework can put in the way. But from the point of view of administrative data about pure numbers, there's no particular reason why data protection or protection of privacy should affect the ability of the system to understand the broad -- the broad trends and movements. It's only at the point where you are trying to maybe look at a population and say "Who do we think is most at risk, and where should

we intervene?" that the need to have some form of semi -- what's called pseudonymised data, which had -- might relate to personal details. But from the point of view of planning, long-term forecasting, understanding capacity, there was no -- there is no, as far as I'm aware, no particular data protection or other constraint.

Q. So just to pause there for a moment, there's no problem in gaining access to pre-existing data, what has happened to whom and where and what services they've been provided with, and what services they may need on a historical basis. What is much more difficult is looking to the future prospectively and saying: who in number 13 or 14 or 15, the close in a particular area, is going to require a special need or a special service or is going to require being looked after on account of a pre-existing vulnerability or need? Is that the issue?

A. That can be the issue. I think in our evidence we gave an example from West Berkshire where that evidence -- where they had very successfully managed to bring data from different sources to do precisely that sort of very detailed forecasting.

But from -- just to --

Q. So just to pause there.

A. Yeah.
Q. For the purposes of preparedness and planning, it's forecasting that matters, it's the ability to be able to plan for all eventualities and to make plans to make sure that individual members of the population receive whatever services they're going to need. That system of forecasting, is that in a good state?
A. I think we should just -- perhaps I will clarify, if I may, a point here.

I am making a -- we can make a distinction between sort of broad strategic planning to ensure that you've got a viable system which is resilient and that you -- is using resources effectively, and that allows you to think about the sort of overall shape of the system, does not require that level of detail about the individual. The --

Q. But specific planning identification of individual needs does?
A. Yes. Yeah.
Q. To what extent, in your experience, does the NHS provide for that level of data?
A. The NHS has, with some issues about community services, generally got fairly good data to allow that sort of planning and capacity planning. However, the fragmented nature of the social care market, the fact that there

are different purchasers (there's local authorities and there are individuals), the problems that local authorities have experienced due to spending cuts that they have been subject to, and in fact the fragmented nature of the social care market means that the data to be able to do that is much less readily available, and I think at the level of the Department of Health has been broadly poorly understood in recent years.
Q. In your statement you address the impact of leaving the European Union, and I absolutely stress you make no political points about the merits or otherwise of leaving the European Union, but do you identify that, even whilst the terms of the departure were being negotiated, so pre-pandemic, the fact of the exit of the United Kingdom from the European Union began to have an impact on the resilience of the health and social care systems? That's a yes or a no.
A. That's a yes.
Q. Did you do so and did you identify three areas in which that impact began to become apparent: workforce, especially in relation to social care; the resilience of supply chains; and the ability to access medicines and supplies?
A. That's correct.
Q. We're not concerned in Module 1 with the resilience of

supply chains and the ability to access medicines and supplies, that's for later consideration, but in terms of the resilience of the sector, the social care sector, how significant was the impact on the workforce of the pre-pandemic commencement of the exit process?
A. There was a substantial drop in migrant -- so it's worth saying that the social care workforce, particularly in some parts of the country, particularly the south of England, has been highly dependent on migrant workers. A significant number of those had been coming from the EU, and there was a distinct drop off in that from 2016, for the two or three years following 2016, which started to be made up from -- with migration from non-EU countries, but there was a hiatus between the drop-off from the EU and the recommence -- the ability of the system to change the rules, to introduce new approaches to issuing visas. And there was also a problem which -- at this point social care was not on the shortage workforce list of the Migration Advisory Committee.
Q. All right, we don't need to go into the detail of it. It seems obvious, though, Mr Edwards, that the government, as might be expected, did start to take steps immediately to try to increase recruitment from other parts of the world in order to make up that looming deficit?

A. In health, but there was, I believe -- I would have to maybe come back to you on the exact timing of this -- but I think there was a hiatus between understanding the implications for the workforce in that particular sector and then changes in the rules to allow for people to be admitted from other non-EU countries.
Q. All right. Well, a hiatus may be forgiven, perhaps, but they took steps to try to ameliorate the problem as they saw it?
A. Yes.
Q. But to what extent -- and we're now, again -- we're still concerned, of course, with pre-pandemic state of affairs, so the state of preparedness and what sort of state of resilience the sector was in. By the time of the pandemic in January 2020, had that anticipated deficit been made up or were we in a position in which there was still a shortfall in terms of the numbers in the workforce at the moment of the impact of the pandemic?
A. There was still a shortfall in the social care workforce. I don't know to what -- it's probably of only academic interest -- extent that reflects the issues around funding, the impacts of Brexit and other factors, but the fact is that, in common with the health sector, the social care sector went into the pandemic

with a significant number of vacancies and problems with both recruiting and retaining its workforce.

Q. Finally, a discrete and separate topic, pre-existing vulnerabilities of different groups.

You've given evidence, Mr Edwards, about how post pandemic the Nuffield Trust carried out research work in relation to the NHS and social care sectors, with a view on what sort of state they were in at the time of the pandemic and on the degree of planning retrospectively that you were able to ascertain.

To what extent did you find that there had been pre-existing planning for the needs of those persons who have particular non-clinical vulnerabilities? So that is to say persons who have vulnerabilities on account of social or ethnic considerations as opposed to purely clinical vulnerability. Did you see much by way of planning for their needs in the context of a planned health emergency?

A. No, I don't think that came up in our research at all.

Q. All right. Does that mean you didn't look for it or you didn't see evidence of it?

A. I don't think we found evidence of it.

MR KEITH: All right.

Mr Edwards, thank you very much. Those are all the questions that I have for you.

There are no applications under Rule 10.

LADY HALLETT: Thank you very much for your help, Mr Edwards.

THE WITNESS: Thank you.

(The witness withdrew)

MR KEITH: My Lady, the next witness is Dr Richard Horton, please.

DR RICHARD HORTON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

MR KEITH: Could you give the Inquiry your full name, please.

A. My full name is Richard Charles Horton.

Q. Dr Horton, thank you for attending this morning and for the provision of your witness statement dated 27 April 2023, INQ000148421, which you have signed and appended a statement of truth on the last page.

A. Correct.

Q. Dr Horton, you are the editor-in-chief of *The Lancet*, an very well known UK-based medical journal, you're an honourary professor at the London School of Hygiene and Tropical Medicine and also of University College London and the University of Oslo, you worked for many years at the London Royal Free Hospital before joining *The Lancet* in 1990, and you became the editor-in-chief in 1995. Is that all correct?

A. That is correct.

Q. You have also served in various roles with the World Health Organisation. You co-chaired a scientific advisory group, you chaired the board of the Health Metrics Network and you've sat on a number of advisory boards for its research strategy division and for its European region division.

For the particular interest of this Inquiry, you've written a book called *The COVID-19 Catastrophe: What's Gone Wrong and* -- even more relevantly for this module -- *How to Stop it Happening Again*.

A. Correct.

Q. *The Lancet* has a number of different parts, does it not? It has a number of journals within it; is that correct?

A. Yes, we have 24 journals and we have offices in multiple countries around the world.

Q. Do each of those journals deal with particular parts of the medical world but including infectious diseases and global health?

A. That's right. The weekly *Lancet* -- it's our 200th anniversary this year -- covers all aspects of medicine, public health and global health, and then we have speciality journals that are, as you say, focused on particular diseases such as infectious disease, oncology, diabetes and so on.

Q. Whilst you give evidence, Dr Horton -- I didn't warn you, it's my fault -- could you please try to go as slow --

A. I apologise.

Q. -- as you are physically capable.

A. I apologise.

Q. That way we won't -- either of us -- speed up.

Evidence has been given in this Inquiry, Dr Horton, about the Global Health Security Index in which, as is well known, and is now well established in the evidence, the United Kingdom did rather well.

Evidence has been received in particular from Professor Woolhouse, whom you'll know, and also the academic Dr Kirchhelle, about some of the learnings or some of the lessons that might be drawn from the obvious feature that, whilst the United Kingdom was rated very highly in the GHSI index, when it came to actual performance we may arguably have been thought to have done rather less well.

Could you just set out, please, your views as to why you think the indicative performance in that index was not translated into actual performance?

A. Certainly. Just before answering your question, I would just like to pay my respects and acknowledge members of bereaved families who are attending today and offer, on

behalf of my colleagues at *The Lancet*, my condolences for the loss and suffering that you have endured during the pandemic.

In response to your question --

Q. And go slowly.

A. And go slowly -- we have tried in the past several decades, as a medical community, to predict resilience. The Global Health Security Index with Johns Hopkins University is one such exercise. The World Health Organisation has its own initiative. We've also tried to make correlations based on the strength of national health systems. What became clear during this pandemic is that none of those measures were effective in predicting response.

In some ways in retrospect that is not surprising. If you take the one you mentioned, the Global Health Security Index, it's an excellent document in setting out the technical capacities of a public health system in the face of a pandemic: six broad categories, 37 indicators, almost 200 separate questions interrogating the competence of a pandemic preparedness and response system; but what it omits is the human dimension.

Q. Pause there. By that, do you mean the realities of the impact of a pathogenic outbreak on members of the

population, or do you mean the response of the particular health system in the country under examination?

A. How our political leaders, our health leaders frame the threat, how we assess the threat, and how we respond to the threat. Those dimensions cannot be easily captured or quantified in a measure such as the health security index.

Q. Is that because, as Dr Kirchhelle might suggest, those indices are too technologically based and fail to reflect adequately the reality of how any human system will respond in the face of a crisis?

A. Precisely; they're necessary but they are insufficient. It is only when you are tested by a pandemic that you really see whether your system operates effectively.

Q. I think there is a well known boxer who said, "Everyone has a plan until they get punched in the mouth". These indices examine plans for countries, they examine systems and anticipated eventualities. Do they, in your opinion, fail to take into account the actual reality of the baseline health systems in each country, or how the governors and the response systems will actually respond in the face of a crisis?

A. The second part, they fail to take account of the way human beings respond in the face of a crisis. They do

adequately document the capacities such as levels of immunisation, laboratory capacities, supply chains, infection control mechanisms; all that is very well documented in these indices. It is the: how do we frame the pandemic? What was the threat? We may come on to this. The focus has been on influenza, but for two decades we've known that that was not necessarily the major or certainly the only threat that we faced.

Q. Was it well known that there had been, of course, an epidemic and then arguably a pandemic relating to SARS and to MERS and that the Far East in particular had responded, one might think, quite well in terms of putting into place structures and procedures for dealing with those emerging epidemics?

A. Yes. Until 2002, we thought that coronavirus -- by "we" I mean the medical community -- thought that coronaviruses were a relatively benign category of virus, and we were truly astonished in 2002 when SARS CoV-1 emerged.

I brought along this report. It is a workshop summary from the Institute of Medicine, from the United States, 350 pages' worth of analysis --

Q. Dated?

A. 2004 -- which reviews our experience from the first SARS outbreak, and it documents our astonishment that --

Q. Just pause there, when you say "our experience", do you mean the Western world or America --

A. Global experience.

Q. Globally?

A. This is a global report, but commissioned by the US Institute of Medicine.

It documents our astonishment about the changed pathogenicity of coronaviruses, so that they're now targeting humans, and it warns the world community that it needs to understand these, this category of viruses, develop better diagnostics, better treatments, vaccines, and really put coronaviruses on the map as a serious human threat.

Now, that was in 2004. We have MERS in 2012 and ongoing, and, with hindsight, we clearly did not elevate the threat -- despite being warned clearly about the threat, did not elevate that threat into our National Risk Register.

Q. Do you have a view, as the learned editor of *The Lancet*, as to why, notwithstanding the degree of knowledge in the public, scientific and academic worlds, that knowledge wasn't translated into governmental planning? And by governmental, I don't just mean the United Kingdom, but generally it would seem across the western world.

A. It's very hard to understand why, and I think -- I mean, I had this book on my shelf for 20 years, and yet we were publishing papers that were talking almost only about influenza as a threat. So I think there was a general groupthink in the medical and public health community that really focused on influenza as the threat.

However, if you were working in China or an Asia-Pacific country, I think there was a different perception. I think this was a Western groupthink, and certainly colleagues I have in China were very well aware that coronaviruses were a major threat.

Q. Did the combination of an arguable lack of focus on non-influenza threats, as well as the high ranking in the GHSI and other indices, engender, do you think, a complacency on the part of the West?

A. I think we were complacent, for several reasons. First, I think that we were overconfident in our National Health Service and public health service to cope with a pandemic. We're very proud of our NHS, but the reality is, as -- we had a commission published in 2021 with the London School of Economics -- some of the chronic weaknesses in the NHS left us very vulnerable, and I think we underestimated those weaknesses.

I think we were mistrustful of evidence coming from

China. I think that was a -- you know, there was a degree of Sinophobia in the international order, which meant that we didn't take signals from China as seriously as we should, and -- and this might be arguable -- but I think at the time, in January 2020, we had a sense of our national sovereignty that might have made us feel stronger as a nation to weather a shock, which was clearly misplaced.

Q. I'm not going to ask you any more questions on that topic, Dr Horton.

Your statement makes obvious and sensible reference to the importance of simulations and exercises, and the Inquiry has heard a great deal of evidence about the extent to which there were exercises and the extent to which lessons and recommendations from those exercises were implemented. But can you express a view as to the general importance of simulations and exercises in readying a state, and particularly the United Kingdom, in preparing it for whatever eventualities may ensue? How important, in the general scheme of things, is the exercise and simulation process?

A. The simulations are crucial for identifying possible weaknesses, and indeed it was the failure to respond to the signals from those simulations that I believe contributed to the UK's early misadventures in response

to the pandemic.

The Exercise Cygnus, for example, clearly documented areas of weakness around surge capacity, triage management, regional and local planning, social care, and even schools. All areas that, of course, subsequently became major concerns during Covid-19.

That simulation took place in 2016. It seems that we did not take note of those vulnerabilities and act on those. There's not much point in doing the simulation if you're not acting on it. I can't explain why we didn't, but the simulation was critical in identifying those vulnerabilities.

Q. The degree to which it was implemented is a matter for my Lady, but may we take it from what you've said -- and it's obvious from your last answer -- that exercises are always essential, they are a vital component in the system of preparedness?

A. Vital because they're testing the resilience of your system, and resilience is the word that overshadows all of our discussion.

Q. Going back to the international indices, Dr Horton, to what extent did the United Kingdom's rankings in those indices take account of the reality that, as you would say, when the Covid pandemic struck, the United Kingdom in particular was in fact struck by two epidemics? You

describe it as a syndemic. Firstly, what do you mean by a syndemic and, secondly, to what extent did those indices reflect that reality, as you see it?

A. The concept of a syndemic was first written about by an American anthropologist called Merrill Singer in the 1990s, and it's important because it's connecting the biological with the social: two biological epidemics interacting to make each worse. It's not just the co-existence, it's the fact that they each make the other worse.

Q. What are the two biological --

A. Well, in this particular case it is the virus and chronic diseases within our population, obesity, heart disease, renal disease, cancer and so forth.

The intersection of those two epidemics overlaid on patterns of social inequality meant that we had this very, very toxic, potent mix of risk profile which -- and it's important, the notion of a syndemic, because it affects your management and your prevention.

Management because you're not only dealing with a virus, you also have to deal with a pattern of disease in your society that makes certain groups of people highly vulnerable. And not only the disease but the patterns of inequality: certain people who are in more deprived communities will be at greater risk than

others.

And it's important for prevention, because you won't have true resilience from a future pandemic shock if you've only focused on the virus. You have to think about the overall health of the population and you have to think about reducing inequalities.

So in the future, pandemic prevention will partly be about identifying and responding to a viral threat, but it will also and equally be important to think about the overall health of the population and patterns of inequality.

Q. If I may attempt to summarise it yet further, is it therefore the duty of government not just to take account of those social disparities, the vulnerabilities, the inequalities, because an intervening viral pandemic will hit them harder, but they must plan for that, prepare for it, and mitigate the risk and the reality that such sectors of society will be hardest hit as a result of a virus which draws no distinction in terms of victims but of course hits those who are vulnerable the hardest?

A. Absolutely. A pandemic preparedness and response plan needs to think about the pandemic as a syndemic; and if we don't, we will not be truly resilient to a future threat. It's absolutely -- it's such a fundamental

point, I think, in the misunderstanding of what Covid-19 has been about and what we need to do to prevent its effects in the future, similar effects in the future.

Q. There is obviously a close relationship between state of resilience, therefore, and proper planning?

A. Correct.

Q. But in regard to both, vulnerability and inequality has to be first and foremost because they are the ones who are most likely to be affected by a future health emergency or a pathogenic outbreak?

A. That's right. This was not an equal opportunity virus. This was a virus that struck different groups of people at different levels of risk, and the way we -- I mean, these are other dimensions of public policy, but in the specific realm of pandemic prevention we should be giving greater attention to those who are living with chronic disease and to those who are living in more deprived communities if we're thinking about pandemic prevention, yes.

Q. You would argue that that must go beyond making appropriate clinical arrangements for dealing with those persons who are infected by a virus, but who suffer fro co-morbidities, to addressing the comorbidities themselves?

A. Yes, and this is where I think we were particularly

vulnerable here, because we have -- we do have an excellent national health system which is able to address people who present with particular diseases, but what we have not got is an effective public health system that is able to focus on health promotion and health -- and disease prevention, and it's that disabling of the public health system that left us particularly vulnerable to Covid-19.

Q. In the latter half of your statement, you set out some separate discrete points of learning or thoughts that you've had following, of course, the --

LADY HALLETT: Sorry, are you moving to a different?

MR KEITH: Yes.

LADY HALLETT: Could I just ask, Dr Horton.

A. Yes.

LADY HALLETT: When you say the "disabling of the public health system", in summary can you say what you meant by that?

A. The chronic underfunding of public health. And also the -- we have a very centralised public health system in the UK -- in England, perhaps I should focus on here, in contrast to some other countries which have a much more decentralised public health system.

So, for example, in Germany in the early part of the pandemic they were able to -- because they have

a decentralised public health laboratory system, they were able to get early data on the distribution of the virus across the country, which enabled them to plan and respond to the pandemic with greater detail and faster than we could. We didn't have a test and trace system at all across the country.

So I think it's that lack of investment in public health, both in terms of health protection and health promotion, that left us vulnerable.

LADY HALLETT: Thank you.

MR KEITH: Picking up on some of the points that you make towards the conclusion of your statement, you say in paragraph 12, we needn't bring it up on the screen, but it's in paragraph 12, that:

"COVID-19 underlined the value and importance of genomic surveillance systems and these should be prioritised in strengthening our national capacities for operational readiness."

Dr Horton, it is, I think, obvious that once academics and medics in China informed ProMED, the international surveillance body, and informed the regional office of the World Health Organisation in the first days of January and the last couple of days of December 2019, that that knowledge of the coming epidemic, then only an epidemic, was well known.

Why does there need to be further attention given or greater attention given to enhancing our genomic surveillance systems, if -- the reality of the last pandemic showed that actually knowledge of the coming wave was well distributed and well known, why do we need more surveillance?

A. Well, I would argue more by accident than design, in terms of those early days. Remember, the initial response by local government officials in Wuhan was to suppress information, not to report information. The initial signal, you are right, came through ProMED, but it did not come through official channels of the Chinese government to WHO.

I have spoken to the person who was leading the WHO office in China. He had no direct contact from Chinese authorities in those early days about the outbreak in Wuhan. So the channels didn't work.

Q. They worked belatedly?

A. Well, they worked by accident. Not even belatedly. He -- the WHO officials had to -- they saw the ProMED posting and then they were the ones who went to the Chinese authorities and said, "Hey, what's going on?" So the information flow was in the opposite direction.

So we desperately need an awareness and a system, a global system to -- genomic surveillance certainly,

but also to detect pneumonias of unexplained origin. And it's relevant to the UK -- because one could say: well, this is all about China, what's that got to do with the UK? The reality is that the UK's national health security depends upon global health security. We are not safe as a population unless the rest of the world is safe. So that puts a responsibility on us to engage with the rest of the world to make sure that the rest of the world is safe.

I mean, over half of countries today do not have the necessary capacities as set out in the International Health Regulations to prevent or respond effectively to a pandemic. 55% of countries. That means that if there is a spillover of a virus, whether it's from an animal to a human or it's from a research-related laboratory leak, the fact is that in over half the countries of the world that spillover could easily escalate into an epidemic and then a pandemic. So we have an interest in making sure that those countries are able to respond effectively.

If we take spillovers, which is the most likely source of a future pandemic virus, we need to take a One Health approach to pandemic prevention. That means thinking about how human health interacts with animal health and the environment, and at the moment

One Health -- the concept of One Health is something of a Cinderella in global policymaking, we're only beginning to realise its importance.

And then, you know, there has been a lot of discussion about the origins of Covid, and I'll only say that --

Q. Let's not go there, Dr Horton.

A. Let's not go -- well, it's only relevant to this point, to your question, and that is: of the biosafety level 4 laboratories in the world that might be dealing with potentially dangerous pathogens, there is no international oversight of those laboratories. It is in our interests to make sure that we are an energetic and muscular proponent of stronger international regulation of biosafety level 4 laboratories, for national health security in the UK. I stop there.

Q. This Tribunal has considerable powers, Dr Horton; I'm afraid the regulation of the international order of controlled detection, surveillance and border closures is probably beyond its remit.

All the things you've mentioned are all, therefore, concerned, aren't they, with the emanation of threat as opposed to the United Kingdom's domestic response to the threat once it presents itself; is that a fair summary?

A. It is. I would argue, though, that we do have

a responsibility to engage globally in the interests of the UK population. That's really, in summary, my point. I want us to be a strong, energetic advocate in the international community in ways that I think we've been less so in recent years.

Q. Well, if I may say so on behalf of my Lady, your call has been heard.

A. Okay.

Q. What can be done about it is perhaps another matter.

A. Okay.

Q. You then turn to the question of whether or not the United Kingdom has sufficient research structures or mechanisms for collating and identifying pathogenicity and transmissibility, that is to say the building blocks of particular pathogens.

The evidence so far and the evidence yet to come, and therefore we mustn't pre-judge it, would suggest, because there has been evidence about how quickly the United Kingdom was able to produce a diagnostic testing device and to find suitable effective antivirals, and of course it's a matter -- it's well known that it punched well above its weight in terms of vaccine discovery and supply.

A. Absolutely.

Q. Does that not all rather indicate that the scientific

and research base in relation to pathogens and the risks of future diseases is very well established?

A. I would say that's one of our -- has been one of our great strengths in terms of pandemic preparedness: the quality and the robustness of the science base, certainly.

However, in relation, if we just rewind back to your very opening question about why did the UK perhaps not perform as well as predicted by these health security indices, it's not just the science base, it's the scientists and the scientific advice that we then give to government, and there was, I would submit, clear failures in the quality of the scientific advice that we gave to government.

Q. Do you mean post January 2020 in terms of the response or the pre-existing position in terms of the risk assessment process?

A. No, I'm talking about those early weeks in January 2020.

Q. All right. We're not going to go there because that's a matter for Module 2.

A. Okay.

Q. But what about the risk assessment process? In your statement you say elsewhere that there is, as with many -- as with all governments, perhaps, and all types of administration, that there's a danger that, in the

field of identifying and judging risk, each part of the system may have a tendency to assume that somebody else in the system is going to be the final arbiter of the nature of that risk and draw the appropriate lesson and raise the appropriate warning, and therefore everyone looks to each other and nothing gets done.

A. Yes.

Q. Is that the nub of it?

A. It is. We have -- and I'm not making any comments about individuals, but in terms of the offices, we have a Chief Scientific Adviser, a Chief Medical Officer, NERVTAG, SAGE, which is -- SAGE is a -- is not really a committee because different people cycle in, they cycle off. This is a very, very good system designed to pass the buck to another group, and in a crisis situation I think one might consider that a more command and control approach might work better.

In Germany, for example -- again I choose Germany as my comparator because they did very well in the early phase of --

LADY HALLETT: Are we on to response?

MR KEITH: I think Dr Horton is drawing comparison with the German scientific advisory committees for the purposes of expressing a view on the efficacy of our risk assessment procedures.

A. Yes.

LADY HALLETT: That's what I thought we were doing, but just from the way you introduced it --

A. Sorry.

LADY HALLETT: -- I thought you were going into response.

A. I was just going to say that the way the German system operated was that the government invested responsibility in the Robert Koch Institute and the president of the Robert Koch Institute, who then assembled a team around him to give advice.

Our system is more decentralised and I think that that fragmentation means that, in terms of assessing the risk, we don't do as well at being decisive at a moment of peril.

MR KEITH: But from what you've said earlier you would say, I think, that that imperfection in the system is of equal importance in terms of pre-emergency drawing up -- identification, drawing up and response to risk as it is when the emergency strikes and you have to respond?

A. Well, clearly that's so, because I would say that we've had 20 years of documented evidence about the growing danger of coronaviruses, and yet that evidence made no headway into UK planning for a pandemic.

Q. Another important and significant feature of your statement is at paragraph 18, where you say this:

"... the [United Kingdom] Government must make strengthening trust one of its principal instruments for pandemic prevention."

Doctor, trust is obviously a vital part of response, which is why we're not going to look at it in detail now, the need on the part of the population to have trust in its government so that when the government tells it how to respond and how to protect itself it will do so.

Why is trust relevant, though, to pandemic prevention?

A. So I think this is new understanding that's come during the pandemic, so I -- I appreciate we're in Module 1 here, so tell me if I'm straying out of bounds, but what we have learnt during this pandemic is that trust in government, interpersonal trust, are two variables that are crucial in their influence of infection mortality rates. We didn't have that understanding before the pandemic in quite the way we do now.

I think that's another contributor to why the Global Health Security Index has not been a good measure, because it doesn't measure trust, it measures technical capacities. But these more nuanced dimensions of the way the public interacts with itself and with government, these are decisive factors which shape the

outcome to a pandemic.
Q. So are you in essence saying, if I've understood you correctly, when a pandemic or a pathogenic outbreak strikes, mortality rates and the ability of a population to respond and to survive depends to some extent on the trust it has in its government so that it will do as it's told in order to protect itself, but that that trust can't be born in a day, it must be nurtured, prepared for, planned for and encouraged so that when the pandemic strikes it's in place?
A. That's absolutely right. It needs -- trust needs to be an essential element of pandemic prevention, preparedness and response, and that goes from -- all the way from believing the government in terms of whether a lockdown is implemented to vaccine uptake and the safety of vaccines which have very rapidly been developed.
If the trust is not in place, it doesn't matter how good your preparedness and response plan is, it isn't going to work.
Q. But it is a necessary part, therefore, of preparedness?
A. Absolutely central.
Q. Right.
My Lady, those are all the questions that I have for Dr Horton. Thank you, Dr Horton.

THE WITNESS: Thank you.
MR KEITH: There are two topics, my Lady, on which you have provisionally granted permission and ten minutes of questioning from Covid Bereaved Families for Justice UK.
LADY HALLETT: Ms Munroe.

Questions from MS MUNROE KC

MS MUNROE: Thank you, my Lady.
Good afternoon, Dr Horton.
A. Hello.
Q. My name is Allison Munroe and I ask questions on behalf of the Covid Bereaved Families for Justice UK and, as has been said, there are two discrete topics that I'd like to ask you about.
The first, in fact, has been touched upon already. It's about the focus on influenza rather than other pathogens, including a coronavirus.
In your paragraph 5 of your statement, you considered that point in particular, and you referred to SARS as having provided "fair warning about the dangers of non-influenza epidemics", and then you go on to express a view that:
"The threat of a newly emerging coronavirus should have been more conspicuous in the risk estimations and the pandemic planning scenarios."
Now, Dr Horton, you've referred to that report from

the US Institute of Medicine from 2004, that's been with you for almost 20 years, documenting the growing danger of a coronavirus.
Was the scientific information and learning from SARS, which could have informed our planning scenarios, was it well recognised in other scientific literature, other than that journal from the US Institute of Medicine, in that period, the run-up to January 2020? And was it something that was accessible to those who give scientific advice?
A. Oh, unquestionably the SARS outbreak in 2002/03 spurred on a huge interest and research activity into coronaviruses, because suddenly we were aware that these were not a benign group of viruses circulating in our communities, causing mild respiratory illnesses, coughs and runny noses; actually they could cause multisystem disease, tipping people into intensive care with high fatality rates. This was utterly new 20 years ago.
That shock led to a surge of new research into coronaviruses, and it only redoubled when MERS in 2012 came on the scene.
So, yes, in the literature, which was entirely accessible, both in the general medical literature and the specialist literature, there's an enormous discussion about the dangers of SARS CoV and MERS -- and

zoonotic infections in general, infections that jump from animals to humans. We recognised and have recognised for many decades that the biggest threat as a species we face from disease, infectious disease, comes from the jumping of a virus from an animal to a human. We knew that, and we knew that it wasn't just influenza. It's a whole range of different viruses, from coronaviruses to Ebola, and others.
So this has been a central debate in the global health community over 20 years about those threats and what we do about them.
Q. Thank you very much, Dr Horton.
Still on the topic of focusing on influenza pandemics, again this was touched upon earlier in your evidence, this concept of Western groupthink.
Do you know of any Western countries or countries in the Global North that implemented any learning from SARS and indeed MERS in respect of training and surge capacity, for example?
A. No, I think we -- I can't identify any country that actually implemented a plan with a coronavirus as a significant potential threat. That was -- I think there was a Western focus on influenza, which was not matched by countries that had been on the sharp end of SARS-CoV-2 in the early 2000s.

Q. Thank you.

Moving on, then, to the second discrete topic, professional education for healthcare workers. Professor Heymann, of course, back in the first week of the Inquiry gave evidence, and in his report he describes a number of measures that were adopted by a number of countries in East Asia in the wake of SARS.

My Lady, we don't need to bring it up, but for reference its INQ000195846, at paragraph 64, page 15.

Just reading a little part of that paragraph, he says this:

"Many countries in Asia (eg Singapore, Japan, Republic of Korea ... Taiwan and Hong Kong ...) had strengthened preparedness after the SARS outbreaks in 2003. Preparedness activities in these countries included cross-government pandemic containment, simulation exercises; teaching and practising outbreak containment skills with healthcare workers through the implementation of formal training and hospital surge capacity exercises; strengthening infection control measures at health facilities including the construction of state of the art patient isolation facilities at hospitals; and strengthening disease detection networks."

So those are the areas that he sort of looked at in

terms of training and education, and in your statement at paragraph 19 you say this:

"A revolution in nursing and medical education is a necessary part of preparing for the next pandemic."

So my question, Dr Horton, honing in on that, the learning and practising aspect of education, in your view should such training -- as well as perhaps other aspects of the training that Dr Heymann has mentioned -- be provided to healthcare workers in the UK as part of that revolution in education that you describe in your paragraph 19?

A. So let me try and offer two parts -- two answers.

First, may I add to Professor Heymann's list the preparing of the public for a potential pandemic. So what all of those countries did, have done, very effectively is they have prepared the public -- this goes to the point on trust -- they have prepared the public for a potential future pandemic. So if and when one comes, issues around physical distancing, quarantine, mask wearing, travel advisories, the public is aware of these issues, they don't suddenly get dropped on them with surprise. They know in advance that these are potential interventions the government might take.

Indeed prior to the pandemic if one travelled widely

in Asia one would see people wearing masks, for example, routinely in the streets, busy streets, in shops, on metros.

So this became embedded in the public culture. A precautionary approach to the potential danger of a pandemic, which governments were able to ...

Now, to answer your main question, put simply, threats to UK health and health security are going to come from outside the UK, which means that our doctors, our nurses, our health workers do need to be aware and apprised of those threats and in readiness to respond to those threats.

I think that our health workers did an absolutely brilliant job during this pandemic. I don't take anything away from their response. However, it was done as an emergency, in something of a panic, and I was receiving messages during those early months and the system was close to meltdown, because we were not ready, and our health workers had not been adequately trained and prepared for the dangers of a pandemic, how to redeploy staff to focus on people in critical illness, how to build surge capacity in intensive care in a moment. Those plans had to be implemented instantly and there was very little planning for that.

So I think this educational revolution is to

relocate the UK in a global community and a community -- a global community at risk. It needs us to have a far more expansive view of what constitutes national health and a national health service.

MS MUNROE: Thank you very much, Dr Horton.

Thank you, my Lady, those are my questions.

LADY HALLETT: A very good line to finish on.

Thank you, Ms Munroe.

MR KEITH: My Lady, that concludes the evidence of Dr Horton and the evidence for this morning.

LADY HALLETT: Thank you very much indeed for your help, Dr Horton, your thoughtfulness.

THE WITNESS: Thank you. Thank you very much.

LADY HALLETT: I shall return at 1.45.

(12.42 pm)

(The short adjournment)

(1.45 pm)

(The short adjournment)

(1.45 pm)

MS BLACKWELL: My Lady, good afternoon. May I call the Secretary of State for Levelling Up, Housing and Communities, the Right Honourable Michael Gove.

MR MICHAEL GOVE (sworn)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: Secretary of State, thank you for the assistance that you have so far given to the Inquiry. You have provided a witness statement which is at INQ000185354, and if we go to page 13, please -- thank you -- do we see that it's signed on 9 May of this year, and it's true to the best of your knowledge and belief?

A. It is.

Q. Thank you very much.

Thank you for coming to give evidence before the Inquiry today. May I invite you, please, to speak slowly and into the microphones so that the stenographer can hear you for the transcript.

By way of introduction, and for the purposes of this module, your ministerial background makes you particularly qualified to assist the Inquiry. My Lady has heard much about the lead government department models, and you have been minister of multiple policy-heavy departments, some of which have been lead government departments. You were Secretary of State for Education from May 2010 to July 2014, Lord Chancellor and Secretary of State for Justice from May 2015 to July 2016, and Secretary of State for the Environment, Food and Rural Affairs from June 2017 to July 2019.

We have also examined the role of the Cabinet Office

and the Civil Contingencies Secretariat, and ministerial roles there, which hold the resilience brief, and you have been Chancellor of the Duchy of Lancaster from July 2019 to September 2021, and Minister for the Cabinet Office from February 2020 to September of 2021.

We have also examined the role of the regional and local tier of government across the United Kingdom, but particularly the role of local resilience fora and the role of RED within the DLUHC department, and you have been Secretary of State for Levelling up, Housing and Communities, firstly from September of 2021 until July of 2022, and then again from October of 2022 until the present date.

Finally, we have looked at the extent of co-operation and engagement between the United Kingdom and the devolved administrations, and you have been Minister for Intergovernmental Relations from September of 2021 to July of 2022, and again from October of 2022 until the present day.

I hope that that is all accurate.

A. To the best of my knowledge, yes.

Q. Thank you.

I'd like to begin, please, by asking you some questions about the preparation for a no-deal EU exit, and I want to take you through what the Inquiry has

heard as being pros and cons of that state of preparation, so far as it affected pandemic preparation and resilience.

I make it clear that we're not here to debate the political issue of whether or not the EU exit was right or wrong, but one of the positive aspects about which the Inquiry has heard is the creation of the XO and XS committees, two committees at the heart of the EU exit work, the Exit Operations Cabinet subcommittee and the Exit Strategy committee.

Secretary of State, you chaired the XO Cabinet subcommittee. Tell us about it please, and how it sat with the XS committee.

A. Thank you.

The XO committee was established shortly after Boris Johnson became Prime Minister. There was a widespread feeling, and one that I shared, that there had been insufficient focus and urgency in our preparation for EU exit overall, and specifically for a no-deal exit.

The decision to adopt this particular committee structure, the advice that the Prime Minister received came originally from Dominic Cummings. Dominic was, as I think is well known to this Inquiry, a principal adviser to the Prime Minister at the time.

XO was established to operate on a rhythm which meant that we met daily on weekdays, and sometimes at weekends, in order to superintend the activity of individual government departments, and also our partners in local government in the private sector and beyond, in order to make sure that contingency planning for all available risks associated with a no-deal Brexit could be bottomed out. XO met under my chairmanship, it had a cast of government ministers -- one of the good things about it is there was continuity in that each government minister from each department with a responsibility for Brexit planning was a regular attender, not always the case with other Cabinet committees.

Q. Yes.

A. Also around the table in the Cabinet Office Briefing Room on terms of equality ministers sat with officials and indeed individuals from government agencies and local government, to horizon scan, plan, and decide in real time what the steps were that were required to enhance preparedness.

Q. Before I ask you to explain how that sat with the Exit Strategy committee, I'd just like to take you through the ten benefits that you have set out in your witness statement in terms of the composition of the committee, how it met, when it met, and how that assisted in the

achievements that it needed to reach.

So you cite the following: first, that there was, as you have said, regular attendance of; second, nominated lead ministers, rather than what you describe as a rotating cast list in some other committees; third, that there was strong No. 10 backing for the committee to ensure that decisions were enacted rapidly; and, fourth, that the attendance at committee was prioritised; fifth, that, as you have made reference to, it was a committee where officials and ministers worked together and sat together around the table; and, sixth, that it was a dedicated and extremely able secretariat that supported the committee; seventh, that decisions were written up in real time and circulated rapidly; and, eighth, there was a daily rhythm, to which you've made reference, which ensured that issues could continually be worked through; eight(sic), that the meetings focused on taking decisions rather than open-ended discussions; ninth, that the meetings took place at the COBR facility; which, tenth, helped to lend a greater gravity, as you describe it, to the discussions.

What do you mean, Secretary of State, when you said in your witness statement that it avoided the problem of the rotating cast list that happened in some other

committees?

A. There are many Cabinet committees that meet, and interministerial groups set up by successive Prime Ministers, to address issues that involve a number of departments. Sometimes, too often in fact, it is the case that the relevant Secretary of State will delegate attendance to a junior minister and sometimes it will not be the same junior minister. I'm not referring to the natural churn of resignation and promotion, but even within a ministerial team you will find that minister A attends in January, minister B in February, and minister C in March, and that weakens accountability and responsiveness.

Q. One of the other strengths of the XO committee was the strong No. 10 backing that you say it had. Is there a suggestion that it is hard to prioritise work within government unless there is a consistent pushing from the centre?

A. Yes. Government is asked and expected to do so much; in order to ensure that effective action is taken there needs to be prioritisation. Strong secretaries of state can drive through change in their own departments, ably supported by excellent civil servants and junior ministers. But there are many issues which involve different departments working together; individual

departments can sometimes be jealous of their own turf and priorities. In order to have heads knocked together there needs to be a knowledge that the centre. No. 10, and those working alongside the Prime Minister, want to see progress made.

Q. Was that achieved by the interconnection between the two committees, XO and XS?

A. Yes, and also by the attendance regularly at XO meetings of individuals from the No. 10 team who were known to have the ear of the Prime Minister, and, in addition, the secondment to the XO committee of some of the very best civil servants within the Cabinet Office.

Within the Civil Service, people will know that even though someone may be not perhaps the most senior in the hierarchy, they're someone who commands respect for their ability to achieve change and to co-ordinate action. So the fact that we had civil servants like Jess Glover, Pamela Dow and others working on the XO committee was a clear sign that some of the crème de la crème in the Cabinet Office were committed to this project.

Q. Insofar as the XS committee was concerned, was that routinely chaired by the Prime Minister?

A. Yes.

Q. All right.

Now, as part of the documents which you have exhibited to your statement, we have been able to consider the report from the Cabinet secretariat on XO lessons learned, a review that took place in December of 2019.

I don't propose, Secretary of State, to take you through it in detail, but would it be a fair summary to say that, given the perceived productivity and success of the XO/XS model, there was a desire to see if its governance structure might be applicable to non-Brexit issues or whether successful elements of its governance structure could be applied to other more normal time committee structures?

A. I think that's fair, and I think it is also the case that the Institute for Government, which acts as a critical friend to successive administrations, also reflected that while not every aspect of Brexit preparedness was perfect, nevertheless the committee structure and the operation of XO brought benefits.

Q. Thank you.

Were there doubts, though, as to how far it might be capable of application, because of the need to maintain pace and focus and engagement?

A. Yes. One of the challenges that Whitehall and ministers faced is because there was a deadline -- of course the

deadline was extended, but because there was a deadline we knew that, with a ticking clock at our back, we needed to proceed at pace. That meant that the normal tempo of papers being produced within Whitehall was accelerated, and I think it is fair to say that outside crisis situations or big projects in which the Prime Minister has invested an enormous amount of interest, that the rhythm that XO maintained, the daily battle rhythm, would be difficult to sustain. But I do believe that it was helpful for all of government to be operating at that pace, because we made government more match fit overall for the terrible events that this Inquiry has been set up to look at.

Q. Yes, and I think the Institute of Government comment piece that you also appended to your witness statement suggests in similar terms that it is a model that is worth replicating in certain circumstances, but that the pace would not always be sustainable, as you've explained.

You also tell us in your witness statement that, in your opinion, one of the central lessons of the pandemic, in terms of preparedness, is that whole-system resilience issues should be planned for better, that the initial structures were simply not adequate for a civil contingency of that scale and nature, and that the

pandemic required a truly cross-government whole-system response with delivery structures on an integrated and co-ordinated basis.

Now, there is a suggestion in the Institute of Government article that the XO/XS model was at least partly borne out of your frustrations with the ability of the United Kingdom Government to handle preparing for a whole-system risk of this nature.

So my question to you is this: given that the whole risk systems have been on the NSRA and NRA for many years, what does it say about the United Kingdom Government that these kind of issues, with cross-government working and the need for whole-system structures for whole-system risks, was not recognised at an earlier stage?

A. I think there would be those who would argue that significant progress had been made following on from the establishment of the National Security Council and the updating of the National Security Risk Assessment and its public manifestation, the National Risk Register. But you can always -- one can always learn and improve.

I was struck when I was at the Department for Environment by two things which relate to your question. The first is that the department for the environment is the lead government department when it comes to floods

and, of course, animal disease. I had observed that LRFs, local resilience forums -- fora, had not performed as they should at the time of the Grenfell fire. I was concerned that they would not be able to cope as they should in the event of severe flooding, and I asked a retired military planner, General Tim Cross, to look at the readiness of local resilience fora in the event of floods.

The report that he prepared for my department, while it highlighted much good work, reinforced the fact that there was a -- there were a series of weaknesses in the transmission mechanism from the local to the central, and from the individual government department to the centre.

In addition, when I was preparing within the Department for the Environment for the effects of a no-deal exit, and they would have been significant on food supplies and on other questions, I was struck by the fact that the centre did not seem to have the galvanic energy required in order to make sure that each government department was doing as it should.

This relates ultimately to a dysfunction in the design of the Cabinet Office, which we may turn to.

Q. Right, thank you.

Moving back, though, to the issue about which I was

asking you, and setting out really the reason why I have focused on the XO/XS model, it's right, isn't it, that that model was adapted for the Covid-O and Covid-S model, which in fact replaced COBR? And when the Inquiry comes to deal with Module 2, it will no doubt examine the efficiency of those committees. But that was the decision that was taken, I think, at that time, that the model that had been created and worked so well during the preparations for an EU exit was the basis for what happened during the outbreak of Covid in government. So in that sense it was a positive outcome of the EU exit preparations.

But the Inquiry has also heard evidence from witnesses within the United Kingdom Government and also the devolved administrations about the adverse impact that the necessary planning for a no-deal EU exit had on other resilience activities and pandemic preparedness, and in particular heard from Katharine Hammond, who was the director of the CCS whilst you were the CDL.

Do you accept that, as a result of the necessity for workforce capacity to move over and deal with matters that were important in terms of the preparation for a no-deal EU exit, that that had a detrimental effect on the preparation for pandemic planning?

A. No.

Q. Why not?
A. Because I haven't yet seen any activity that has been identified that would have enabled us to significantly better deal with the Covid-19 pandemic that did not occur as a direct result of EU exit.
Q. Well, are you aware of Exercise Cygnus and the recommendations that came out of that, and the fact that the Pandemic Flu Readiness Board was created, was stood up in order to take forward the recommendations that came out of that exercise, but that that board could not meet and the work that it was expecting to do could not be carried out because of workforce capacity issues?
A. I have. My understanding is that the work of that team was shared with the then Chancellor of the Duchy of Lancaster, David Lidington, in January of 2019. Various workstreams were requested to be carried forward. That was agreed, and then the PFRB met again in November of 2019 to review process. And I think in Katharine's evidence, she mentions that a significant proportion of that which was required, including stocking the appropriate antivirals to deal with a pandemic flu, carried on. But as the Inquiry has heard, ultimately the pandemic that occurred was not a flu pandemic, it was one for which we were unprepared because few Western nations, if any Western nations, had anticipated the

particular type of pandemic that Covid-19 was.
Q. The Inquiry has also heard that certain aspects of the preparations within government for a pandemic influenza, and indeed the 2011 guidance which was in the process of being updated, were capable of assisting in relation to the pandemic that hit, the pandemic of a coronavirus. So wouldn't you accept that the stalling of the work on the updating of the guidance and the Pandemic Flu Readiness Board undoubtedly had an effect on the country's preparedness for the pandemic which hit?
A. I don't think that can be proven. In Katharine's own evidence, she alludes, I think, to three areas where she feels that CCS, as the central co-ordinating secretariat, could have done better, in the specific area of the pandemic. She talks about emergency funding, she talks about the work of the Department for Education, and then she talks about CCS's own readiness to adapt its structures to a pandemic response.

I actually think, and I have an enormous regard for Katharine, that on the first, emergency funding, the speed with which HMT initiated the furlough programme and the Covid business intervention loan scheme shows that the Treasury was agile, and I can't imagine that it could have been much more so.

I do think she has a fair point when it comes to the

whole question of school closure, and we may touch on that.

But on the third point, CCS's own readiness, I also think that Katharine is being modest there, in that CCS and the Cabinet Office overall did flex rapidly once it was clear what the scale of the pandemic was.
Q. Well, we've looked at two documents dealing with staffing resources. There's a lessons learned report from the Cabinet Office regarding Operation Yellowhammer --

Which we see at INQ000100183, please, and could we go, please, first of all to paragraph 5 of page 5.

Look at 5(b), which tells us that:

"Staff resourcing was and remains a concern for January 2020 for the majority of Departments, DAs, IGs and the central secretariat, including CCS."

Could we now go to page 14, please, and look at paragraph 28(a), which deals with the balancing of business as usual and Yellowhammer work. Thank you. In fact, can we go to paragraph (d), please, instead. Thank you.

"Balancing [business as usual] and [Yellowhammer] work ..."

Pausing there, there were two periods of time dealing with Yellowhammer, weren't there, and this is

the second such period.

"... a number of people divided their time between ongoing BAU work and YH work in the months and weeks leading up to the IOC."

IOC being? What does IOC mean in this context?
A. I'm not entirely sure.
Q. All right. We'll find that out.
LADY HALLETT: It proves my point that acronyms don't always assist communication.
MS BLACKWELL: Quite, my Lady.
A. Indeed.
Q. "This was deemed necessary prior to the arrival of the Fast Streamers, but it did result in significant overloading of staff, and caused line managers problems in scheduling work to deadlines."

It is obvious, is it not, that if an additional important workstream that is to be prioritised over business as usual work takes the workforce away from its business as usual, that is necessarily going to cause overloading of staff and problems in terms of focusing on the work which they were originally doing? Isn't that a logical conclusion of giving more work to the same number of people?
A. I'd say three things. The first thing is that the Civil Service grew and expanded in readiness for EU exit, and

the number of people that we recruited overall, both in the Cabinet Office and in other departments, grew to take on this additional load.

The second thing is, as I mentioned earlier, the nature, the pace and the intensity of the work undoubtedly placed pressure on individuals in the system, but it also ensured a greater degree of match fitness for what none of us anticipated but what was to come the year after.

The third thing is, as I say, it is difficult to identify what was anticipated, what could have been planned, and what was not carried forward that might have put us in a better position.

Katharine identified three areas in her evidence. I've mentioned the areas where I agree and disagree. But the fact that a committee did not meet does not mean that if it had that that meeting in and of itself would have meant that we were significantly better prepared. And indeed I would argue that the skills acquired, honed and refined during EU exit preparation helped us, not only to have an organisational system that was better in dealing with a crisis, but having a cadre of people who had been through an intense process that enhanced their ability to respond.

Q. In terms of workforce capacity, of course it cannot be

proved that the fact that a committee didn't meet means that we were not as well prepared for the pandemic as we might have been, but doesn't it stand to reason that a significant overloading of staff, as is set out in this paragraph here, is a reflection of the fact that there was too much work for the workforce in the civil service at the moment whose focus was bent away from what they should have been doing, preparedness for a pandemic, towards EU exit?

A. No, I don't agree with that, because I think that the preparation for EU exit in and of itself was some of the best preparation that could have been undergone for any future crisis.

One of the points that has, I think, been well made by Oliver Letwin and by others, is that it is training, it is the acquisition of general skills in crisis management, that is among the most useful ways of ensuring that we have pandemic preparedness. And of course it is possible that had a particular meeting or had a particular workstream been taken forward then we might have identified something that could have strengthened our ability to weather the pandemic, but nowhere have I seen, I think outside, you know, one or two scholarly articles from Johns Hopkins and elsewhere, anyone who was suggesting that government should be

orienting its work towards the particular type of pandemic that Covid was to become.

Q. All right.

The Inquiry has heard evidence that there is likely to be an increase in concurrent and cascading risks due to the ever more complex world in which we live, and you have set out in your witness statement why you do not think it appropriate for there to be a "standing capacity ready to co-ordinate fully an emergency situation or a dedicated team of officials on hand to create the scale of intervention which lockdown [or something akin to lockdown] ultimately required".

But what you suggest in the witness statement is that it's reasonable to expect the centre of government to have tried and tested plans in place, by way of an alternative to a standing capacity.

You have mentioned Sir Oliver Letwin. He gave evidence to my Lady on the issue of the creation of a national resilience institute, which he suggested to my Lady was certainly worth considering.

What do you think about that suggestion, and would the creation of a resilience institute, bringing with it its new architecture, a chair, a board, the work which it could be doing full-time, does that go any way to fitting the bill in terms of what we need going forwards

for the additional challenges that lie ahead?

A. I think, as is so often the case with Oliver, that it is a very good idea. And I think it is necessary but not sufficient.

Q. Why not?

A. Because more, I think, requires to be done.

So, in some of the work reviewing the fitness and appropriateness of our structures, including Oliver's own evidence, I think there is much that is good, I think that the notion that there should be a lead minister at Cabinet level with responsibility for resilience -- I don't think it should be a minister just for resilience -- I can expand on that if required -- but I think that that is appropriate. I think that elevating the role of the deputy National Security Adviser, who is responsible for dealing with threats and hazards and resilience, is important as well. I think that strengthening the role of the Civil Contingencies Secretariat, the Resilience Directorate, is important. But there is one more thing, which is that my own view is that the relevant minister responsible for resilience should be the lead minister in the Cabinet Office, whether they are called Chancellor of the Duchy of Lancaster or whatever.

Q. Yes.

A. They would have other responsibilities. But one of the problems within the Cabinet Office is that whoever is the lead minister there does not have full oversight over the whole of the Cabinet Office in the way that a secretary of state does over their department. The National Security Secretariat was an area that was to an extent shielded from my view during a lot of my time when I was nominally in charge of the Cabinet Office, and I think that this is an overhang from the way in which the Cabinet Office was originally set up, to serve the Cabinet Secretary rather than to be a department with a lead minister wholly responsible for its operation.

Q. Do you also agree with the evidence that the Inquiry has heard not only from Sir Oliver Letwin but also from others, including Sir Chris Whitty, that ministers working within resilience need to have appropriate training?

A. Yes.

Q. Right.

There is a balance to be struck, is there not, between the challenge that ministers bring to the scientists who are advising government departments, in not being scientifically qualified -- and the importance of that challenge as far as this Inquiry has heard is in

order to alleviate the possibility of groupthink within the scientific advice that's being given.

What level of training do you think ministers should have in order to get the balance right?

A. I think ministers definitely would benefit from training, and I think there are several aspects to it.

The first is learning from those ministers who either have experience or ex-ministers who have experience in handling crises. I think also undertaking exercises -- again, I think Sir Oliver's recommendation of a much more regular tempo of exercise, involving military planners, so that it is close to the sorts of simulations that the armed forces undertake, is absolutely right, and it's having something as close to an emergency as possible that will enable ministers to learn better.

But your other point is absolutely spot-on. Sir Oliver is right, politicians, as he said, are amateurs. When we are engaging with professionals and experts, what we bring is not deep subject expertise, but what we bring is the capacity to ask the daft laddie question, and sometimes it is only when someone asks that question that we find out that the Emperor has no clothes or the pandemic preparedness plan has a huge hole in the middle.

Q. There needs, doesn't there, to be a level of understanding, though, within ministers --

A. Yes.

Q. -- as to what questions to ask? The way in which Sir Chris Whitty explained that conundrum to the Inquiry was to say that in every emergency he has ever seen there is a desperate need to get scientists in the room, but "Between emergencies you have to kind of elbow your way in", is how he explained it.

So does there need to be a standing capacity for the provision of scientific advice and a need, perhaps through exercising or through other organised workshops for ministers, to have and to keep having, in other words so that that doesn't get stale, a level of understanding as to what sort of pathogens and pandemic situations or other scientific matters of risk are coming down the line?

A. Yes. It would be a very rare person who had a level of knowledge which would mean that they would be omnicompetent in every emerging crisis. It would be rare to have someone who would simultaneously understand terrorist threats, cyber threats, pandemic threats and the threats to critical national infrastructure.

I think the only person I can think of who comes close to that is Oliver Letwin, and as I think David Cameron

said, you can't clone Oliver, if only you had a government composed of Olivers, it would be a better world. But your basic point is absolutely right that ministers, particularly if they have departmental responsibilities, do need to acquaint themselves with some of the scientific issues, and most recently one science issue, a science risk and opportunity, the growth of artificial intelligence, has been discussed around the Cabinet table with the Government's Chief Scientific Adviser, and ministers brought to that conversation a base level of knowledge enhanced by what Dame Angela was able to tell us.

Q. Finally on this point you raise in your witness statement the need for consistent challenge, for what you describe as red teaming?

A. Yes.

Q. That's something which should always be present in any of the groups, be it scientific or governmental or a combination of both, that meet in relation to pandemic planning going forwards and also a nod to resilience?

A. Yes, I do think that, and I think -- there is a danger in groupthink. There is also a danger, and again Oliver Letwin brought this out, that people within a civil service hierarchy or within a political culture will not wish to seem awkward. They will not wish to be

the person questioning their superior in front of another. So having people who are charged explicitly with being awkward and thinking of what may be wrong in a particular case is useful, and I have found that in some of the departments in which I have worked, having a team within the department to do that is useful. So within DLUHC at the moment we have a unit, a policy unit, that is there both to complement but also to challenge the policy propositions that are put forward by others.

Q. The Inquiry has heard that there are very few risks which don't require the involvement of more than one government department, especially, as I've already made mention of, the fact as we go forwards in time there are more concurrent and cascading risks that are likely to occur.

Taking that into account, is the lead government department system flawed?

A. It has its flaws. There are obvious areas where the expertise and the personnel within the lead government department will be well equipped to deal with a particular situation.

I mentioned flooding earlier. DEFRA, its relationship with LRFs, and the Environment Agency, and the expertise that it has, means it is the natural lead

government department. Sometimes the nature and scale of a flood will mean that there needs to be a MACA request, a request to the military to help the civil power, and you will need an Armed Forces minister or the Secretary of State for Defence there. Sometimes there will be local government or health ramifications. But essentially DEFRA is the logical lead government department there.

But as Covid-19 showed, DHSC, even though it had, I think, a very good secretary of state and an excellent ministerial and official team, simply could not co-ordinate the scale of activity across government required.

Similarly, while it is obviously the Home Office that has the expertise in dealing with terrorism, if, God forbid, there were to be another terrorist incident on UK soil, I don't believe that the Home Office on its own would necessarily be able to play the role that an enhanced team in the Cabinet Office could provide.

Q. So is there one system which works for the situation that might be created by all risks, or does the lead government department system have within it a suitable level of flex in order to be able to adapt to the situation?

A. I think in the Resilience Framework that the government

has just published there's an acknowledgement that the lead government department model broadly works, which I think is right, as I hope I have explained, but that there needs to be a strengthening of the centre, and I hope that one of the things that the Inquiry will be able to help this government and future governments with is a better understanding of how that strengthened centre might operate.

Q. On a slightly different topic, but connected, I think, is the division of roles between various government departments in terms of preparedness and resilience.

A. Mm.

Q. We know that the Department for Levelling Up, Housing and Communities has within it the Resilience and Recovery Directorate, which was formerly known as the Resilience and Emergencies Division, and the connection that has with local government, which we'll come on to speak about in a moment.

But the Inquiry also knows and understands that the CCS sits within the Cabinet Office, and indeed connected is the Department for Digital, Culture, Media and Sport, which has within it the Civil Society and Youth system, which touches upon the voluntary sector.

If all of these different groups and bodies are necessarily part of planning and resilience, should they

all sit within the same government department?

A. Yes.

Q. Right, and how would that be achieved?

A. By what is known as a machinery of government change. It is the case that from time to time areas which are the responsibility of one government department move to another, so it might be the case that the handling of or policy on privacy and freedom of information might move from the Ministry of Justice to the Cabinet Office, depending. My view is that RED should move from DLUHC to the Cabinet Office. And RED developed, as the Inquiry has heard, following the abolition of government offices of the regions --

Q. Yes.

A. -- with the personnel there moving to DLUHC, not all physically in the same building, several of them dispersed across the country, but the liaison function between local government, local resilience fora and the centre was subsumed within that directorate.

My view is, while the people leading it are excellent and the people working in it are very good, that it is logical for that to go into the Cabinet Office.

Again, I reflected, and I hope that this isn't outside the scope of Module 1, early in the onset of the

pandemic, when I was briefed by CCS on what my responsibilities might be as the lead Cabinet Office minister at the time, CCS placed a special emphasis on dealing with excess deaths because that was an area that other government departments didn't deal with, but they did. But there was less emphasis in that conversation on the need for the type of co-ordination which I believe only a central department like the Cabinet Office can lead.

Q. Are there plans within government to effect that change?

A. Discussions are ongoing.

Q. All right.

Moving on, then, to talk about local government and the connection, as you've set out, between the local resilience fora and the government associations going up to central government. You will know that the Inquiry has heard from Catherine Frances, and she told my Lady that, in her experience, there was or has been no detraction from the relationship between local government and central government with the abolition of the regional level.

As you've explained, to a certain extent some of those tasks that were carried out by the regional level have moved up to the central level, although they're still being maintained.

Given that there is such a plethora of types of local authority in terms of their size, complexity -- I think it was described as a patchwork quilt of different types of organisation -- is there an argument for reinstating the regional level of governance or of the presence of a regional level of connection?

A. I'm not sure, is the honest answer. Even though the resilience team within DLUHC, and formerly of course within MHCLG, operates to the Secretary of State within that government department, many of the people who work in it are based regionally, and there are five regional hubs, and the people who work there as government liaison officers and resilience advisers are out in the field. So there is a regional structure, as it were, within the department.

So should one recreate the government office of the region structure? I personally don't think so, because I think, though it is obviously arguable, that what we should be seeking to do is to empower local leaders rather than -- obviously there needs to be liaison, but empower them rather than have someone watching over them as a Big Brother.

But, as your question clearly implies, there is a variation in quality and resource and structural power within local government, and I observed in my time at

DEFRA that there were some local resilience fora which are excellent, and others not so much, and the whole question about how we improve and strengthen the hand of local leaders to respond is, I think, a vital one.

Q. Catherine Frances described to my Lady that one of the purposes of RED is to act as a critical friend --

A. Yes.

Q. -- to the local resilience fora and the Local Government Association. The Inquiry heard yesterday from Mark Lloyd, who is the chief executive of the Local Government Association, who explained to the Inquiry that in his view -- which is gleaned from the members of his organisation who are local authorities -- there is a problem with information cascading down from central government to the local level. By way of an example, or examples, he told my Lady that it took the launch of judicial review proceedings for the Exercise Cygnus your Ladyship to be published --

A. Yes.

Q. -- despite the fact that six years earlier, when the exercise had taken place, local resilience fora had been involved in the exercise. And as concerning, one might think, the entire existence of Exercise Alice and its report was only discovered by the Local Government Association during its preparations for this Inquiry.

Do those examples show that there perhaps is a difficulty in central government acting with secrecy and not as the critical friend that has been described?

A. Yes, is the short answer.

I'll expand a little. I have found in government that DLUHC or its predecessor department, MHCLG, is a good friend of local government, but not every arm of government -- and I think this is true across administrations, Conservative, coalition and Labour -- has been as open, trusting and collaborative with local government as it should be. I think that that is part of politics.

But change has come, and in the Resilience Framework that Oliver Dowden has published, it is clear that we will share information more effectively, that we will use platforms like ResilienceDirect in order to ensure that the whole resilience community, as it were, is involved in these conversations.

I would add two other things briefly. The first is that the people who lead local resilience fora will tend to be uniformed officers, principally from the police or the fire and rescue service, and sometimes elected councillors and officials within local government will feel that even at a local level there isn't always the sharing of information that there should be, never mind

between local and national.
Q. Yes.
A. A wider sharing of information is in everyone's interests.

Then the second thing is, in terms of the role of critical friend, I think again, as the Inquiry has heard, improving the quality of training matters. We have an Emergency Planning College which the Cabinet Office maintains just outside York. I think more, significantly more, could be done to improve the work that it does and to share best practice.

Again, the Government Skills and Curriculum Unit within the Cabinet Office, which was established by one of the great officials I mentioned earlier, Pamela Dow, and is now being led by another brilliant official, Sapana Agrawal(?).
Q. In addition to which, does there need to be reflection given to whether or not the practical manner in which information is provided to local authorities and local resilience fora, and I'm thinking in particular in terms of the National Risk Assessment information --
A. Yes.
Q. -- cascading down so that that can be taken into account in the local risk assessment, there needs to be an assurance, surely, within central government that

that practically is working, and that everybody who needs to --
A. Yes.
Q. -- have access to the resilience hub is able to do so?
A. Absolutely, and I think that that is there in the Resilience Framework that has been published, that the NRA/NRSA work must be shared with those who will potentially be at the frontline of response.
Q. What do you say about the evidence that my Lady heard yesterday from Mr Lloyd about the level of assurance in terms of pandemic preparedness and resilience of what is going on at a local level? Because we know that the central government doesn't have an assurance role in terms of the plans that are drafted locally.

One option which Mr Lloyd presented to the Inquiry yesterday was that there needed to be a procedure developed during which local resilience fora could check each other's plans, some sort of inline assurance given, but that also he said democratic leaders -- locally, democratic leaders should be involved in providing a level of assurance.

Would that work, in your view, or should consideration be given to some sort of central assurance during and involving the RED process --
A. Yes.

Q. -- or another body?
A. I think both. Again, when I was at DEFRA, I mentioned I commissioned General Tim Cross to look at the level of preparedness across local resilience fora for flooding, and that work was useful in both stress testing, how well prepared LRFs were, and making recommendations, and one of the recommendations that Tim made, and again is there in your question, is peer challenge and peer review helps, that the democratically elected leader who will be accountable -- and he or she will often be the face and voice of a community at a time of crisis -- should be involved.

Also there will be a level of expertise, whether at an emergency planning college or equivalent or within the Cabinet Office and RED, that can really test plans and preparedness to make sure that they -- I was about to say "conform", but at least match expectations.
Q. Yes. So a combination of both?
A. Yes.
LADY HALLETT: Mr Gove -- sorry to interrupt -- you said a little while ago that in your experience some local resilience fora were excellent and I quote you, some "not so much".
A. Yes, my Lady.
LADY HALLETT: What kind of weaknesses did you identify in

the local resilience fora where they were not so much excellent?
A. The most conspicuous example was in the aftermath of the Grenfell fire. I rejoined government just a few days before the fire occurred. I used to live very close to where the fire occurred and in the days afterwards I spent some time just walking around the scene, and my department is now responsible, obviously, for the aftermath. And it struck me then that essentially, and no individual is to blame, that that individual London borough was simply not up to dealing with that tragedy.

Secondly, when I was at DEFRA I also had responsibility -- or the department had responsibility for some of the clean-up work after the Salisbury Novichok poisoning. The local government figures in Wiltshire, leader of the council and others, were excellent, but some of the other people involved in emergency work there a little less so, and I sensed that sometimes we needed to, as we did at Grenfell, step in, in order to help to shore up a structure that wasn't as robust as it needed to be. In an ideal world every LRF would be as strong as the best.
LADY HALLETT: Thank you very much.
A. Thank you, my Lady.
MS BLACKWELL: Community engagement.

The Inquiry has heard from John Swinney, the deputy First Minister from the Scottish Government, that resilience has to be everybody's business, a sentiment echoed by Gillian Russell, the former director of Safer Communities in Scottish Government, and also Professor Alexander, who told my Lady in his evidence that at one level risks are essentially owned by all of us, rather than by governments alone, and that we are all responsible for our own safety.

Is it imperative that in preparing for a pandemic and attempting to ensure that the community is as resilient as possible, that there is significant community engagement?

A. Yes, and even before. I think there are obviously elements of preparedness for certain threats and hazards that can't be shared with everyone, particularly with threats. It would be obviously foolish to share with states and non-state actors who might wish us harm how we would respond in the event of a cyber attack or so on. However, a broader conversation about the impact that certain threats and hazards can have and how we can build resilience within society, I think, is a good thing.

As we saw in our media and in families and workplaces, during and after the pandemic there has been

a lively and informed conversation about the merits and demerits of lockdown. I think that while government can't mandate, it can help to lead and facilitate conversations about how we, as a country, can be more resilient in the face of certain threats and dangers, whether those are as a result of climate change or as the result of some of the threats to which I've alluded.

So I think having that conversation and also more broadly reflecting on how civil society can remain strong is part of a broader programme of resilience.

Q. The Inquiry has received witness statements from those in positions of authority representing the British Red Cross, the Campaigns and Justice at Inclusion London, and also Disability Rights UK, which is a leading pan-disability charity, whose evidence reflects many organisations in a similar situation, and that is that, in terms of pandemic preparedness, they were not engaged with at all, at any level, by government. Does that need to change?

A. I think it is important with preparedness for all sorts of threats and hazards, including pandemics, that the widest possible conversation takes place. But sometimes it will be the case that government will disappoint a particular group. As the Inquiry has heard from David Cameron, George Osborne and others, politics

involves competing priorities. It's not always possible to satisfy every organisation, however noble its aims and means, it's not always possible to provide them with the list of policy changes or resource allocation for which they press, but it is important to have as many people as possible involved in conversations about risk so that we can hear from voices which, as your question implies, have sometimes been marginalised and overlooked and who represent groups that were, of course, hit particularly hard by Covid-19.

Q. It's important, isn't it, for those who, as you acknowledge, might be the most affected --

A. Yes.

Q. -- by a pandemic for the government to understand the ways in which that might happen and therefore might be avoided, and it isn't difficult for the government to reach out to -- particularly to those who represent a great deal of people who are vulnerable both in terms of general levels of vulnerability and health inequalities?

A. Absolutely, but I think it is important when we have these conversations that while groups that advocate for those who are living with vulnerabilities should be heard and should be respected, that we also make sure that the conversation is not exclusively one in which

pressure groups take the lead, but wider society has its voices heard.

A brief point: we discovered during the pandemic, medical experts would have known beforehand, that one of the greatest vulnerabilities, one of the likeliest comorbidities, was for those people who were living with obesity, and I think that a broader conversation about public health and the diet that we have and the pressures that that creates is one which no single group, I think, has a monopoly of wisdom on.

Q. Are you able to assist the Inquiry by telling my Lady what plans are afoot in terms of a greater level of co-operation with and consultation with these sorts of groups?

A. In my view, government has to ensure, and this Inquiry helps, that we are in conversation with those in local government who are elected leaders from a variety of parties and traditions, and that we are also in conversation with groups that represent the marginalised and those who are vulnerable. And in my own department, the levelling up component involves me and my ministers and officials spending as much time as possible hearing from those people who are economically more vulnerable and socio-economically more disadvantaged, and when it comes in particular to one of my other areas of

responsibility, housing, what has struck me, not just because of the pandemic but because of other factors, is that many of those who suffered most in the pandemic were living in overcrowded housing conditions or poor housing conditions, and the quality of housing particularly but not exclusively in the socially rented sector, has been an issue that has been underplayed. And we've made it our mission to ensure that the voices of tenants, particularly in the socially rented sector, are amplified when it comes to policymaking.

Q. Are you confident that the ties between those organisations, representing as they do the most vulnerable and those with health inequalities, are tight enough or could more be done?

A. More can always be done. I do not wish to make it seem trite, but I think health inequalities are some of the most striking inequalities within our society. But our society has a number of levels or layers of inequality. Again, in my work on levelling up, it's striking that while there is an enormous amount to celebrate about our country, that regional inequality, geographical inequality, is quite marked, and health inequalities are also geographically very striking, and the point has been well made that the difference in life expectancy between Kensington and Chelsea and Blackpool or even

Glasgow is something that no country can contemplate with equanimity.

Q. You tell us in your witness statement that as the pandemic took hold and you became involved in meetings specific to the government response, that it appeared that the assumption had been that behaviours such as lockdown would not be viable for more than a brief period?

A. Yes.

Q. You will know that the Inquiry has heard from Matt Hancock, who talked about flawed assumptions being in place which affected the way in which planning went forwards.

This week we heard from Dr Kirchhelle, who suggested to my Lady that it was imperative going forwards for behavioural science and social science to form an important place in any planning of how we are going to be able to fight the next pandemic coming down the line, and the importance of appreciating the effect of how that pandemic is not only going to affect different people in different ways, but what society is likely to do by way of reaction to rules being imposed and matters of that nature.

Do you agree that behavioural science and social science has an important place in planning?

A. Oh, completely, but one of the reasons why ministers were told that there was a risk in lockdown and that toleration of lockdown would be limited was because of the behavioural science consensus with which we were presented. That's not to say that the people who were presenting were anything other than entirely rigorous and thoughtful in the way in which they assessed the evidence and presented it to us, but it's simply the case that the behavioural science assumptions turned out to be less, what's the word, accurate about the durability and the willingness of the public to accept restrictions on liberty.

Of course none of us would want to impose these restrictions, but it was an example, as it were, of a scientific consensus, framed on the basis of what was known, then changing over time as new evidence and new facts force the existing theory to adapt.

When -- you know, it became a cliché during the pandemic when people said we needed to "follow the science", what some sometimes forgot is that science itself changes and evolves as models improve because new evidence arrives.

Q. Does that suggest that the advice that was being provided to the government then on behavioural science and behavioural reactions to the imposition of rules and

regulations, that that was out of date?

A. Well, I think it was the best available evidence at the time. So, again, all of us have to recognise that when it comes to behavioural science it is different from, as it were, physics, chemistry and mathematics, where there can be a greater degree of precision in the expectation of what is going to happen if you -- you know, if you introduce one element into water or if you apply a certain degree of force to mass then certain things are likely to follow. Behavioural science, by its very nature, is based on observation but it is also the case that human beings in our infinite, what's the word, unpredictability will sometimes react to new crises in ways that people cannot predict accurately.

So behavioural science, like economics, is informed by past evidence and is shaped by expertise, but it cannot predict with certainty in the way that the hard physical sciences can.

So it became out of date, as we saw how people changed, but I would not want to criticise the people who put forward that evidence because they were acting in good faith, that was the best available evidence, it was just that new facts meant that we saw that it wasn't as accurate a predictor as we might have hoped.

Q. Is there a need, do you think, for there to be a greater

challenge to behavioural science before the advice gets to ministers? In other words, if there was a wider pool of scientists from whom that advice was sought, there might be challenge inside the system which would bring about perhaps a more accurate depiction of what the reality is.

A. I think that is fair, but I think it is also politicians who are sometimes at fault. Because we ask our advisers for the facts, and, as I've mentioned, sometimes it is -- what we're really asking for is a prediction, and expert advisers can offer their best advice, we seek certainty but it's often elusive, and it would be better if politicians and decision-makers were to say, "Tell me about the debate, what is the lead option within the academic community here, but what also are the alternatives?"

So most people think that a lockdown would be very difficult, but are there some who argue that the tolerance for it would be greater? Similarly, most people assume that this virus emerged in the wet market, but some suggest it might be a lab leak. Where is the evidence? We need to have a certain degree of tolerance for the fact that we can't have certainty.

MS BLACKWELL: My Lady, I'm about to go on to a new topic. Is that a convenient moment to break?

LADY HALLETT: Mr Gove, we take a break for the benefit of the stenographer, but we'll make sure that you leave this afternoon, we'll finish your evidence today.

THE WITNESS: Thank you very much, my Lady.

LADY HALLETT: Back at 3.10.

(2.57 pm)

(A short break)

(3.10 pm)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: Thank you, my Lady.

Mr Gove, I'm asked to revisit one of the questions and answers that took place in the earlier session before the break, and it related to the evidence that you gave that, in your view, there was no proof that the workforce within government being focused or refocused on planning for the possibility of a no-deal EU exit had a detrimental effect on pandemic planning.

I have been asked on behalf of Scottish Covid Bereaved to draw to your attention one aspect of the result of the workforce being diverted that was covered by Mann and Alexander, Bruce Mann and David Alexander, in their expert report, in which they considered the recommendations and actions that had arisen out of Exercises Alice and Cygnus, including the adaptation of plans for and the revisiting of plans for social care,

for the workforce capacity, and infrastructure of social care, and the fact that the lack of attention or the diversion of attention away from those recommendations, particularly in relation to adult social care, were a direct result of staff having to concentrate on preparations for a no-deal EU exit.

Do you accept that example as being a concrete example of a detrimental effect in terms of adult social care?

A. I'm not sure that I do, because I don't know what it is that would have been different in the approach that was taken toward adult social care that could have been anticipated beforehand. But of course the way in which the discharge of patients from NHS beds into adult social care was handled is an object of regret and concern, and in particular also the spread of Covid-19 because of the use of agency staff who sometimes worked in more than one care home was a factor as well. So I think it is open to reflection.

Q. Thank you very much.

You are currently Minister for Intergovernmental Relations. What does that mean?

A. It means that I act on behalf of the Prime Minister in liaison with the devolved administrations. The Prime Minister, Boris Johnson when he took office,

wanted to emphasise the importance of the Union and, as well as being Prime Minister and Minister for the Civil Service, was also Minister for the Union.

Q. Yes.

A. He wanted to have a minister working alongside him when he was liaising with the Scottish Government, the Welsh Government and the Northern Ireland Executive, to take up some of the day-to-day liaison work, and that devolved on to my shoulders.

Q. What does that liaise work consist of?

A. There are two aspects to it. One is there was an overhaul of structures, influenced very much by Andrew Dunlop's excellent report, which put on a firmer footing the nature of the co-operation conversations that we have.

The second is making sure that when the First Ministers and deputy First Ministers and other ministers --

(Interruption)

MS BLACKWELL: I think that's my voice, unfortunately.

A. I'm so sorry, terrible moment.

The -- so it involved making sure that when they needed to talk to the UK Government, if the Prime Minister was otherwise engaged that I would always be there, and particularly during Covid I had regular

calls with -- Zoom calls with representatives from the devolved administrations.

Q. John Swinney, deputy First Minister from the Scottish Government, has told the Inquiry that at one point in the run-up to Covid, and as the four nations were attempting to do their best to work together, that the relationship between the administrations, particularly in terms of Whitehall and Scotland, were pretty poor. Is that something that you recognise?

A. I think it operates on two levels. So quite a lot of the time -- the majority of the time, in fact -- there was effective co-operation, and I think in the witness statement from the former First Minister she was pretty clear that, even though she has a radically different view of what the future of Scotland should be within the United Kingdom and a radically different view from the UK Government about Brexit, nevertheless on a day-to-day basis there was effective co-operation, and that was my experience.

However, the Scottish Government and those leading it have -- because of that divergent political view that I mentioned, they sometimes have an incentive to accentuate the negative in the relationship, because the overall political aim of the SNP is to present the United Kingdom as a dysfunctional state. But to their

credit, Scottish Government ministers and Scottish Government officials on a day-to-day basis operate in a collaborative way.

Q. How often do you, in your role as intergovernmental minister, meet with relevant representatives from the other four nations and does that happen altogether or individually or both?

A. Both. The government publishes a quarterly report on the meetings that take place between the United Kingdom Government and ministers in the devolved administrations. There are some government departments that meet more frequently, like DEFRA, because of certain shared interests, others that meet less often, and sometimes the frequency intensifies. During Covid-19 it was very regular.

Q. Yes. Do you see your role as minister being beneficial to the sharing of plans for pandemics and for other national risks going forwards between the four nations?

A. Yes, for everything. Again, it can sometimes be the case that there will be some ministers at UK Government level who will express irritation that the Scottish Government or the Welsh Government might, after a particular meeting, place a political slant on it. I accept that, and it can be an irritation, but ultimately we all benefit from working as closely as

possible together, and I believe that although there have been ups and downs in the relationship that it is important to see and talk to colleagues in the devolved administrations as often as possible.

Q. In the situation that is currently persisting in Northern Ireland, the breakdown of the power-sharing agreement and the lack of ministerial oversight, how do you keep contact with Northern Ireland? Is there somebody in the absence of a minister there with whom you will share your concerns and reflections?

A. Yes. So, in the absence of the Executive, it will be the Northern Ireland Civil Service, and the respective leads in the Northern Ireland Civil Service government departments with whom we will interact. Jane Brady, who leads the Northern Ireland Civil Service at the moment, for example came along to the recent British-Irish Council meeting at which the First Minister of Scotland, the First Minister of Wales, the Taoiseach, the Tánaiste, the UK Government and others were represented, and she did very effective job in making sure that Northern Ireland's interests were represented. But ultimately it's regrettable that we don't have ministers there.

Additionally, there is a bigger role to play for the Northern Ireland Office in the absence of an Executive,

not direct rule, of course, but certainly a bigger role to play in making sure that the liaison between UK Government and NICS is effective.

Q. Finally I would like to touch upon the United Kingdom Resilience Framework.

LADY HALLETT: Sorry, just before you do, could I ask a question following on --

MS BLACKWELL: Yes, of course, my Lady.

LADY HALLETT: I don't know if you heard the evidence, Mr Gove, but Michelle O'Neill talked about how, when she had worked at the Northern Irish equivalent of DEFRA, they had had a Fortress Ireland policy with the Republic of Ireland, and she was talking about how the same kind of thing ought to apply in the course of a pandemic because it's one epidemiological unit. I can never say that word.

So, question: to what extent, as far as intergovernment relations are concerned, you're involved with liaising with the devolved administrations but would it be the Foreign Office who would be involved with liaising with the Republic of Ireland?

A. It's a very good point, my Lady, because during the course of Covid-19 I would also have conversations with Simon Coveney and others in the Irish Government, and, for precisely the reasons that you mention, because the

island of Ireland is a single epidemiological area, there were questions about people who might arrive in the Republic of Ireland, because they had a slightly different approach towards flights and ferries, who could then obviously, using the Common Travel Area, go to Northern Ireland and then into the rest of the UK.

So we needed to have those conversations. The conversations were generally led by the Foreign Office and by our ambassador in Dublin.

It was also the case that there are very good relations between our Cabinet Secretary, whoever he or she is, and their equivalent in the Irish Government. So it operates on several layers, but the FCDO is the lead department.

LADY HALLETT: Thank you.

MS BLACKWELL: I was turning to ask you about the United Kingdom Resilience Framework and to seek your views on this: Bruce Mann and Professor David Alexander have told the Inquiry that they don't think that, in its present form as currently drafted, it fulfils the function of a UK-wide resilience strategy.

The Inquiry has also heard that the Scottish Government has published a hub and spokes model of guidance, and that in Northern Ireland a civil contingencies framework now replaces and consolidates

a series of former protocols.

Will the government reflect upon the evidence that the Inquiry has heard and look again at the way in which the Resilience Framework is currently drafted and seek to improve the current state, if indeed those reflections suggest that improvement can be made?

A. Absolutely, and I think in my own evidence I reflected on that. It's important that the devolved responsibilities of the devolved administrations are respected, and we can learn from, and I'm sure the Inquiry has and will learn from, good practice in each of the different parts of the United Kingdom.

But sometimes it is the case that the UK Government needs to think UK-wide, and one of the reasons why Public Health England was reformed and the UKHA was set up was because, quite properly, some pandemic preparedness and indeed some public health advice should always be the province of devolved administrations, but sometimes you do need, particularly in a polycrisis, a UK-wide response that will involve consultation with the devolved administrations but where sometimes you need to take decisions at speed and the UK Government flex there is critical.

MS BLACKWELL: Thank you.

My Lady, that concludes the questions that I have.

You have provisionally provided permission for ten minutes of questioning from Covid Bereaved Families for Justice. May that be done, please? I think it's Mr Weatherby.

LADY HALLETT: Mr Weatherby.

Questions from MR WEATHERBY KC

MR WEATHERBY: Mr Gove, I ask questions on behalf of Covid Bereaved Families for Justice UK, which represents the interests of many families from across the UK, and I've got permission just on a discrete area, so not many questions from me, you'll be pleased to hear, but relating to the interplay between no-deal planning and its effect on the response to Covid.

So I think your position is that there were advantages that were gained from the no-deal planning which -- they were unintended, but there were unintended advantages which assisted with the response to the pandemic as it happened.

So, for example, I think it's your position that the standing up of a whole-system emergency structure was something of a rehearsal which gave people experience; is that fair?

A. Yes, it is fair.

Q. Now, would you also agree, though, that the planning for no-deal identified a number of systemic weaknesses which

were as likely to arise in the event that the UK was affected by another type of civil emergency, and obviously we're looking at pandemics here, but which hadn't been previously identified in that sense; would you agree with that proposition?

A. Yes, I think that preparation for any significant challenge of that kind will stress test systems and will expose some weaknesses within those systems. Government is a project of continuous improvement, so it is undoubtedly the case that some areas for improvement will have been identified.

Q. Yes, they're pretty big areas, some of them. I just want to advert to a couple of them. Did you hear Mr Hancock's evidence?

A. I heard some of it and read all of it.

Q. Okay, that's helpful. I don't need to put it on screen, then, but I'll just read to you a short passage from Mr Hancock.

For the record, Day 10, page 64.

He said this:

"... the work done for a no-deal Brexit on supply chains for medicines was the difference between running out of medicines in the peak of the pandemic and not running out. We came extremely close, within hours, of running out of medicines for intensive care during the

pandemic, it wasn't widely reported at the time, and I think the only reason that we didn't run out is because of the work that Steve Oldfield and his team did, which they did during 2019, in preparation for a no-deal Brexit, but became extremely useful in saving lives during the pandemic.

"At the point at which the pandemic struck, because of the no-deal Brexit work, we knew more about the pharmaceutical supply chain in the UK than at any time in history, and we had relationships with the pharmaceutical suppliers, and the data to know exactly who had what available and where, and the extent of that information was the difference between running out and not running out of drugs in intensive care in the pandemic."

Do you agree with that, first of all?

A. I don't disagree with it. It certainly chimes with my recollection, yes.

Q. Yes, so a major unintended advantage coming from the no-deal preparation; but the corollary of that is that it highlights that before that the pandemic planning hadn't identified this key problem?

A. Yes, I think that both the preparation for a no-deal Brexit and the pandemic itself reinforced the fact that, not just with medicines but with many other

medical goods and items of medical equipment, that the nature of our supply chains in a globalised world -- and I know it's something of a cliché -- was such that we were -- they were fragile, and we reliant on -- as other countries were -- the just-in-time delivery --

Q. Yes.

A. -- of commodities from some countries and actors that, at a moment of crisis, would not necessarily be reliable for us.

Q. Yes. So without the happenchance of another near miss civil emergency, the no-deal Brexit arising, then we would have gone into the pandemic in a very vulnerable position with respect to vital drugs and, as you follow on, other medical devices?

A. Yes, and I think that -- I hope it's not taking things too far, but obviously one of the issues of concern during the pandemic was the availability of PPE --

Q. I'm coming on to that, if I may.

A. Okay. Please, please.

Q. Sorry to cut across you there.

A. No, not at all.

Q. But, before I do, you mentioned earlier in your evidence food supply.

A. Yes.

Q. And of course you were at DEFRA.

A. Yeah.

Q. And the lack of knowledge of food supply chains was something that was identified with DEFRA around 2018 as part of the no-deal preparations. So again, something which may well have turned out to be highly pertinent in a pandemic situation, again something that hadn't been spotted before the happenchance of the no-deal situation arising?

A. I think that is a perfectly legitimate conclusion. I take one step back, which is that overall -- and this is a critical question of resilience -- overall one of the lessons of the pandemic is that if you are reliant on just-in-time supply chains --

Q. Yes.

A. -- and if you're reliant on a very integrated network of suppliers, some of whom if they come under stress might fall over --

Q. Yes.

A. -- that has an impact on resilience, and there's a trade-off between the efficiency that globalisation has brought and the resilience of what might either be called reshoring or friend-shoring.

Q. That raises the issue, doesn't it, that there may well be clear economic advantages of last minute supply chains, but in terms of planning for potentially

catastrophic events, we had the nearest of misses, according to Mr Hancock, in terms of medicines, and so that was headed off at the pass, if you like, by the happenchance of no-deal planning.

In terms of food supply chains, again we'll no doubt look at this later on in another module, but perhaps the same position wasn't quite so acute in the response with food supply chains, but it might well have been.

But then you raised PPE. So PPE doesn't really arise with no-deal preparations, so here we have a systemic problem and it's not spotted by the happenchance of something else and things turn out to be not so great, again because of last minute supply chains?

A. Yes, I think that's true, and I think it was true for most western democracies. PPE was, in many cases sourced, either from countries in the Middle East or the Far East, not all of whom are necessarily reliable democratic partners. And it was the case, I think, that, for example, in Germany doctors protested outside the Bundestag because of the lack of PPE, and there was a strain here.

So I think again, to be fair to Matt Hancock and his team, as part of pandemic flu preparedness there were PPE stockpiles.

Q. Yes. We're going to deal with that later, but my point here is in terms of supply chains --
A. Yeah.
Q. -- and the fact that fortuitously in some areas another near miss problem --
A. Yes.
Q. -- led to them being averted with Covid, but in other areas it didn't, because it didn't arise.
A. I think that's --
Q. That's right, isn't it?
A. I think that's a legitimate point, yes.
Q. Okay.

Just finally, in terms of looking back at the Brexit readiness, there was a report in December 2019 from the Brexit Readiness Unit of the Cabinet secretariat. I think you'll be familiar with that report, so I probably don't need to go to it, but I can if we need to.

Now, just for the record, it's INQ000149081, and at paragraphs 5 and 6 it highlights that there were a variety of issues regarding borders and in paragraph 6 what were termed regional sector support. So the --
A. Oh yes.
Q. -- there were challenges of the flow of people and goods, security, trade, problems related to strategy,

policy, planning, contingency and operational management; and reference was made to political direction and accountability, and a confusion of co-ordination roles and the inefficient use of data, all relating to borders.

I stress that this was related to the Brexit preparedness or the no-deal preparedness, but the issue of borders is again something that needed to be planned for for pandemics, so some of those issues may well have overlapped with pandemics as well, and again these are issues that are only arising through no-deal; is that right?
A. Yes. I think that there would have been some people in government who would have been aware of them, but -- again if it's helpful -- the barriers to data sharing referred to I think is a reference to the fact that HMRC was not able, for understandable reasons, to share commercial data with other government departments because of the obligation of confidentiality it has to the commercial actors with whom it deals. I found that frustrating, but I can understand why it's a policy factor.

More broadly, one of the issues is there was no single government department in the lead for border issues, so when it came to the sanitary and

phytosanitary checks that food required, then DEFRA was in the lead.
Q. Yes.
A. When it came to intelligence-led checks on migration and whether or not there were individual bad actors who might pose a threat to the country, obviously the Home Office --
Q. Yes.
A. -- was in the lead.
Q. Yes.
A. Again, the point that I would make is that of course when you have the sort of challenge that no-deal planning required, you can often find that there are parts of government or parts of the operation of government that can be strengthened and were, but it is never the case that any government can anticipate all of the --
Q. Yes.
A. -- weaknesses within its operation.
Q. The point being, the conclusion at paragraph 5 is that "These must be resolved quickly" and here we are in December of 2019, just about on the cusp of Covid occurring.
A. Yes.
Q. No doubt some of these wouldn't be related to the

pandemic, but some of these issues would overlap with it, and yet here again there's a systemic failing, isn't there, to recognise in planning for pandemics that there are issues that need to be looked at at borders?

I mean, borders are an obvious point with pandemics, because you may need to control the flow of people through them or to screen people or to quarantine people.

So again, a systemic weaknesses in the pandemic planning; yes?
A. Yeah, well, I'd put it slightly differently, which is that: no matter how much thought might have been given to some of the lessons learned from no-deal planning, there was a broader question as well -- which the Health Secretary alluded to -- which is that our approach towards pandemic flu planning was that, and that of many other countries, was that it was almost impossible to so control our borders as to prevent the disease spreading, it was about the mitigation of the disease once it was here.
Q. Yes. Okay. With respect, that's a slightly different point.
A. Indeed.
Q. As it turned out, we know that the control of borders or issues relating to borders were relevant.

A. Oh, they absolutely were.
Q. Yes --
A. But I think --
Q. -- so a failure?
A. But I think for the Inquiry -- again, it's not for me to say, but I do think that for the Inquiry one of the interesting questions -- and again I think Matt Hancock mentioned this -- is, you know, he outlined what one might call the Hancock doctrine, which is that rather than simply dealing with the consequences of a pandemic one should seek to prevent it arriving in the first place.
Q. Yes.
A. And I think that that is a lively debate and I have a lot of sympathy with the position he put forward.
Q. Yes. And if that's the way forward, then getting the border situation and the co-ordination of people and all the matters I've just been through --
A. Completely.
Q. -- is absolutely key and --
A. Completely.
Q. -- therefore was a systemic failure at the time?
A. Well, it was -- there are live counterexamples of countries that closed their borders, New Zealand being the most prominent, and again I'm sure the Inquiry will

want to look at what the strengths and weaknesses of that approach were --
Q. Yes.
A. -- because again, lockdown and border closure inevitably impose economic and social costs --
Q. Okay.
A. -- even as they can be very powerful tools in preventing or slowing the spread of a disease.
Q. Yes. So having the option was essential?
A. **(Witness nods)**
Q. Now, finally what was referred to in this report as regional and sector support --
A. Yes.
Q. -- which is aka business and economic support.
A. Yes.
Q. The same point arises here, doesn't it, that here were issues spotted with respect to no-deal, a whole-system civil emergency, where there was a realisation -- certainly in the no-deal planning, and here in the report at just before the Covid strikes -- that with such a whole-system civil emergency there may well be a need for proper economic support, both to businesses and furlough and other stuff, and again a systemic failure to look at that at all in terms of pandemic planning. Yes?

A. I don't think there was a failure at all. I think the point that was made here was, again, there was a tension between the Treasury, which wanted to make sure that it was aware of what the differential impact on certain sectors might be of a no-deal Brexit -- certain sectors would have been more exposed, others much more resilient -- and the individual government departments that hoped that they might be able to appeal to the Treasury for support for their particular sector, whatever it might be.
Q. Yes.
A. But if we look at the pandemic --
Q. Yes.
A. -- I think one of the things that was striking is the speed with which the Treasury --
Q. Okay.
A. -- was able to provide support and, as George Osborne pointed out in his evidence, that was a consequence of two things: one, the relative fiscal strength that the --
Q. Okay, well --
A. -- government had as a result of the decisions he took.
Q. All right. I think, with respect, you're moving on to what actually happened in the response --
A. Sure.

Q. -- and no doubt the Inquiry will come back to that, and no doubt it will be arguable about the position that --
A. Of course.
Q. -- Mr Osborne adverted to.

But here what I'm focusing on is that here's an identification that there isn't -- there hasn't been the thinking put into how you stand up quickly business and economic support more generally; and it's a systemic failure, isn't it, in respect of pandemic planning that that hadn't been thought of at all?
A. I'm not sure that's the case, and I think that one would have to look at what the Treasury had prepared in the event of requiring rapid economic support for certain sectors, because the Treasury as a department tends to play its cards very close --
Q. Okay.
A. -- to its chest.
MR WEATHERBY: All right. No doubt we'll do that. Thank you very much.
THE WITNESS: Thank you.
MS BLACKWELL: My Lady, that completes Mr Gove's evidence and indeed the evidence for today.
LADY HALLETT: Thank you very much indeed for your help, Mr Gove, and you are now free to go, really grateful to you.

THE WITNESS: Thank you very much, my Lady, thank you.

(The witness withdrew)

LADY HALLETT: We shall resume at 10.30 on Monday for the final evidence and closing submissions in this module.

MS BLACKWELL: Thank you, my Lady.

LADY HALLETT: Thank you very much.

(3.43 pm)

(The hearing adjourned until 10.30 am on Monday, 17 July 2023)

INDEX