IN THE UK COVID-19 PUBLIC INQUIRY

CHAIR: BARONESS HEATHER HALLETT

On behalf of the TUC

Kate Bell Statement

First

Dated: 21 April 2023

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WITNESS STATEMENT OF KATE BELL (THE TUC)

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1. I am Kate Bell, Assistant General Secretary of the Trades Union Congress ("the TUC"). My office address is Congress House, Great Russell Street, London, WC1B 3LS.

2. I make this statement on behalf of the TUC in response to a letter dated 9 January 2023 sent on behalf of the Chair of the UK Covid-19 Public Inquiry ("the Inquiry"), pursuant to Rule 9 of the Inquiry Rules 2006. This statement is made for the purposes of module 1 of the Inquiry which is examining emergency preparedness, resilience and pandemic planning. The timeframe with which the module is concerned is June 2009 to 21 January 2020.

3. The statement is structured as follows:

   A. Introduction
   B. The structure and role of the TUC
   C. The readiness and resilience of public health structures
      - Fragmentation, Health and Social Care Act 2012
      - NHS funding crisis
      - NHS staffing crisis
      - Crisis in social care
      - Deteriorating patient safety
   D. The structures and specialist bodies concerned with pandemic and whole-system civil emergency risk management

- The Health and Safety Executive
- Local authority health and safety enforcement

E. Resilience and preparedness in education

F. Planning for a pandemic

- Foreseeability of the pandemic
- Government consultation with unions
- Fire and rescue services
- Railways
- Availability of PPE across sectors
- Role of the TUC in respect of preparedness

G. Conclusion

A. INTRODUCTION

4. The TUC was founded in 1868 and brings together 5.5 million working people that make up its 48 member unions, from all parts of the UK. The TUC seeks to stand up for everyone who works for a living, making sure their voices are heard, by publishing research and evidence and campaigning for changes to the law and in society. We seek to put working people at the heart of our society, economy and politics. We do this by supporting trade unions to grow and thrive, helping them represent their members and keep pace with the changing world of work. We advocate for collective bargaining and trade unionism and we aim to help union members get on in life.

5. Our values guide us in all our work. We stand for equality, fairness and justice, and for dignity and respect for all working people. We believe in solidarity: that working people can achieve more acting together than they can do on their own. And we are internationalists, acting with trade unionists around the world to promote working people's interests.

6. I joined the TUC in 2016 as its head of economic, international and employment rights department. I played an active role for the TUC during the course of pandemic, particularly in relation to liaising with ministers and civil servants in relation to the furlough scheme. I have also led the TUC's campaign for a £15 minimum wage, common ownership in the energy sector and stronger worker bargaining rights. Prior to joining the TUC I worked as Head of Policy and Public Affairs for a local authority.

7. The inescapable context in considering the preparedness for the pandemic and resilience of public services is over a decade of sharp and deliberate reductions in funding for public services, henceforth referred to as austerity, with a range of public services being increasingly undervalued, underfunded and fragmented.

8. In short, austerity has taken its toll. Chronic underfunding of public services has caused serious harm to the services and those who rely upon them, leading to a situation where capacity and resilience of public services were less than they should have been at the start of the pandemic had warnings from the TUC been acted upon. From hospital waiting times, to police and fire and rescue services, care provision and school budgets, the public sector has been stretched to breaking point by government cutbacks. Public services were at breaking point as we entered the pandemic.

9. The specifics of pandemic planning are important, but the central and salutary lesson from the pandemic should be a fundamental re-evaluation of the critical importance and value of our public services. Specific planning for future pandemics must rest on a foundation of public services that are valued and adequately funded.

10. It would be easy for the Inquiry to ignore that broader context, but it must not do so. We understand, of course, that the Inquiry cannot solve all of the acute problems across public services; but it must highlight how and why the underfunding and fragmentation of public services frustrated the response of public services to a pandemic, and will do so again in any future pandemic. If the Inquiry in its recommendations focuses only on pandemic-specific planning, and ignores some of the foundational problems in public services pushed to the fore by the pandemic, then the Inquiry will not have served its function.

11. It may well be that the fullest extent of the impact of austerity on the pandemic response will not be immediately apparent to the Inquiry in module 1, but we believe that as the Inquiry moves through the modules it will repeatedly hear of how underfunding and fragmentation of services frustrated an effective response to the pandemic.

B. THE STRUCTURE AND ROLE OF THE TUC

12. The TUC has 48 member unions, each of which is listed at [KB/1 - INQ000103540]. The TUC exists to support its member unions and the members of those unions. In doing so,

it brings together 5.5 million working people. The member unions of the TUC span a wide array of sectors, across the UK, all of which were affected by the pandemic. The sectors represented by the TUC member unions include workers in the whole range of health and social care services, construction and manufacturing, railways, aviation, education, food industries, communications workers, fire and rescue services, the civil service, and the arts.

13. During the course of the pandemic, the TUC was led by its then General Secretary, Frances O'Grady. Following her retirement, she was replaced as General Secretary by Paul Nowak, who commenced his role in January 2023.

14. TUC policy is set by Congress each year. There have been 152 TUC Congresses. Between Congresses, responsibility lies with the General Council. The 56 members of the General Council meet every two months at Congress House to oversee the TUC's work programme and sanction new policy initiatives. The larger unions are automatically represented on the General Council, with up to ten members depending on the size of the union. The smaller unions ballot for a number of reserved places. There are also seats reserved for women and black workers, and a reserved space for one representative each of young workers, workers with disabilities and lesbian, gay, bisexual and transgender workers.

15. Each year at its first post-Congress meeting, the General Council appoints the Executive Committee for the year from amongst its own members. This meets monthly to implement and develop policy, manage the TUC financial affairs and deal with any urgent business. It also appoints the TUC President for the year.

16. Task groups are set up by the General Council to deal with specific areas of policy such as learning and skills or representation at work. Committees are permanent bodies which link to other parts of the trade union movement. The Women's Committee includes members elected at the annual TUC Women's Conference as well as General Council members. The Race Relations Committee, the Disability Committee and the Lesbian, Gay Bisexual and Transgender Committee have similar links to their own conferences. The Young Members' Forum also reports to the General Council, as does the body representing Trades Union Councils (local trade union bodies).

17. There are a number of ways in which the TUC works with its member unions, in particular:

(a) The TUC briefs member unions on economic, equalities, workplace and social policy, and on trends in the workplace and economy. The TUC also supports unions by engaging with government and political parties on the development of policy. The TUC co-ordinates union representation on public bodies and supports ongoing formal discussions with government, such as the joint forum for government and unions with members working in the public sector.

(b) Every year, the TUC trains thousands of union reps, enabling them to develop the skills, knowledge and confidence to represent their members at work.

(c) The TUC helps unions to grow, running organising training and working alongside unions to develop their recruitment and organising strategies.

(d) The TUC supports the professional development of staff who work for unions, through formal training and through best practice events. We run a number of informal networks for trade union staff in similar jobs – for example, legal officers, HR officers, political staff and communicators.

18. The TUC also operates a TUC Code of Practice to which all member unions subscribe as a binding commitment and condition of affiliation and which serves to build positive relations between member unions.

C. THE READINESS AND RESILIENCE OF PUBLIC HEALTH STRUCTURES

19. The foundation to a public health system that is able to respond to a major crisis such as the Covid-19 pandemic is, firstly, a system that functions effectively, such that it can be resilient when crisis hits. A system stretched to breaking point, if not beyond, will inevitably struggle to respond. The pandemic threw into sharp relief the structural and foundational problems in health and social care which trade unions, commissioners and policymakers have been concerned about for over a decade. Some of the issues are addressed in the TUC report of 1 February 2022 [KB/2 - INQ000103541]. The NHS and social care sectors have dealt with years of chronic underfunding and understaffing pressures, with the workforce being overworked and undervalued by government before having to deal with the pandemic.

20. I hope that some of these issues will be considered further in Module 3, but they are crucial to understanding the resilience (or otherwise) of public health structures, and the ability of those structures to respond to a future pandemic.

21. I will address, in particular:

- The Health and Social Care Act 2012 and the fragmentation of health and social care
- The NHS funding crisis
- The NHS staffing crisis
- The crisis in social care
- Deteriorating patient safety

Public Health England and the National Institute of Biological Standards and Control

22. The 2012/13 structural reforms precipitated by the Health and Social Care Act (HSA) 2012 led to the dismantling of the world-leading institution focused on infectious disease, the Health Protection Agency ("HPA"). The HPA operated under relative independence from ministers, as a non-departmental agency. Under the HSA 2012, Public Health England ("PHE") was established and took up the HPA's role of protecting the public from infectious diseases and environmental hazards, as well as absorbing several other organisations. In contrast to the HPA, PHE was an executive agency of the Department of Health, taking instructions from ministers.

23. In its 2021 proposed reforms of the public health system, the UK Government acknowledged that the lack of dedicated focus for health security and health improvement, caused by the 2012/13 reforms, needed to be addressed [KB/47 - INQ000145934]. As a result, PHE was disbanded. In February 2022, Prospect submitted evidence to the House of Lords Select Committee inquiry into designing public services fit for the future, which explained that [KB/48 - INQ000145935]: *"Lack of investment and prioritisation of planning can have serious long-term costs. Work initiated by the Health Protection Agency before its transformation into Public Health England involved staff in mapping the existing workforce, identifying skills gaps and framing organisational aspirations. But, a member said, "none of this was implemented as basically there was no investment in the workforce and its skills, A totally wasted opportunity and arguably some aspects being contributory factors to the Covid-19 response car crash"."*

24. Also of relevance is the role of the National Institute of Biological Standards and Control (NIBSC) which, over the years, has suffered from a real-terms cut in funding. It plays a significant role in providing scientific advice, control testing of virological medicines, and works closely with the World Health Organisation. Analysis by Prospect indicates that funding for the NIBSC from the Department of Health fell 17% in real terms in the years between 2014/15 and the pandemic. That was against a context of a service that was already stretched. A review of NIBSC was chaired by Sir Patrick Sissons in January 2014 [KB/3 - INQ000103542] and warned that:

> *The Panel considers that the consequences of any further reductions in central government funding should be considered very carefully, and would be likely to compromise the Institute's function. Furthermore, there may be little room for manoeuvre should NIBSC be called to respond to a sustained crisis (e.g. an influenza pandemic).*

25. As a consequence of the above, public services that play a fundamental role in ensuring the country is in a place to tackle a pandemic, and play a leading role during one, did not have the capacity and staffing needed as we entered the pandemic.

Health and Social Care Act 2012 and the fragmentation of health and social care

26. The HSA 2012 brought in extensive structural reforms of the NHS and public health more widely, transferring significant public health functions to local authorities. At the time, Unite the Union ("Unite"), had concerns that these reforms could lead to the fragmentation of public health and substantial cuts due to local government's tighter budget constraints. In December 2015, in its written evidence to the House of Commons Select Committee 'Public Health Post-2013' [KB/49 - INQ000145936], Unite explained that its concerns had been realised, setting out in detail the negative impact of the changes to public health in conjunction with the wider cuts agenda. Unite members reported:

    a. Swingeing cuts to public health services;

    b. Reductions in staff terms and conditions, training and pay;

    c. Poor morale and de-professionalisation;

    d. Loss of status, independence and innovation within the service; and

e. False economies, as reduced services and quality leads to greater costs in acute services down the line.

27. The TUC had alerted the Government to its concerns regarding the fragmentation of services in its 2011 Budget submission [KB/4 - INQ000103543] at paragraph 5.8, stating "*The TUC has serious concerns about the direction of government policy on public services. Our vision for public services is for directly delivered, world class services, with genuine equality of access and high levels of quality for users and workers. We therefore have serious concerns that the Government's vision for public services will lead to fragmentation, increased private sector involvement and irreconcilable tensions such as between the plurality of provision and democratic accountability*". At paragraph 5.12, the TUC warned of the impact upon patient safety, stating "*The Government's proposed reforms of the NHS are likely to cost up to £3 billion to implement at the same time as fundamentally altering the make-up of the health service. Coming at the same time as increasing demographic pressures and a requirement to make £20bn in savings, there is a very real risk that the quality of patient care will suffer. Despite the Government's stated intention to protect NHS spending, unions are already reporting cuts across the health service*".

28. On 5 April 2017, the Select Committee on the Long-term Sustainability of the NHS published a report [KB/5 - INQ000103544], stating:

> *We asked many of our witnesses the same question—what does the healthcare system of 2030 look like and what do we need to get there? As a result, we were able to obtain a very clear articulation of what key components a sustainable system would need to include. A number of consistent themes emerged: (1) The urgent need to shift more care away from the acute sector into primary and community settings; (2) Widespread support for closer integration of health and social care services (as far as organisation and budgets are concerned); and (3) The need to resolve the current fragmentation of the health system, which is making the provision of co-ordinated care impossible and frustrating efforts to move toward place-based systems of care.*

29. The TUC in its 2015 Comprehensive Spending Review submission [KB/6 - INQ000103545] highlighted the impact reforms had on the NHS and patient safety stating that *"the government's top-down restructuring of the NHS and a prolonged funding squeezing have created endemic financial stress throughout the health service which is*

leading to a deterioration of outcomes for patients" (page 18). The same submission also highlighted that fragmentation was preventing the collaboration needed to resolve challenges, stating: *"The fragmentation and complexity of commissioning brought about by the government's top down restructuring of the health service is acting as a barrier to the collaborative solutions required*".

30. As a consequence of the above, health and social care systems were fragmented and less able to respond in a strategic manner to the pandemic.

Funding crisis

31. By the time of the Covid-19 pandemic, the NHS had been subject to a decade of funding cuts. The NHS Long Term Plan, launched in January 2019, [KB/7 - INQ000103546] stated that funding for the NHS would rise on average by 3.4% in real terms over the next 5 years. By contrast, NHS funding rose by an annual average of 6% in real terms between 1997/98 and 2009/10. Providers reported a deficit of £571 million in 2018/19, even after an injection of additional central funding [KB/8 - INQ000103547].

32. As a result, health and social care systems were already struggling to cope with demand. Indeed, between 2011/12 and 2015/16, ambulance services demand increased at almost twice the rate of funding [KB/9 - INQ000103548]. A report by the Health Foundation and the Institute for Fiscal Studies in May 2018 [KB/10 - INQ000103549] found that UK spending on healthcare would have to rise by an average 3.3% a year over the next 15 years just to maintain NHS provision at the 2018 levels, and by at least 4% a year if services were to be improved. Social care funding would need to increase by 3.9% a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities. That was in order to meet 'ordinary' demand, and without even contemplating the impact of a global pandemic.

33. The TUC highlighted the impact that a crisis of funding across public services was having across numerous budget submissions to the Government, including the impact on patient safety and capacity. In the TUC budget submission of 2011 [KB/4 - INQ000103543] the TUC explained, at paragraph 4.6, that "*Part of the reason that cuts damage public services is that they make it much harder for staff to deliver a good service. In March 2010 the Audit Commission published 'Surviving the Crunch: Local finances in the Recession and Beyond'. This report noted that where jobs are lost, so are skills, knowledge and capacity*". The same submission highlighted the risks for public sector bodies to plan for

contingencies together, stating at paragraph 5.6 that "*The depth and speed of the cuts make it extremely difficult for unions and public sector bodies to work together to plan for, mitigate and adapt to the impact of the changes*".

34. In the TUC's March 2014 budget submission [KB/11 - INQ000103550] the TUC made it clear that "*Prolonged austerity is having a major negative impact on the quality and capacity of public services. For example, in the NHS, the combination of £20bn efficiency savings and real terms funding cuts has equated to a four per cent cut in the budgets of hospitals and community health services every year from 2010 to 2014, with income falling far behind increased demand. These savings have largely been met through pay freezes, staff cuts and the rationing of services, with the Public Accounts Committee concluding that this was having a "damaging impact on the quality and safety of care*" (page 44). On page 45, the TUC also warned that "*While transformative change is required to achieve greater integration of services and the delivery of long-term efficiency gains, the government's continued pretence that NHS funding is being protected masks a failure to acknowledge a growing financial crisis within the health and social care system that could pose serious problems in the very near future and requires action in the short-term*".

35. The 2014 submission also highlighted the leading role public services play in supporting communities in emergency situations and warning of the threats sustained under funding could cause stating "*At a time when local authorities and other government agencies have demonstrated the leading role that public services play in supporting communities affected by floods and other emergency situations, the government should recognise that far from acting as a drag on the economy, public services play a dynamic role in supporting communities and local economies. Further cuts are unlikely to be sustainable without significant impacts on service delivery and quality"* (page 46).

36. The TUC's 2015 budget statement raised similar issues [KB/12 - INQ000103551] once again highlighting the impact the funding crisis was having on capacity: "*Austerity has had a major negative impact on the quality and capacity of our public services. To date we have seen cuts to services, reductions in staffing, increasing rationing of services through targeting and thresholds and a significant squeeze on funding across both the public and voluntary sectors"* (page 23). In its 2016 budget submission [KB/13 - INQ000103552], the TUC called for increased investment in public services to be a government priority, as the

health service's ability to find the £22 billion in efficiency savings in order to close the remaining funding gap, without hindering service quality, was questionable.

37. The 2016 budget submission also raised concerns from others on the impact of the sustained funding crisis, citing a survey by the Kings Fund, which found that over half (53%) of NHS Finance Directors claimed that services have worsened in the previous 12 months as a result of financial pressures. Performance metrics across the health service supported this, with negative impacts in key target areas such as waiting lists, A&E waiting times, cancer treatment times and delayed discharges.

38. In a submission on the 2016 Autumn statement [KB/14 - INQ000103553], at page 15, the TUC urged the government to bring forward investment in both physical infrastructure and in the vital social infrastructure provided by public services. It highlighted on the following page that "*The NHS and social care services are facing financial crises as a result of an unprecedented squeeze on funding which is set to last until the end of this parliament at the earliest. Evidence from Sustainability and Transformation Plans suggests that financially-led reconfiguration of services will lead to closures and additional service rationing in a number of areas of the country as the NHS struggles to find ways to find efficiency savings within a context of flat-lining funding*". It is worth noting that "*until the end of this parliament"* effectively meant until immediately before the pandemic, with that parliament expected to last until 2020 following the 2015 General Election.

39. In its 2017 Autumn budget statement [KB/15 - INQ000103554] the TUC highlighted, on page 8, that "*The impact of austerity across the health, education, social care and prison sectors is increasingly clear, with services failing to deliver key targets or to meet need. Without action, these pressures are likely to intensify, leaving the country with struggling public services, at a time when workers are already feeling under economic pressure*". The TUC also warned that public services were finding it increasingly hard to deliver effective, safe and sustainable services as a consequence of the continued funding crisis.

40. The submission also pointed to the November 2016 joint report by the TUC and NHS Support Federation '*NHS Safety: Warnings from All Sides*' [KB/16 - INQ000103555]. This report found that throughout the previous 12 months there had been an unprecedented wave of organisations flagging up significant concerns about the growing crisis in the NHS. Fifteen different groups issued reports in 2016 sounding the alarm, including Royal

Colleges, trade unions, NHS providers, health experts and the government's own Mental Health Taskforce.

41. The TUC submission for the 2018 Autumn budget statement [KB/17 - INQ000103556], on page 20, highlighted that the funding crisis had led to a situation where capacity demands were unable to be met, stating "*In health, services have deteriorated in recent years after an unprecedented decade of constrained spending. And a crisis in social care funding is putting even more strain on the health service. The latest Quarterly Monitoring Report from the Kings Fund states that "there is simply not enough capacity in hospitals to cope with rising demands for both emergency and planned care", with 4.2 million patients on waiting lists today compared with around 2.5 million in 2010*".

42. The NHS in Wales faced similar issues. A report by Nuffield Trust in June 2014 [KB/18 - INQ000103557] found that funding for the NHS in Wales had increased in real terms each year between 1992/93 and 2010/11 by an average of 4.7% a year, however, since 2010/11 that trend had ceased, with funding instead falling by an average of 2.5% a year in real terms between 2010/11 and 2012/13. They estimated that there would be a funding gap of £2.5 billion for the NHS in Wales by 2025/26, based on the rate of efficiency savings at the time and assuming even further efficiency savings worth 3.7% a year in real terms after 2015/16.

43. Shortly after publication of the Nuffield Trust report, the Wales TUC warned of the challenges faced by NHS Wales, calling for support for what was such a vital public service [KB/50 - INQ000145937]. They stated, "*NHS Wales is facing growing pressure and increasing demand on its services due to a complex mix of financial constraints, changing demography and long term public health challenges. As austerity at a UK level continues to deliver unprecedented cuts to the overall Welsh budget, all of our public services now face unjust funding pressures*".

44. As a consequence of the above, by the time of the pandemic, NHS systems were struggling with capacity, particularly during high demand periods such as winter, and not in a position to react accordingly to the pandemic as they otherwise may have been able to.

NHS staffing crisis

45. Over a decade of real-terms cuts to earnings, determined by government pay policy, has contributed to a staffing crisis across many parts of our public services – perhaps most notably in the current NHS staffing crisis.

46. The value of NHS workers' wages has been severely eroded by the public sector pay cap introduced by HM Treasury from 2011/12 and ongoing pay restraints thereafter. TUC analysis shows that wages of NHS staff are still below 2010 levels after taking into account inflation, even after factoring in the 2021 pay award for staff [KB/2 - INQ000103541]. By the point of the pandemic, workers across the NHS had faced significant real-terms pay cuts.

47. The April 2017 Select Committee on the Long-term Sustainability of the NHS report [KB/5 - INQ000103544], to which I have already referred, described that (at [153]):

> *There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade.*

48. In March 2010, the total vacancies among NHS medical and dental staff (hospital doctors and dentists excluding training grades) was 4.4 percent [KB/19 - INQ000103558]. By June 2019, that had risen to close to one in ten jobs, with a vacancy rate of 9.2 percent. By September 2021, NHS England was operating short of almost 100,000 due to unfilled vacancies [KB/2 - INQ000103541]. Nursing and midwifery continue to experience some of the worst recruitment and retention issues.

49. The results of a UNISON UK-wide annual survey of nursing professionals, published in April 2016, revealed that staffing levels had worsened significantly in the previous year [KB/51 - INQ000145938]. Almost two-thirds – 63%, up from 45% the previous year – of respondents said they felt there were inadequate numbers of staff on the wards to ensure safe, dignified and compassionate care. More than two-thirds (70%) reported not having enough time to spend with each patient. Three-quarters (75%) said because they were so busy, there was no time to comfort or even talk to patients. Nearly half (47%) the survey respondents thought their organisations were at serious risk of a care failing developing,

and more than one in ten (15%) felt that care failings were already happening in part, or across, their workplaces.

50. Similarly, in October 2016, the TUC commissioned YouGov to survey NHS workers across England to find out from staff at the frontline what the impact of NHS finances was having on clinical standards and patient safety [KB/16 - INQ000103555]. The responses received gave a very strong message:

    a. 7 in 10 (69 per cent) NHS workers said that reductions in staffing and resources were putting patient care at risk.

    b. 9 in 10 (88 per cent) NHS staff believed the health service was under more pressure than at any time in their working lives.

    c. Three-quarters (77 per cent) of NHS workers thought resources and staffing in the NHS had gone down in the previous five years.

    d. Two-thirds (60 per cent) of NHS staff said their employer had cut patient services to make financial savings.

51. Whilst the public perception of health and social care staff may have improved during the pandemic, the staffing pressures have only been worsened. The pandemic has led to a very significant impact on levels of resilience, workforce stress and burnout across the NHS and social care sectors (as described by the GMB in its submission to the Health & Social Care Select Committee inquiry into staff burnout [KB/20 - INQ000103559]). During the pandemic, health and social care staff were exhausted following long hours and extreme service pressures. Coupled with the fear of spreading the virus to patients and their own families and friends, personal protective equipment (PPE) shortages, and dealing with more patient and service user deaths.

52. There are also inadequate numbers of professionals in training, such that the high levels of vacancies will inevitably continue without some long-term planning. Considering the number of vacancies in the NHS and social care respectively prior to Covid-19, it is obvious there are insufficient numbers of people in training for careers or career progression in both health and social care. The removal of nursing bursaries and those for other allied healthcare professions and the introduction of fees was a huge barrier to many people being able to start training to work in the NHS. In 2017 the Nursing Times revealed nursing degree applications fell by 23% from 43,800 in 2016 to 33,810 in 2017 in the wake of the

bursary loss [KB/52 - INQ000145939]. This only addresses the nursing and allied health care profession shortages, but there are shortages across all professions in the NHS.

53. Again, similar issues were faced by the NHS in Wales. A review panel, independent of the Welsh Government, was established in April 2015 to consider many of the issues affecting the NHS in Wales highlighted by the Nuffield Trust report (to which I refer above). Martin Mansfield, then General Secretary of the Wales TUC, was a panel member. The panel produced a review in February 2016 [KB/21 - INQ000103560] concluding "*The long term strategic direction for pay in the NHS must be to keep pace with wage growth in the wider economy if the NHS is to avoid serious recruitment and retention difficulties, a worsening of staff morale and a decline in levels of competency*".

54. The staffing crisis in the NHS as we entered the pandemic meant a system already under significant stress and strain struggled to cope. The crisis meant further pressures, such as staff sickness caused by the pandemic and the lack of available PPE, were felt even more acutely than they otherwise might have been.

Crisis in social care

55. Social care has faced continuous challenges from fragmentation and low levels of funding, with the impact of huge reductions in the central government grant to Local Authorities having significant consequences for its resilience as we entered the pandemic.

56. The GMB in its June 2020 evidence to the Health and Social Care Committee [KB/22 - INQ000103561] stated:

> *Our social care system right now is in crisis. It is crumbling beneath us after years of austerity and chronic underfunding. Social care is an essential part of the infrastructure of our society. An ageing population who need support and access to high quality and sustainable services to help them live with dignity. A social care workforce over worked and undervalued despite finally being recognised as the essential key workers they are. Social care needs to be put to the top of any Governments agenda. Staff working in social care need to be celebrated, recognised and valued.*
>
> *The lack of sufficient social care funding over many years quickly became apparent in recent months and has led to the catastrophic impact on social care during Coronavirus*

(Covid-19). The current model of social care funding isn't just unsustainable, it's fallen apart.

57. Unions such as the GMB warned for many years that the business model used in the private care sector was unsustainable, with the care home business transforming from small, family run firms to large and complex multi-level chains with holding companies in tax havens. The starkest example was the collapse of Southern Cross. In brief, Southern Cross Healthcare was a company, founded in 1996, that, as at the time of its collapse, operated 753 care homes across the UK with a total of over 38,000 care beds for the elderly. However, in 2004 it was acquired by the US private equity firm Blackstone, which supported a sale-and-leaseback strategy, effectively separating ownership of the care homes from its operating company assets, with Southern Homes having to rent the care homes from the separate owners. In 2006 Southern Homes floated on the London Stock Exchange, with the Qatar Investment Authority (QIA) ultimately owning the freehold of roughly half of the care homes [KB/23 - INQ000103562]. The result was that Southern Cross had to pay increasingly extortionate rents to the QIA, which, following the financial crisis in 2007-2008 and falling occupancy rates, became unsustainable. This led to deteriorating standards of care for the care home residents and, ultimately, the collapse of the company in 2011 with the loss of thousands of jobs. A social care sector susceptible to these pitfalls of the private sector is not well placed to serve the public good in a pandemic. It also, ultimately, worsens the funding difficulties, with profits, largely derived from the public purse, siphoned off to tax havens.

58. Chronic low levels of pay have also led to staffing difficulties. As the GMB CEC described in its report to the GMB Congress 2016 [KB/24 - INQ000103563], very low pay causes a high level of staff turnover. Low status, low pay and poor working conditions were making it difficult to retain staff in the care sector. Accordingly, as described in 2016, *"England has a turnover rate of 24.8% for all care staff with a high of 30.6% for care workers and low of 12.5% for registered managers. A Skills for Care briefing report states that a turnover of 15% presents a problem and over 20% is a major deterrent to a quality service. The cost of the constant replacement including advertising, selection, induction and training is unsupportable. At 28% turnover, an average domiciliary care agency replaces its entire workforce in less than 3.5 years, which prevents any real development."* Reports published in September 2019 suggest there were 122,000 staffing vacancies within social care just across England – with an average vacancy rate of 7.8% – putting extreme

pressures on the ability to provide services to adequate standards [KB/25 - INQ000103564].

59. Low pay is also linked to insecurity at work, analysis by the TUC showed that in 2017 the median pay for a zero-hours contract worker was around a third (£3.50) less an hour than for an average employee [KB/53 - INQ000145940]. Analysis from Skills for Care [KB/26 - INQ000103565] shows that over a third of care workers were on a zero-hours contract in 2019/20 – a figure that has remained constant over a number of years. The same report also shows that 14% of care workers were on non-permanent contracts in 2019 on the eve of the pandemic, either through bank, agency or temporary employment. The high staff turnover and use of non-permanent care staff was seen to have undermined attempts to manage contagion between residential care settings during the pandemic [KB/54 - INQ000145941].

60. The April 2017 Select Committee on the Long-term Sustainability of the NHS report [KB/5 - INQ000103544] stated:

> *Immediate and sustained action on adult social care: The funding crisis in adult social care threatens to overwhelm the NHS and will undermine any efforts to transform the system as a whole. A long-term financial settlement—preferably one on which the political parties can agree—is needed to put social care on a sustainable footing. A long-term programme, with clear leadership, governance and accountability for the better integration of health and social care, is the single instrument that would do most to enable the NHS to break through to a sustainable future*

61. As is well understood, the inadequate capacity in the social care sector has a huge knock-on impact for the NHS. The reliance of the NHS on the care sector was particularly acute during the pandemic. Hospital beds that had been filled with older people that were unable to cope at home or without community care packages were forced into care homes to release the beds to make space for Covid-19 spaces. The circumstances of that decision, ruled unlawful by the High Court[1], would have catastrophic consequences, and I am sure that will be considered in detail in later modules. It is important to recognise, however, that the social care sector could, with adequate funding, take some of the pressures from the NHS by addressing the needs of many older people, before NHS provision is required.

[1] *R (Gardner and Harris) v Secretary of State for Health and Social Care and others* [2022] EWHC 967 (Admin)

The sector has a skilled workforce that is providing nursing care which goes mostly unrecognised. The pandemic has underlined the importance of care homes and domiciliary care to the NHS as they have acted as a buffer, preventing many more deaths. The NHS would not have been able to provide the care for as many people as they have done within the social care sector.

62. This difficulty was flagged by Exercise Cygnus in 2016, which described *"Local responders"* as having *"raised concern about the expectation that the social care system would be able to provide the level of support needed if the NHS implemented its proposed reverse triage plans, which would entail the movement of patients from hospitals into social care facilities"* [KB/27 - INQ000103566]. The report further described the *"the complexity and potential impact of a pandemic influenza response, which draws in actors from across the public and private sectors"* and that consideration *"should be given to developing support to the local response"* in the areas of excess death planning, social care and health. It underlines that social care capacity is very much a matter of pandemic resilience and preparedness.

63. Of course, planning in the care sector, in the public interest and for a future pandemic, is difficult to achieve in a fragmented and largely privatised sector. That is part of the reason why the TUC supports the care sector being brought in-house and under local government control, or at least a national care body/service which would provide a national identity for social care.

64. The social care workforce has been let down and feels absolutely abandoned by the government, and this has been exacerbated by the pandemic. The workforce was left out of original PPE Guidance, priority was given to the NHS for access to PPE, and there were severe delays in and poor access to testing, as well as being denied full pay for Covid-19 related absences and self-isolation instructions. It is no wonder that there are few people coming forward to work in social care.

65. The lack of support for the care sector is relevant to issues of discriminatory impact of the pandemic. Care workers are more likely to be older, disabled, and members of BAME groups than other workers. 21% of adult care workers were identified as BAME in 2018/19 compared to 14% of the working age population. 11% of social care workers were identified as Black/African/Caribbean/Black British backgrounds, compared to 3% of the working age population. Care was also one of the three broad occupational groups

identified as having statistically significantly higher than average increases in excess deaths in 2020 compared to all occupations [KB/22 - INQ000103561].

66. The skilled, predominantly female care workforce must be properly valued. Their critical worth to society was demonstrated in a pandemic, and will be again in any future pandemic. Yet nowhere is pay justice and equality needed more than in the care sector. Our social care workforce is still not recognised for the incredible work they do.

67. The Covid-19 pandemic has shone a light on the crisis in regards to the supply of future health and social care workers to meet ongoing and future demands. Access to training for those looking at starting careers within the sector but also career progression needs to be better resourced and available. The standing of the social care profession should be raised with a standardised training and career progression framework and a workforce strategy.

68. As we entered the pandemic, health and social care was buckling under numerous crises such as low pay, staff shortages and fragmentation. This left the system under intense pressures and, as with the NHS, exasperated by staff sickness and a significant lack of PPE for the workforce.

Deteriorating patient safety

69. The crises in funding and staffing led to a serious deterioration in patient safety by the time we entered the pandemic.

70. The current crisis in emergency services is by no means a new one. The GMB stated in 2014: *"The cracks are already beginning to show as a result of Coalition policy, most notably in the emergency services we all rely on. In the past year we've witnessed the disgraceful sights of tents set up outside A&E's to hold emergency patients who can't be admitted fast enough. Our elderly, waiting in corridors to be admitted on wards because community services are in meltdown. Dozens of A&E departments across the country face closure or downgrading"* [KB/28 - INQ000103567]. Subsequently, in a statement to the GMB Congress in 2017 it described that by December 2016 waiting times for A&E had risen again with record breaking waiting times of 12 hours, and the elderly *"waiting in corridors to be admitted on wards because community services are still in meltdown"*. It described that the GMB's ambulance service members *"are being pushed to the brink"* [KB/29 - INQ000103568].

71. The TUC's 2016 report '*NHS safety – Warnings from all sides*' [KB/16 - INQ000103555] described that since the beginning of that year there had been an unprecedented series of warnings raising the alarm about the pressures on the NHS. A number of organisations had issues warnings, supported by evidence from NHS staff, about threats to patient care. That included reports from unions, but also bodies such as the Royal College of Physicians and the BMA. In that same year Unite and RCM made submissions to the House of Commons Health Committee, which published a report in September 2016 on 'Public health post-2013' [KB/30 - INQ000103569]. It expressed the view that *"Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health."*

D. THE STRUCTURES AND SPECIALIST BODIES CONCERNED WITH PANDEMIC AND WHOLE-SYSTEM CIVIL EMERGENCY RISK MANAGEMENT

72. In this section I set out the TUC's views on the suitability of the government structures and specialist bodies concerned with pandemic and whole-system civil emergency risk management, planning and preparedness.

73. Limiting the tragic loss of life in a pandemic is, in significant part, an issue of health and safety. Non-pharmaceutical interventions (NPIs) in workplaces, and the effectiveness of those NPIs, was a key part of the pandemic response. Health and safety at work must, therefore, be seen as a central part of the state readiness for and response to a pandemic.

74. There is a well-established legal framework for health and safety, and regulatory bodies responsible for enforcement, that ought to be in a position to respond in a pandemic.

75. The law relating to health and safety is in significant part enforced by local authorities and the Health and Safety Executive (HSE). The HSE inspects many of the high hazard workplaces (chemical plants, oil rigs, etc), and also local authorities, the NHS, schools, colleges, construction and agriculture. Most shops, offices, and some other services are inspected by local authorities. There are specialist agencies for some specialised sectors such as rail, air, nuclear and maritime.

76. The HSE is significant not just in terms of enforcement, but also in respect of guidance. HSE guidance sets out the clear practical steps that employers have to take to make the workplace safer. The HSE must be able to provide urgent and quality amended advice when a pandemic arrives. Further, inspections are not only to ensure the law is being complied with, but also to assist employers in giving advice and support and promoting good practice.

77. Over a period of decades, but particularly during the period of austerity, the ability of these bodies to enforce health and safety, particularly the HSE, has been decimated.

The HSE

78. The HSE has suffered from the twin effects of significant cuts in its budget, and a misconceived narrative which took hold as to health and safety being burdensome on business.

79. In October 2010 the TUC issued a report, observing that the HSE then employed around 3,200 people, which was 25% fewer people than 15 years previously [KB/55 - INQ000145942]. Previous cuts, even as of 2010, had led to a big fall in the number of inspections and prosecutions. In 1999/2000 the HSE Field Operations Division undertook 75,272 inspections, but by 2008/09 that had fallen to 23,004. Inevitably, that also resulted in a fall in enforcement activity with a drop from 1,986 prosecutions in 2001/02 to 1,090 in 2009/09. There was a similar fall in local authority enforcement.

80. As with other services, public sector pay has been problematic. In 2014 the then 1,220 HSE members of Prospect undertook strike action in a dispute over pay. Prospect described at the time that *"pay constraint is now impacting on recruitment and retention as HSE staff vote with their feet, resulting in operational difficulties which are hampering HSE's ability to delivery a services that the public deserves and expects"* [KB/56 - INQ000145943].

81. By April 2014 the TUC had published its report, '*Toxic corrosive and hazardous – the government's record on health and safety*' [KB/31 - INQ000103570], which observed that in the four years of the coalition government state funding for the HSE had been cut by a further 40%. A damaging narrative had also taken hold of health and safety being a wasteful burden. In part as a consequence of that narrative, the government directed a move away from proactive inspections of workplaces. The HSE and local authorities had

historically used a mix of proactive inspections (routine and unannounced) and reactive inspections. Around 60% of HSE inspections were proactive, in order to promote health and safety in the workplace. However, in March 2011 the government issued instructions to the HSE to stop all proactive inspections in a wide range of industries including postal services, transport (including docks), education, electricity, light engineering, textiles, health and social care. It was said that this would reduce the number of inspections by 11,000 a year. The primary reason given was that premises in these industries were said to be 'low risk', whereas, in fact, many of the sectors identified have much higher levels of ill health caused by work than those that were still allowed to be inspected. This came at the time of the launch of David Cameron's 'Red Tape Challenge', in April 2011, vowing to reduce the 'burden of regulation' [KB/57 - INQ000145944].

82. In 2009/10, the HSE received £231 million from the Government, and in 2019/20, it received just £123 million: a reduction of 54% in ten years. Less funding means fewer inspections: over the same ten-year period, the number fell by 70%, and over a twenty-year period, the number of prosecutions has fallen by 91%.

83. The result, inevitably, is that employers in many workplaces were able to act recklessly, and with impunity. The HSE was not in a position to respond. By early June 2020 the HSE had received over 6,000 additional concerns from workers about social distancing and other pandemic related matters. Of over 6,000 concerns, only 47 were responded to with a physical inspection, and there was one prohibition notice. Six months into a pandemic which had such terrible consequences in so many workplaces, that was wholly inadequate. The HSE also confirmed that it had not conducted a single inspection of a care home since 20 March 2020.

84. This was recognised to be a problem: on 11 May 2020 the Prime Minister described a system of 'spot inspections' to ensure safety in workplaces, including with an additional £14 million of funding for the HSE. However, a regulator, already decimated by decades of swingeing cuts, cannot instantly surge its inspections. By June 2020 the HSE was able to make no more than the vague assertion that it "*has started a programme of interventions to check how businesses are implementing social distancing.*" The Government's £14 million fixed-term grant to HSE did not increase the number of inspectors. Instead, most of these funds went to contractors who were unwarranted, lacking a right of entry to workplaces or any enforcement powers, and did not have the specialist health and safety knowledge of trained HSE inspectors.

85. The spot inspections programme itself was significantly flawed, essentially consisting of a telephone call followed by a visit if necessary. For example, in education, the questions being asked in the spot check calls were rapidly disseminated across the system so schools were ready with answers which may or may not have reflected actual practice. Even so, 1% of the schools contacted required formal intervention. Despite this indicating around 250 schools having significant failings, the spot inspections programme was ended.

86. The inability of the HSE in responding to the pandemic was highlighted in the report of the Institute of Employment Rights, '*HSE and Covid at work: a case of regulatory failure*' (February 2021) [KB/32 - INQ000103571]. Indeed, Unite made repeated offers to provide Unite health and safety representatives to carry out inspections and risk assessments in workplaces and for employers, in order to pick up the slack and plug the gaps that the HSE could not fill.

87. In a future pandemic, seeking to fill the void in inspection and enforcement with a one-off grant to the HSE will be similarly ineffective. The lesson is an obvious one: long-term, adequate funding of safety regulation is required if society is to keep workplaces safe in a future pandemic.

Local authority health and safety enforcement

88. Local authority workplace health and safety enforcement is achieved through environmental health officers who are also responsible for other enforcement areas including food safety, housing and environmental nuisance. Sectors such as retail, wholesale distribution and warehousing, hotel and catering premises, offices, and consumer/leisure industries, several of which faced significant challenges during the pandemic, are inspected by local authorities.

89. Local authorities have seen huge reductions in their budgets, see, for example, the 2019 GMB Report '*Local Government and Austerity*' [KB/33 - INQ000103572].

90. How much of a budget is spent on health and safety enforcement is up to each local authority, and so the impact of austerity on local authority enforcement does not fall equally between authorities, but the reduction on enforcement has, across the board, been significant. In 2014 the TUC observed that *"overall local authorities have reduced their inspections by a massive 93 percent since 2009/2010"*, although that was in part

contributed to by a pressure from government to reduced inspections [KB/31 - INQ000103570].

91. As with the HSE, in 2014 government instructions were issued to local authorities to cease most of their proactive inspections. Overall, between 2010 and 2016 the overall number of inspections (both proactive and reactive) and other interventions fell by 65 percent [KB/34 - INQ000103573]. Over the period 2010 to 2017, the number of local authority inspectors almost halved, falling from 1,020 to 543. Over the same period, the number of enforcement notices fell 64% from 6,780 to 2,420.

92. Chronic underfunding of health and safety regulation and enforcement cannot be fixed in the middle of a pandemic by a short-term government grant. The pandemic has underscored the need for effective, quality enforcement, with a long-term investment in the HSE and local authority environmental health teams to allow for fully-trained inspectors, infrastructure and resources needed to keep workers safe.

E. RESILIENCE AND PREPAREDNESS IN EDUCATION

93. I do not address issues in education in any significant detail as to the best of my understanding issues relating to the education sector are going to be considered in a subsequent module. However, it is important to recognise that there are significant issues relating to resilience and preparedness arising in the education sector.

94. The government's stewardship of the education system over the course of a decade leading up to the outbreak of coronavirus positioned education as anything but resilient. Policy and political decisions created a system teetering on the edge in normal times: increasingly unable to rely upon outside, or collaborative, expertise from other overstretched and underfunded public services; and with highly limited thinking or demonstration of contingency measures.

95. The drive to ensure schools left Local Authority maintenance to become academies, known as academisation, had also resulted in an incredibly fragmented system, comprising thousands of separate employers, and local authorities being largely side-lined. This led to a complete lack of oversight and many schools, particularly in single academy trusts or small multi-academy trusts, were left to fend for themselves, resulting

in many examples of wholly inappropriate responses being taken in some schools that actively put pupils and staff at risk of contracting the virus. This is exemplified by the NASUWT having to create a dedicated team to deal with the volume of concerns being raised by members.

96. More broadly, the education system should be considered within a wider children and young people's services framework. All such services play distinct yet interrelated roles in securing positive education-, social- and health-related outcomes for children and young people. Not only did these services experience significant underinvestment in the decade preceding the pandemic, the systems and structures in place previously to promote collaboration and partnership working were dismantled and neglected across the same period as a consequence of policy. The impacts of this dismantling and underinvestment were exposed and further exacerbated during the pandemic as schools and other services for children faced significant barriers to meeting the needs of children and co-ordinating their activities.

97. Responsibility lies with the Department for Education and across Whitehall, and proper preparedness for whole-system civil emergencies should have much better considered the context and readiness of the education system – to help protect children, to educate them, and to support non-pharmaceutical interventions for the safety of children, the workforce of keyworkers, and the wider community – and risk management on a much more significant scale.

98. Covid-19 arrived in the midst of established crises in teacher supply, workforce wellbeing and workload, funding, and pupil mental health. Class sizes had been increasing, and classrooms were often too small, in dilapidated buildings, many without basic services such as adequate ventilation. Research by the Institute of Fiscal Studies revealed that between 2009-2010 and 2019-2020 funding per pupil fell by 9% in real terms [KB/58 - INQ000145945]. It was not uncommon for many school buildings to have understrength facilities, be in poor states of repair, and with insufficient funding sources to address such problems. The NEU's '*State of college and school buildings*' survey had 36% of respondents noting poor ventilation in their college and school workplaces [KB/59 - INQ000145946]. There were limited resources of PPE – most critical in special education – and an expensive, largely privatised, system of recruiting supply teachers when the permanent workforce was absent. Government preparation for this type of civil emergency seemingly did not understand that schools could lose income (e.g. from letting out

buildings), stretching their resources further. There was no national infrastructure for using technology to educate outside of school sites and overstretched staff hadn't been given the skills to design or deliver such. It had become increasingly difficult to access specialist support from non-teaching children's services – whether in children's social care, education psychology, or through children and adolescent mental health services. The system of school/college qualifications had been deliberately rebuilt since 2010 in ignorance of the significant need for contingencies and managing exceptional circumstances. Ministers were disinterested in the benefits of expertise from the profession that trade unions could provide and maintained, at best, very limited industrial relations.

99. Whilst acknowledging a recent boost to the schools budget, none of these issues show any signs of being properly addressed soon – making Inquiry findings and recommendations that may highlight ongoing exposure to risks and impacts of a 'whole-system civil emergency' all the more important.

100. School staff were left massively exposed – to virus transmission; to stress; to needing to reconceive their jobs; to taking on tasks of wider public services, such as Covid testing; to supporting children and families in poverty; to difficult community relations and tensions; and to effectively educating the pupils they care about so much.

101. It is right to ask what more government could have done before the start of 2020 that might have reduced systemic weaknesses and avoided some, or all, of these problems.

F. PLANNING FOR THE PANDEMIC

102. In this section I address some more specific issues relating to pandemic preparedness, namely:

- The foreseeability of the pandemic
- Consultation with unions on pandemic planning
- Fire and rescue services
- Railways

- Availability of PPE across sectors
- Role of the TUC in respect of preparedness

Foreseeability of the pandemic

103. The pandemic was certainly a foreseeable event. Since 2008 the Cabinet Office, which is responsible for civil contingencies, has published the National Risk Register. There had been six revisions by the start of the pandemic. It sets out the "*assessment of the likelihood and potential impact of a range of different risks that may directly affect the UK*". The first National Risk Register (2008) [KB/35 - INQ000103574] stated, with some accuracy:

> *Experts agree that there is a high probability of another influenza pandemic occurring, but it is impossible to forecast its exact timing or the precise nature of its impact. Based on historical information, scientific evidence and modelling, the following impacts are predicted:*
>
> *• Many millions of people around the world will become infected causing global disruption and a potential humanitarian crisis. The World Health Organisation estimates that between 2 million and 7.4 million deaths may occur globally.*
>
> *• Up to one half of the UK population may become infected and between 50,000 and 750,000 additional deaths (that is deaths that would not have happened over the same period of time had a pandemic not taken place) may have occurred by the end of a pandemic in the UK.*
>
> *• Normal life is likely to face wider social and economic disruption, significant threats to the continuity of essential services, lower production levels, shortages and distribution difficulties.*

104. In 2008, out of the 12 main risks assessed, an influenza pandemic was assessed as having the largest relative impact and fifth greatest likelihood.

105. The 2017 edition [KB/36 - INQ000103575], operative at the beginning of the Covid-19 pandemic, had a substantial section devoted to human diseases. Pandemic influenza was still regarded as the highest risk for impact and was joint highest for likelihood. It stated

that *"the emergence of new infectious diseases is unpredictable but evidence indicates it may become more frequent"*. The strategies listed to respond included:

> *Personal protective equipment - emergency responders have personal protective equipment for severe pandemics and infectious diseases. There are also protocols in place for infection control both before and during an incident.*

Consultation with unions on pandemic planning

106. In 2017 Public Health England produced a report on pandemic preparedness called Exercise Cygnus [KB/27 - INQ000103566]. Exercise Cygnus was a command post exercise delivered by Public Health England on behalf of the Department of Health. The exercise was designed to assess the United Kingdom's preparedness and response to a pandemic influenza outbreak.

107. Findings in this report indicate that the risk of pandemics should be one that requires cross-government planning given the potential to impact every sector. The UK's preparedness and response, in terms of its plans, policies and capability, was found to be insufficient to cope with the extreme demands of a severe pandemic that will have a nation-wide impact across all sectors.

108. The report goes on to give specific recommendations, for example the Department for Work and Pensions to examine the health and safety issues around an employer's duty of care to staff in specific sectors (e.g. healthcare, prisons, poultry workers), including provision of appropriate PPE where relevant.

109. The Cabinet Office and many other Government departments were privy to recommendations in this paper, yet we are not aware of any unions having been consulted on Exercise Cygnus and we are unaware if any of the recommendations in the report had been acted upon prior to the pandemic especially with reference to health and safety recommendations and cross government pandemic planning.

110. Following the Civil Contingencies Act 2004 much of the responsibility for emergency preparedness was shifted towards Local Resilience Forums, but I am not aware of any meaningful engagement by such Forums with our member unions.

Fire and rescue services

Fragmentation and austerity

111. The post-war fire sector was governed by the Fire Services Act 1947 and overseen by the Home Office for the whole of the UK. The 1947 Act created minimum staffing for fire brigades (known as establishment levels), which meant local fire authorities could not reduce fire cover without the permission of ministers. The Act created the Central Fire Brigades Advisory Council (CFBAC) as the statutory stakeholder body to provide ministers with expert fire advice. The CFBAC was chaired by the fire minister and included representatives from the Home Office, local government, chief fire officers, the FBU and other fire specialists.

112. At the turn of the century the fire and rescue service was subjected to so-called 'modernisation reforms', which fragmented the sector. The Fire and Rescue Services Act 2004 in England and Wales, with similar devolved legislation in Northern Ireland and Scotland replaced the previous statutory framework. This process introduced Integrated Risk Management Plans (IRMPs) and scrapped the fire inspectorate in England. Fire responsibility was transferred to the Department for Transport, Local Government and the Regions in 2001, then the Office for the Deputy Prime Minister (ODPM) in 2002 and finally the Department for Communities and Local Government (DCLG) in 2006.

113. At the same time the Westminster government introduced the Civil Contingencies Act 2004, which made the fire and rescue service a category 1 responder. The Act made it a statutory requirement for emergency responders to assess the risk of an emergency occurring, to publish plans to respond to an emergency and put in place business continuity management arrangements.

114. Ministers took their advice from the chief fire and rescue adviser (CFRA) in England to coordinate advice and guidance on fire and rescue matters. This was Ken Knight until 2012, followed by Peter Holland. The Chief Fire Officers' Association (CFOA) was given the lead on policy drafts, planning and implementation. The FBU was excluded from most official channels.

115. Responsibility for fire in England returned to the Home Office in January 2017. CFOA formed the National Fire Chiefs Council (NFCC) in April 2017. Her Majesty's Inspectorate

of Constabulary and Fire & Rescue Services (HMICFRS) extended its remit to include inspections of England's fire and rescue services in July 2017.

116. After the introduction of the Civil Contingencies Act 2004, a number of ad hoc committees were convened by chief fire officers.[2] These were voluntary, not statutory bodies, and by invitation. The FBU is not aware of how or even whether these meetings were reported to ministers and senior civil servants. If so, the likely route would have been through the CFOA.

117. Between 2007 and 2010, the FBU participated in the Fire and Rescue Service Health and Safety Group. The group was made up of representatives from the FBU, CFOA, Local Government Association (LGA), Welsh Local Government Association, Scottish Executive, Institute of Fire Engineers, UNISON, HSE, the chief fire and rescue adviser's unit (CFRAU) and the Fire Service College. The meetings were chaired by Mark Smitherman, chief fire officer in South Yorkshire Fire and Rescue Service. The group discussed pandemic flu as a priority during this period.

118. Accordingly, it appears that, during those years, some planning and preparation took place with fire and rescue to tackle the risk of pandemic flu. However, this appeared to have ceased in 2010. The FBU is not aware of any further meetings about pandemic planning and the fire and rescue service. It would be helpful for the Inquiry to request records from the CFRA, CFOA and the NFCC from 2005 until 2020, so that any of their preparedness planning for pandemics can be examined. If discussions were held, there appears to have little or no communication with the FBU regarding preparedness, including the training of firefighters. This left fire and rescue poorly prepared for Covid-19.

119. The agenda in fire and rescue changed dramatically when the coalition government took power in May 2010. The imposition of austerity cuts, the attack on pensions and within fire and rescue, the Fire Futures project,[3] cut across these early efforts at national resilience.

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[2] These were convened in the place of the Central Fire Brigades Advisory Council (CFBAC) which had been created under the Fire Services Act 1947 as the statutory stakeholder body to provide ministers with expert fire advice. It was chaired by the fire minister and included representatives from the Home Office, local government, chief fire officers, the FBU and other fire specialists.

[3] A Home Office commissioned review into the fire and rescue service.

120. As with a range of other services addressed above, austerity has deprived the fire and rescue service of the resilience it needs to respond effectively to a crisis such as the pandemic. The FBU made numerous, explicit public warnings about the consequences of job cuts for national resilience and public safety. In autumn 2010, the FBU warned the Westminster government of the consequences of austerity. The FBU's submission to the Comprehensive Spending Review (September 2010) stated [KB/37 - INQ000103576]:

> *The fire and rescue service has to be ready for an emergency, national or local, 24/7 and 365. Whether it is a fire or a flood, terrorist attack or explosion, the public rightly expects that professionals will be available to deal with the situation. We cannot predict the future; but we do know that there are many challenges on the horizon that can be foreseen and planned for now.*

121. On 20 October 2010, ministers published their spending review. The FBU's press release warned that ten thousand fire service jobs were under threat from central funding budget cuts. Matt Wrack, General Secretary of the FBU, said [KB/60 - INQ000145947]:

> *This government seems intent on imposing cuts that will wreak havoc within the fire and rescue service and short change both the public and firefighters.*
>
> *These pernicious cuts must be fought to defend public safety. They are not inevitable, but politically driven. The FBU will oppose these draconian attacks on an essential frontline service and robustly defend the key role firefighters play in keeping communities safe.*
>
> *We cannot just meekly roll over and accept this. Neither should the employers. Firefighters are professionals – and we won't stand by and see our service dismantled piecemeal.*

122. The FBU repeatedly warned ministers over the next decade that central funding cuts would lead to savage cuts in firefighter jobs, weakening national resilience, emergency response and putting public safety at risk. In September 2014, the FBU's 'Sounding the Alarm' report [KB/38 - INQ000103577] stated:

> *Since the coalition government came to power over 5,000 frontline firefighter jobs have been cut across the UK, threatening national resilience…*

The FBU has been accused of 'scaremongering' when our representatives have highlighted the threat these jobs cuts make to national resilience. However even chief officers are now warning that any further reductions to fire and rescue service funding will compromise our ability to resource the national resilience requirements… This confirms FBU warnings that cuts are threatening national resilience.

123. Shortly before the start of the pandemic, in October 2019, the FBU made a submission to the Treasury ahead of the budget on 6 November 2019. The FBU warned ministers [KB/39 - INQ000103578]:

Since 2010, around 12,000 firefighter jobs have been cut across the UK – almost one-in-five (20%) of the total number of jobs. This is a travesty, without precedent in the history of the fire and rescue service.

124. The FBU repeatedly made representations to MPs in the form of lobbies, briefings, publications and bulletins on resilience matters. The FBU has published annual job cut figures in the FRS Matters bulletin. While the FBU did not anticipate nor warn specifically about the scale of the Covid-19 pandemic, the union did warn of the consequences for national resilience of cuts and other central government policies.

Failure of ministerial oversight

125. Under the Fire and Rescue Services Act 2004 the Secretary of State was required to produce a National Framework. This was touted as a strategic plan outlining how targets and other objectives are to be delivered. The first Fire and Rescue National Framework in England (2004) [KB/40 - INQ000103579] stated that the government was *"responsible for setting clear priorities and objectives for the Fire and Rescue Service".* The National Framework would do this by making clear: (a) the government's expectations for the fire and rescue service; (b) what fire and rescue authorities are expected to do; and (c) what support government will provide.

126. The first National Framework did explain that fire and rescue services should establish business continuity management arrangements, so that an authority can function in an emergency. However, it is striking that there was no mention of the risks of pandemic flu, despite the recent experience with Severe Acute Respiratory Syndrome (SARS) in 2002-03. The National Framework is revised biennially, so there have been numerous changes over the years. These strategic plans have been much reduced in length since the early

publications. More importantly, none of the National Framework documents have highlighted pandemics as a strategic priority for fire and rescue services in England to manage.

127. Under Section 25 of the Fire and Rescue Services Act 2004 the Secretary of State is required to provide the Westminster parliament with a biennial report on how well fire and rescue authorities are meeting their statutory responsibilities. Although fire and rescue authorities are implored to have effective business continuity arrangements in place, these reports have been very brief and blithely signed off. The paucity of recent Section 25 reports is visible in successive editions. Again, none highlight pandemics as a significant risk that fire and rescue services are equipped to tackle.

FBU warnings on resilience and failure of localism

128. The modernisation agenda introduced in 2004 included the introduction of local Integrated Risk Management Plans (IRMPs). These were promoted as a major improvement to fire and rescue service resilience. The assumption was that these local IRMPs would sit beneath the structure of the national risk assessment and the national risk register. The operative term was that "risks" would be fully evaluated. Instead, the process has often ignored or downplayed national and local risks, while allocating an ever-smaller quantity of "resources" as best they could. Local IRMPs have a range of titles, including Community Safety Plan, Corporate Risk Management Plan, Safety Plan and Strategic Plan. They also cover different periods of three to five years, illustrating the fragmentation.

129. In 2006, the FBU warned ministers and the ODPM Select Committee of the problems with the new fire safety regime. The FBU's memorandum warned [KB/61 - INQ000145948]:

> *A central fault line in current national resilience planning is that IRMPs allow fire & rescue authorities to "manage" their local risks and in some instances contemplate and carry out significant cuts in personnel. We see little evidence that they are assessing risk and planning their levels of personnel with any view to the national need to be capable of responding to a series of protracted major incidents. And we see little evidence that ODPM is giving sufficient, if any, guidance on this matter; guidance that*

is urgently needed before the collective national response capability of the service is degraded any further…

There needs to be a meaningful review of the stakeholder consultation process. In its haste to rid itself of the national committee structure covered by the Central Fire Brigades Advisory Council, the ODPM had little or no idea of what it would do to replace the functions that the CFBAC covered, including the creation of policy documents that all organisations were signed up to. The national structure no longer exists leading to disputes which are breaking out across the fire and rescue services in England.

130. In late 2012, fire minister Brandon Lewis commissioned the recently retired chief fire and rescue adviser Ken Knight to produce an "efficiencies" review. His report, Facing the Future, which the FBU called a fig-leaf to justify austerity, was published in May 2013. It was the subject of an inquiry by the CLG select committee at Westminster. The FBU's submission to the select committee inquiry stated [KB/62 - INQ000145949]:

1.15 Over the last decade the service has increased its role and function significantly. Only since 2008 have national risks been assessed and drawn together in the National Risks Register. Since the advent of the Civil Contingencies Act, fire and rescue authorities have responsibilities to involve themselves in Local Resilience Forums and to create and update the Local Risk Register for their area. Fire and rescue services are required to address the risks and to account for their operational response arrangements within their IRMP.

1.16 There is no evidence of any fire and rescue services carrying out their requirements to assess, and report their planning assumptions. The [Knight] Review makes no comment on this matter and makes no impact assessment of the ability of fire and rescue services to meet their response requirements.

131. On 9 September 2013, Matt Wrack gave oral testimony to the select committee. Asked about Knight's claims that national resilience had not been affected by austerity, Wrack told MPs [KB/41 - INQ000103580]:

Yet again I cannot see how Ken Knight can reach that conclusion. If you reduce significantly the resources the fire and rescue service has in terms of fire engines, firefighters and their availability, then you must impact on your ability to respond to major incidents. A related question is: how does Ken Knight know? How does the

Minister know? Who is doing any monitoring? For example, for a local IRMP that might decide to close a number of fire stations, who is doing centrally any measurement of the impact of that on planning nationally for resilience? I am not convinced anyone is doing it…

132. The FBU's Comprehensive Spending Review submission (September 2015) mentioned "Pandemic influenza and related outbreaks of disease" as one of eight risks in the National Risk Register that the fire and rescue service may have to tackle [KB/42 - INQ000103581].

133. In April 2020, the FBU examined the most recent local IRMPs [KB/43 - INQ000103582]. The FBU's analysis found that 30 out of 50 (60%) did not even mention "pandemic" or "flu" as a risk. Almost all of those that did simply referred to the national risk register or local resilience forums. The terms generally only appear once or twice in documents sometimes 50 pages or more in length. None set out the detailed steps that would be taken in the event of a pandemic. None appeared to reference a separate pandemic plan.

134. The FBU believes that planning for emergencies should take place before the emergency occurs. This should have been the guide for the fire and rescue service and for all public services in relation to the threat of a pandemic or any other national emergency. The public will rightly want to know what their local fire and rescue service has done in advance to prepare for pandemics. There is little information in IRMPs to reassure people that such planning has taken place, at best only promises that it ought to have been undertaken.

Railways

135. From as early as 2006, Network Rail, and later also the Rail Delivery Group (a leadership body established to take responsibility for coordinating and leading on cross-industry initiatives), provided guidance for passenger train operating companies and Network Rail Routes on the planning for and implementation of contingency arrangements in the event of an influenza (flu) pandemic. I exhibit Issue 4 of the Guidance Note, dated October 2019 [KB/44 - INQ000103583]. The Guidance Note highlights the importance of planning well in advance of a pandemic, including with regard to stockpiling supplies necessary for maintaining personal hygiene at work and identifying key roles, processes

and procedures that might be required in the event of a pandemic. However, the thrust of the guidance is largely that train operating companies should follow Government advice and guidance "whenever that is available". This appears to have been the approach adopted in the Covid-19 pandemic, therefore the railways were reliant on the Government to be able to issue appropriate advice and guidance. However, rather than such guidance being issued to assist in planning and preparedness, in practice it was not available until the effects of the virus were already beginning to take hold.

136. Privatisation on the railways has created a hybrid system in which a high level of central government direction and control is combined with fragmented service delivery. In practice, there is an inability to deliver central coherence in its core service and there is little resilience to shocks. Private train operators attempt to drive out cost and raise profits by de-staffing the network. Since 2011, the government has attempted to support this process by putting financial pressure on Network Rail to cut its maintenance regimes and by supporting or pushing moves to close ticket offices and encourage operators to move to 'Driver Only Operation'. The net result is a rail system with little resilience, liable to break down at any time, as in 2018 when an attempt to introduce a new timetable led to the near collapse of the system.

137. In 2009, the National Union of Rail, Maritime and Transport Workers (RMT) warned about the staffing and safety risks posed by the 'swine flu' pandemic [KB/63 - INQ000145950]. Bob Crow, the then General Secretary of the RMT, highlighted the potential devastating impact the virus could have on transport services and how it might expose the shortage of staff and inadequate planning across such a fragmented system. Mr Crow demanded to see the contingency transport plans that the government had drawn up and for the RMT to be involved in future discussions on how to deal with the pandemic.

138. Without wishing to stray into future modules of this Inquiry, it appears that, despite these warnings, the same issues arose again with the Covid-19 pandemic.

The availability of PPE across sectors

139. That there were significant difficulties in health and social care staff getting access to adequate PPE is well known. It was not an unexpected requirement: an HSE study from 2008 concluded that FFP3-style masks were required in coronavirus-like exposures at work [KB/45 - INQ000103584]. Similarly, an HSE evaluation of PPE published in 2019 recommended that all healthcare workers should wear a gown, FFP3 respirator mask and

visor when dealing with High Consequence Infectious Diseases (HCIDs) [KB/46 - INQ000103585].

140. However, a BBC Panorama investigation in April 2020 found that vital items were left out of the stockpile in 2009 when it was set up. There were no gowns, visors, swabs or body bags in the Government's pandemic stockpile when Covid-19 reached the UK [KB/64 - INQ000145951]. The same report highlighted that the Government subsequently ignored warnings from its own advisors to buy missing equipment when the expert committee that advises the government on pandemics, the New and Emerging Respiratory Virus Threats Advisory Group (Nervtag), recommended the purchase of gowns in June 2020. These were in short supply during the first stages of the pandemic.

141. Panorama also revealed that millions of FFP3 respirator masks were unaccounted for with 33 million on the original 2009 procurement list only 12 million had been handed out by the point of the programme airing in April 2020.

142. Less high profile, but also of significant importance when considering preparedness for a future pandemic, is that there was a PPE demand across sectors. The CWU received numerous accounts from Royal Mail staff in 2020 that sourcing PPE was next to impossible, and that newly introduced safety regulations, such as social distancing, were in some instances non-existent. At Royal Mail sites in Barnsley and Wellingborough, reported outbreaks ended with several workers contracting Covid-19 and leaving at least two workers in hospital. These conditions meant that many CWU members at Royal Mail walked out due to feeling unsafe at work and some took unpaid leave for fear of infecting themselves or their family members.

143. This unacceptable situation was exacerbated by Royal Mail having dramatically reduced its health and safety operations since privatisation in 2013. The current team is less than a third of the size it was 10 years ago, which, despite good industrial relations with the company at the time, made responding to the Covid-19 pandemic more challenging. This coupled with the drastic reduction to the HSE budget over the past decade meant there was next to no chance of health and safety breaches being noticed by the authorities. The few health and safety inspections made of Royal Mail facilities throughout the pandemic only resulted in three 'fine for intervention' letters. When considering that Royal Mail is one of the biggest employers in the country, this speaks volumes to the lack of regulatory oversight regarding health and safety in the workplace.

144. Similarly, many low paid workers bore the brunt of the huge demand in warehouses delivering on-line shopping, with numerous reports of unsafe practices. For example, a Boohoo warehouse was reportedly described by staff as a breeding ground for the virus with no social distancing or PPE [KB/65 - INQ000145952], and similar reports were made about a JD Sports warehouse [KB/66 - INQ000145953].

The role of the TUC in respect of preparedness for future pandemics

145. The fragmentation of services delayed the ability to implement policies and resolve complex challenges, each time adding additional pressure and losses of capacity to a system that was already struggling to cope. Any future pandemic preparedness must tackle the issue of fragmentation and the detrimental 'silo working' that fragmentation can cause.

146. A failure to work and engage with trade unions as experts in workplaces, the workforce and health and safety meant that opportunities may have been missed to ensure key issues were considered and more robust plans were in place. With engagement. trade unions would likely have been able to play a positive role. Any such preparations in future must take this into account and engage trade unions in line with their unique and wide-ranging expertise.

147. In particular, there needs to be a specific role for those trade unions who bring a wealth of experience and expertise in workplaces with unique features or central roles in the delivery of care and treatment during pandemics, such as, but not limited to, health unions, education unions and transport unions. By involving such specialism, decision-makers could take greater account of the various realities facing such sectors.

G. CONCLUSION

148. For many years prior to the pandemic, the TUC and its member unions made loud protestations and warnings about the impact of funding reductions on public services, of fragmentation across numerous sectors, and of the government's approach to the HSE.

The government took little consideration of these warnings and the UK's pandemic preparedness has suffered as a result.

149. Trade unions have a clear role in, and can make a significant contribution to, not only pandemic preparedness exercises, but exercises relating to all major events and incidents that require public services to assist in response. This is also the case for any such exercises that would have to consider workplace health and safety to mitigate against infections or any other risks to workforces.

150. Put simply, a decade of underinvestment in and fragmentation across our public services, and a failure to heed the warnings of the consequences, led to a situation where the UK was not in the position it should have been to tackle the pandemic.

151. It is imperative the Inquiry does not ignore or fail to grasp the significance of these decisions. It should not be afraid to make recommendations about safe minimum levels of funding, to highlight the damage caused by fragmentation and to recommend that future pandemic planning must involve the expertise of trade unions.

Statement of Truth

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

Signed: Personal Data

Kate Bell

Dated: 21 April 2023