Monday, 17 July 2023

(10.30 am)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: Good morning, my Lady. May I please call Kate Bell and Gerry Murphy.

MR GERRY MURPHY (affirmed)

MS KATE BELL (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS BLACKWELL: Thank you both for the assistance that you've so far given to the Inquiry, and for coming to give evidence this morning.

Ms Bell, if I can turn to you first, please, you have provided a witness statement which is at INQ000177807. It's dated 21 April of this year, and can you confirm, please, that it's true to the best of your knowledge and belief.

MS BELL: I can.

MS BLACKWELL: Thank you.

Mr Murphy, your witness statement is at INQ000177806. It's dated April and, again, can you confirm that it's true to the best of your knowledge and belief?

MR MURPHY: I can.

MS BLACKWELL: Thank you very much.

Whilst you're giving evidence, please keep your

voices up, speak into the microphones so that the stenographer can hear you for the transcript. If either of you would like a break at any time, please just say so, but we will break throughout the course of your evidence at least once.

Ms Bell, you are the assistant general secretary to the Trades Union Congress. The TUC was founded in 1868 and, as you tell us in your witness statement, brings together 5.5 million working people which make up its 48 member unions from all parts of the United Kingdom.

Do you have members, therefore, in England, Wales, Scotland and Northern Ireland?

MS BELL: We do, and just to start, can I say thank you for the opportunity to give evidence to the Inquiry.

MS BLACKWELL: Not at all, thank you very much.

You've provided a very helpful document, which we can see at INQ000103540, which sets out the broad range of sectors and professions covered by the TUC's 48 member unions. As we can see, as we scroll through this document, they come from a very wide range of professions: mobile civil aviation workers, workers in the food industries, chartered physiotherapists, teachers, lecturers, fire and rescue workers, the hospital doctors' union, musicians and performers, building society workers, journalists, copywriters, coal

mining people, footballers, radiographers and academics, and the Writers' Guild of Great Britain being represented as well.

Can you tell us a little about what the TUC does, its purposes and its aims, please.

MS BELL: Thank you.

So thank you again for the opportunity to give evidence. I just want to recognise the sacrifice that so many of our members made during the pandemic across all of those industries that you mentioned. Many of them were affected.

So the TUC exists to represent working people across the economy. We co-ordinate unions, we provide them with services, whether that's education services or services around the development of union services, and we also represent those unions, whether that's to government or to other decision-makers in society.

So we aim to provide a voice for working people right across the economy.

Just to pick up your question about those members we represent, so we represent workers right across the UK on matters which are not devolved, and that includes in Wales. There's a separate Scottish TUC and workers in Northern Ireland are of course represented by the Northern Ireland Committee of the Irish Congress of

Trade Unions, represented by my colleague here today, Gerry.

MS BLACKWELL: Thank you.

You mentioned Wales there. Your statement to the Inquiry has been served on behalf of the TUC and also the Wales TUC; is that right?

MS BELL: That is right.

MS BLACKWELL: And WTUC Cymru has 48 member unions and represents 400,000 workers; is that right?

MS BELL: That is correct.

MS BLACKWELL: Is the WTUC run along the same lines? Does it have the same purposes and aims as the TUC and is there a great level of interconnection between the two organisations?

MS BELL: Absolutely. So the Wales TUC does form part of the UK TUC, but of course has its own devolved structures and general council and decision-making and representing directly to the Wales Government as well.

MS BLACKWELL: Thank you very much.

Mr Murphy, coming to you, you are the incoming assistant general secretary of the Irish Congress of Trade Unions, the ICTU; is that right?

MR MURPHY: That situation has changed slightly, in that I'm now the assistant general secretary of the Irish Congress of Trade Unions and have been so from 13 March

this year.
MS BLACKWELL: All right, thank you very much.
The Congress is the largest civil society organisation on the island of Ireland; is that right?
MR MURPHY: That is correct. We are 800,000 people, we represent 800,000 people across the island, 200,000 of which reside in Northern Ireland.
MS BLACKWELL: Are there currently 44 unions affiliated to the ICTU, which -- again, you've provided a very helpful document that lists them. It's at INQ000108532. If we can scroll through this document, please, we can see, as with the previous document, there are a great range of organisations represented: teachers, nurses, prison officers, transport salaried staff, Veterinary Ireland is represented, and also USDAW.
Can you confirm what the ICTU has as its purpose and its aims, please?
MR MURPHY: The ICTU's purpose very largely mirrors that of the Trades Union Congress in England and Wales and indeed Scotland and Wales. We represent and advance the interests of working people, we negotiate national agreements when empowered to do so by the constituent unions, we promote the principles of trade unionism, we seek to assist and develop the capacity of our affiliate trade unions and we seek to regulate relationships

between those trade unions, and indeed between those trade unions and government.
MS BLACKWELL: How closely related is the ICTU to the TUC?
MR MURPHY: We're very closely related to the TUC and, indeed, to the STUC and the Welsh TUC as well. We meet formally on an annual basis in a body called the Council of the Isles. Indeed, over the course of the pandemic, we met more frequently than annually. We met virtually weekly.
In addition to that, we work very well informally together, there's a lot of exchange on a very regular basis on an informal level between the organisations.
MS BLACKWELL: Thank you.
Now, as you've both made reference to the Scottish Trades Union Congress, I just want to pause for a moment.
My Lady has received a statement from Rozanne Foyer, who is the general secretary of the STUC, which we can see is on screen now. It's at INQ000180759 and it's a statement which is dated 27 April of 2023.
Now, Ms Foyer is unable to attend today to represent the Scottish Trades Union Congress, but I would seek permission, my Lady, for her statement, together with the statements of Mr Bell and Mr Murphy, to be published. Thank you.

She says in her witness statement that:
"The STUC is an Independent Trade Union Centre to which independent trade unions affiliate their Scottish membership."
It represents over 545,000 trade union members in Scotland from 42 affiliated trade unions and 20 trade union councils.
She goes on to say that:
"The STUC maintains a formal relationship with the TUC, Wales TUC and the Irish Congress of Trade Unions through the Council of the Isles."
As you have already made reference to, Mr Murphy.
"The STUC works in partnership with the TUC on non-devolved areas of policy. The STUC also lobbies and campaigns directly with Westminster on UK non-devolved policy issues when deemed necessary or appropriate by our affiliates."
Thank you, we can take that down, please.
I want to begin my questioning by first of all coming to you, Ms Bell, and touching upon the fragmentation of public health institutions and the consequent effect on resilience.
The Inquiry has heard evidence about the complex restructuring of health and public services in England which occurred as a result of the implementation of the

Health and Social Care Act of 2012 and the consequences of that, including the fragmentation of the public health services.
Did Unite, which is one of your member unions, report to the TUC in 2015 that many of its fears about the wholesale transfer of public health to local government in 2013 were being realised? And if so, what detail did they give you about the effect that had taken place in relation to fragmentation?
MS BELL: So yes is the answer to that question, and in 2015 we have evidence that Unite submitted to a select committee inquiry which talked about the fears it had raised. They said that those working in public health had reported swingeing cuts to public health services, reductions in staff terms and conditions, training and pay, poor morale and deprofessionalisation and loss of status; and of course that fragmentation was accompanied by sharp cuts to the public health body, a public health body which we also believe had an impact on pandemic preparedness.
MS BLACKWELL: Was there a concern about the divergence of the workforce, with non-medics moving towards local authorities and medics moving towards Public Health England and the NHS? This was something which my Lady heard about during the evidence of Dr Kirchhelle. Was

that reflected in the reports that the TUC began to receive, according to what your members were experiencing in relation to public services?

MS BELL: I think that fragmentation more broadly was certainly something that unions representing members in these services were reporting: both the fragmentation between public health authorities and of course the NHS, but also the broader sense of fragmentation following the Health and Social Care Act.

This was something, again, that the TUC had raised in submissions. So, for example, in our 2015 submission to the comprehensive spending review, we talked about increasing fragmentation. We said:

"... the government's top-down restructuring of the NHS and a prolonged funding [squeeze] have created endemic financial stress throughout the health service which is leading to a deterioration of outcomes for patients."

Again, we talked around the fragmentation and complexity of commissioning.

So that was, again, throughout public health but also across kind of the wider NHS services.

MS BLACKWELL: What reports did you get about concerns around the status and independence of directors of public health following the implementation of the Act?

MS BELL: I don't think we have direct -- I don't have evidence of direct concerns around the independence of public health officials, but we do have some concerns here around plans to scrap strategic health authorities. So in 2011 Unison's head of health, Karen Jennings, said that the union was very concerned about plans in the Health and Social Care Act to scrap strategic health authorities, and she says they played a key role in co-ordinating the response to issues such as swine flu, monitoring standards and overseeing workforce issues. So I think when it comes to the strategic level, those are the concerns we have evidence of being raised.

MS BLACKWELL: Dame Jenny Harries has provided evidence to my Lady that the divergence of the workforce was occurring even before any budgetary changes, and that clinical capacity was a declining resource. She also said that fracturing of the links between public health specialists and NHS colleagues was something that she recognised as a recurrent theme every time there was a change in the system. She did acknowledge, however, that it was particularly difficult over this period of time.

Is that something that you recognise through reports that you were getting from your members?

MS BELL: I think that is an accurate reflection of what our

reports were telling us, and I think it is of course, as you say, difficult to separate the impact of those significant cuts to the public health budget -- and, you know, our members have cited the analysis by The Health Foundation showing that public health was cut by 24% per capita in the latter half of the decade, and I think certainly the impact of cuts coupled with the impact of fragmentation is what our members were reporting to us at the time.

MS BLACKWELL: In terms of the impact upon your members of the fragmentation and also budgetary cuts, which we will come to, what did they tell you about both the mental and physical resilience, particularly of the NHS workforce, in the years leading up to the pandemic?

MS BELL: Do you mean to refer to the NHS workforce more broadly --

MS BLACKWELL: Yes.

MS BELL: -- as opposed to just in public health?

MS BLACKWELL: Yes.

MS BELL: I think we have significant evidence of the impact of severe cuts on that NHS workforce. To give one example, the TUC surveyed 1,000 NHS staff in the run-up to 2016 and, to give you one finding from that, 88% of NHS staff said the health service was under more pressure now than at any time in their working lives,

and I think if you think about the impact of that stress, that reduction in resources, the impact of the decade of pay cuts that NHS staff experienced, so we know that the average NHS worker was paid £3,000 a year less in real terms than they were in -- at the end of the decade, in 2019, than they were in 2010, you can see that impact on their own well-being and morale of those pay cuts but also of operating in a service which was constrained, under significant stress, on their ability to do their job and the levels of stress they experienced on a day-to-day basis.

MS BLACKWELL: Do you have any comment to make on how that effect made them or may have made them less able to respond to what happened when the pandemic hit?

MS BELL: I think, you know, there is clear evidence of the workforce shortages on the ability to respond. I think, you know, even in 2019, Unison was saying half of NHS workers on the frontline of patient care say there are not enough staff on their shift to ensure patients are treated safely and with compassion, and I think you can see those impacts going through to the pandemic.

In our written evidence I think we raise issues around workforce shortages being identified as a critical barrier to increasing NHS capacity during the pandemic, for example, to staff the NHS -- the

Nightingale hospitals. And I think we also talk about work-related burn-out in that experience, additional pressures brought by Covid-19 -- you know, lack of ability to rest -- and those severe workforce shortages. Vacancy levels in the NHS had doubled during the period between 2010 and 2019 running up to the pandemic.

So I think we had a situation where NHS staff were already under significant pressure as we went into the pandemic. The lack of resilience for those staff, both in terms of their personal well-being but in terms of the capacity of the service, really was highlighted during the pandemic itself, and of course we continue to see those NHS staff under significant pressure today.

MS BLACKWELL: Well, let me ask you about the resilience of the NHS and hospitals in particular going into the pandemic, because the Inquiry heard last Thursday from Nigel Edwards of The Nuffield Trust, and he told my Lady that the UK has traditionally run with very low margins of spare capacity, and that in the years leading up to the pandemic, the number of beds in the NHS remained static whilst the population grew and aged, and he also said that, in terms of demand, that grew by 2% a year whilst the beds remained static, and the number of nurses went up by 0.2% over that period, which meant that hospital systems were highly constrained.

Does that accord with the information that you have received?

MS BELL: Absolutely. I think, you know, the Inquiry has heard widespread evidence about the impact of austerity on the health service, and I think it's important to note that the TUC was warning about this continuously throughout this period.

In 2016, we published a joint report with the NHS Support Federation, which was called *NHS Safety: Warnings from All Sides*, and that set out an unprecedented series of warnings raising the alarm about pressures on the NHS. That was from a wide range of organisations, and it talked about how it was common for health organisations to report that staffing was below safe levels and that low levels of funding increase from the government were leading to, I quote "short-term fixes that ultimately ... increase the cost of healthcare". That report brought together evidence from a wide range of organisations. Our own member unions reporting those significant pressures, but also professional organisations, The Nuffield Foundation -- I think, from memory, The King's Fund were also included in that.

So I think there was very clear evidence that the NHS was under pressure in terms of its capacity, in

terms of, as you said, bed space, but also in terms of staffing levels, and this was having a significant impact on the ability to cope with additional shocks.

MS BLACKWELL: You say at paragraph 41 of your witness statement that the TUC in their 2018 autumn budget submission referenced the latest quarterly monitoring report from The King's Fund, which stated 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 [that's as at 2018] compared with around 2.5 million in 2010."

But it wasn't just the amount of staff and capacity, wasn't it also the fact that there was an increasing amount of temporary staff? In that, I think we heard from Nigel Edwards last week that there were growing demands but there were many more people being employed on temporary contracts.

What effect does that have in terms of the workforce being able to respond to emergencies and an increasing level of demand?

MS BELL: Well, we know kind of across the whole workforce, not just in the NHS, that the use of temporary staff can add to additional pressures. Of course those staff will need extra time to familiarise themselves with ways of

working within the health service, with their colleagues, and have the understanding and trust that obviously builds up when you have been working with people over a long period of time.

I think just to give you a bit more of the evidence from that survey of NHS staff I referred to previously, they found that 69% of NHS workers said reductions in staffing and resources were putting patient care at risk, and I think that again relates to that big vacancy level, basically, that you were seeing, that doubling in vacancies, some of that being plugged by temporary staff, but that really -- you know, health workers reporting time and time again that this was something that was not only making their jobs more difficult but putting patient care and safety at risk.

MS BLACKWELL: Moving over to Wales, please, what were the key challenges faced by NHS Wales leading up to the pandemic? I'm thinking in particular in relation to funding and capacity.

MS BELL: So, as with the rest of the UK, ten years of austerity did have a damaging effect on public services in Wales, and the Wales TUC set out in 2019 some of the impacts of that.

At that point the Welsh Government's block grant was around 5% lower in real terms than in 2010/11 and, to

respond specifically on the NHS, that meant you had 6,000 fewer people working in the NHS at that time.

Obviously the Welsh Government did have the opportunity to make some different choices, we know that social care had some more protection during that period, and the Welsh Government did not impose the Health and Social Care Act; and I think in the evidence from the NHS Confederation you see a little bit around the impacts of that on kind of the ability to co-ordinate, but we did have those very significant reduction in the Wales NHS, those big staffing reductions and similar kind of reports of staff shortages being reported there.

MS BLACKWELL: Thank you.

Mr Murphy, I want to come to you now, please, and ask you about health spending in Northern Ireland in the ten years running up to the onset of the pandemic.

What do you say about the level of spending and how that might have affected workforce capacity and also surge capacity within the health organisations?

MR MURPHY: Before I answer that, can I just say that our experience overall very much reflects that which my colleague is after reporting for England and Wales.

MS BLACKWELL: Thank you.

MR MURPHY: In terms of health spending over that period, the per capita spend compared to England and Wales in

Northern Ireland over the period was 11 -- almost 11% lower than the spend in England and Wales over the same period. It was 5% lower than the spend in Scotland.

The consequences in terms of capacity are very much as has been previously described.

The impacts -- at a strategic level health and social care remained within the ambit of the Department of Health, so we didn't have that particular piece of fragmentation. But what did happen was that the health and social care was outsourced to private contractors, to provide, which did cause fragmentation to occur, as unfortunately we saw, you know, later on.

The impacts fall, I think, in two areas. There was the direct impact of that decade of austerity, if you like, on public health. So by the middle of the decade, for example, in 2016, we already had 400,000 people on waiting lists. That was in 2016. That number has increased subsequently.

We had large numbers of workers, for example, employed in the health and social care sector who were earning less than the real living wage. In 2020 that figure was still 55%.

So the -- I suppose, without repeating all of what my colleague has said here, the impacts, I think it's not understatement to say, were pretty negative.

MS BLACKWELL: One event, significant event, of 2016 was the publication of the Bengoa report, about which my Lady has heard, which stated at paragraph 22 that the:

"Health and social care systems in Northern Ireland and in other jurisdictions, are reporting severe difficulties in recruiting and retaining staff. There is a growing doomsday scenario of not having enough GPs, hospital consultants and junior doctors, nurses, Allied Health Professionals, and social care staff that will inevitably lead to people not receiving the care they need."

It also went on to say:

"In recent years there have also been stark increases in costs associated with the locum and agency staff to provide a safe service where it is not possible to recruit to permanent positions."

Again, is that something which you recognise, that there was a difficulty in Northern Ireland in recruiting permanent positions which meant that locum staff had to fit in?

MR MURPHY: Absolutely. Of course, yes, I do recognise it very much indeed. That issue, and the issue of provision of services and, you know, appropriate levels of staffing and safe staffing levels continue to be issued to this very day.

We began in 2010 as a Congress -- the Irish Congress of Trade Unions, in 2010 -- a campaign around jobs and services, we moved on with the second campaign in 2018 around the same issues, and we're currently on the third iteration of a campaign around jobs, services and funding.

In between times we consulted and, you know, made submissions on a number of programmes for government on the same subject. We currently have two -- a brand new acute hospital in Enniskillen with an ability to fill posts.

This -- you know, this is reflective also of the experience in England and Wales. Unite, for example, brought this to the attention of the British Government in 2011 in a submission they made. Unison, indeed, brought it to the attention of the Northern Ireland Executive in 2016 in a submission which they made, and, as I've already pointed out, we have been doing it as a Congress continuously really for a decade. So huge impacts again.

MS BLACKWELL: One of the issues as my Lady has heard about from several witnesses that pertained and continues to persist is the lack of ministerial oversight from time to time.

Robin Swann told my Lady that the lack of

an Executive between 2017 and 2020 had an adverse effect on the preparation of the health and social care system because it contributed greatly to inadequate staffing levels at the time, and key decisions couldn't be taken around those issues in the lack of any ministerial presence and oversight.

When he gave evidence, Mr Swann said that he was of the view that Stormont had let the NHS in Northern Ireland down because it hadn't looked after health and social care services as well as it could, and that vital services were underfunded, that short-term decisions were preferred over long-term planning, and that difficult choices were ducked.

Do you agree with the description that he gave to the Inquiry about how things were left to drift, if I can put it in that way, in the absence of any ministerial oversight?

MR MURPHY: I entirely agree with him, and I think we should all be very grateful to Robin Swann, not only for the work that he undertook over the course of the pandemic but for his frankness to this Inquiry.

It's particularly disappointing given that Rafael Bengoa had produced what was at that point the third iteration -- or the third reporting on the inadequacies of the existing health and social care

system in Northern Ireland. And compounding that, the minister at the time, Michelle O'Neill, had produced a report which had achieved something pretty unique in Northern Ireland circumstances insofar as everybody was bought in, so five political parties and the trade union movement generally all bought into the plan which had been brought forward. Then on -- in January of 2017 the Executive collapses and it's not possible to enact any of that.

So I would agree with the thrust of your question, yes.

MS BLACKWELL: All right, thank you.

Professor Sir Michael McBride also gave evidence to the Inquiry. He told my Lady that the health service in 2020 was not as resilient as it had been back in 2009, for a number of reasons, there were several contributing factors to the increased lack of resilience.

How resilient do you consider the NHS in Northern Ireland was going into the pandemic?

MR MURPHY: Going into the pandemic, it had already been on the receiving end, as indeed had the entire public service, of ten years of austerity. You know, that had saw, for example, over that period the recurrent budget fall by £177 million or 1.6%.

Given that health inflation is generally accepted to

run at approximately 6% per annum, you don't have to be a genius to work out that, you know, there have got to be negative consequences.

So it wasn't in a particularly good place, I believe, and the evidence would suggest that, indeed the evidence this Inquiry has heard would suggest that further.

So it wasn't in a good place. That's pretty evident and Rafael Bengoa references it in his report in terms of political -- or, sorry, medical health and social care inequalities. So it was pretty clear that, you know, those who were less well off were ... the actual reference point I think Bengoa uses is hospital admissions, so those from less well off areas, their hospital admissions were considerably more than those from more prosperous areas, shall we say. But that was manifested not only in that it was premature death, suicide rates, all sorts of negative indicators.

MS BLACKWELL: Thank you.

I'm just going to pause for a moment and move over to Scotland to see what Ms Foyer's witness statement says on these subjects. It's at INQ000180759. We can see, if we read from paragraph 13, that:

"At the start of the pandemic Scotland's health, social care, local authorities and other key public

services were already struggling. Staffing levels had been cut across devolved public services including the civil service, other public bodies, colleges, local government and schools. The UK Government's austerity programme slashed government spending across departments and reduced the Scottish Government budget year on year.

"14. Scottish Government spending decisions had also consulted in cuts to local authority budgets at a higher rate than the reduction to the Scottish Government budget. COSLA [that's the Convention of Scottish Local Authorities] represents local authorities across Scotland and reported in Fair Funding for Essential Services:

"'In the last 5 years, the Scottish budget has reduced in real terms by 0.4%. Local government budgets have reduced 10 times that much by 4%.'

"15. In the same publication, COSLA reported that:

"'The workforce had fallen by 15,000 in the last 5 years' and warned 'there is no room left for manoeuvre.'

"16. This evidence aligns with reports by Unison Scotland who conducted a series of surveys of members working in local government which showed the impact of the budget levels on services and workers. Unison Scotland represents over 150,000 members and is the

largest union in local government in Scotland. Unison reported that:

"'cuts to staffing and increased workloads are placing enormous strain on staff. The majority of members report that their workload is growing and that they are working long unpaid hours and skipping breaks to try and maintain a quality service ... [Morale] is very low, staff feel undervalued and exhausted by the efforts they put in to maintain services. The loss of business support staff means that many spend time on admin tasks when they should be focusing on other parts of their jobs which would provide a better service to the public. Salami slicing of services avoids headlines but the long years of austerity are having a severe impact on our services and the staff trying to deliver them with limited resources'."

Thank you.

Were the concerns in relation to what we have seen in NHS services also reflected in the social care sector?

I'll come to you first, Ms Bell.

Thank you, we can take that down, please.

MS BELL: Absolutely, and I think, you know, we've been long referring to a crisis in social care, and that happened significantly before the pandemic. To give you one

example, in 2016, GMB, a union which represents a large number of social care workers, presented a special report to their congress that talked about campaigning to prevent the collapse of social care, and that stated:

"The adult social care sector is under unprecedented strain and it is care workers and service users that are bearing the brunt of disastrous and wholly unacceptable trends in the way that care is funded, commissioned and provided."

I'm a member of the government's Low Pay Commission that hears evidence from social care employers and workers every year, and every year since 2017, at the point at which I became a member of that commission, we have heard both from employers within the social care sector and from workers themselves that the sector is in crisis, that terms and conditions are particularly poor.

To give you some specifics on the terms and conditions for the social care workforce, so that GMB report, using data from April 2015, found that a quarter of all care home staff were earning less than £7 an hour, and that's at a time when the national minimum wage was £6.50, so a very, very low paid workforce. Turnover rates across the whole sector were 25%, 30% for care workers, and a quarter of those workers, as is still the case today unfortunately, were on zero hours

contracts. So an underpaid, insecure workforce and one coping with significant funding pressures.

MS BLACKWELL: Thank you.

The Inquiry will hear this afternoon from Dr Jennifer Dixon of The Health Foundation. She has provided a witness statement which sets out the fact that, as the pandemic emerged, England's system of adult social care was underfunded and understaffed and that, when adjusted for an ageing population, funding per person fell by around 12% in real terms between 2010/11 and 2018/19.

She goes on to say that despite rising needs, fewer people were receiving support from local authorities over that period, and that workforce shortages were estimated at approximately 120,000, and that many care homes relied on agency staff working across multiple sites.

She describes that the organisation and delivery of social care in England was complex and fragmented.

Does that description sit alongside what you have received from your members?

MS BELL: Absolutely. I think you have that combination of factors: the sharp cuts in funding to local authorities, which have been described in our witness statement and of course throughout the Inquiry, affecting the funding

of social care; the fragmentation, so I think the National Audit Office found in 2020 there were 14,800 registered organisations providing care across 25,800 locations, so a hugely fragmented and diverse sector; and one which was not able to and was not paying its staff adequately or giving them the decent terms and conditions they needed.

I think one other impact of that I'd like to bring out in this evidence, if that's okay, is not just the impact of that insecure work, which, as the evidence you've heard from Professors Marmot and Bambra, is a key determinant of health, so impact of that insecure work on the care workforce, but also their lack of decent sick pay. So our evidence shows that those on zero hours contracts, again a quarter of the social care workforce on zero hours contracts, are much less likely to have access to decent sick pay. So around a third of those on zero hours contracts don't earn enough to qualify for sick pay when they fall sick.

We also had evidence throughout the pandemic, again highlighted by GMB, that many workers in the social care sector were not receiving contractual sick pay, so they were simply receiving the statutory minimum, and we have some evidence from Unison that when care workers asked for access to full sick pay funded by the government's

infection control fund, they were told, for example -- this is a quote from an employer writing to a social care worker:

"The law states it's not compulsory to pay it [that's full pay for self-isolation]. These are not my decisions. It's head office that decides it all."

LADY HALLETT: I'm sorry, we're moving on now, we're going way beyond the scope of Module 1.

MS BLACKWELL: My Lady, I was just about to invite Ms Bell to bring herself back to the period of time that Module 1 is concerned with.

I would, though, like to ask you about planning within the care home sector for infection prevention and control.

Before the pandemic hit, but accepting that some of the evidence that you will rely on has come to you since the pandemic hit, what level of planning and preparation have you come to understand was taking place within care homes in terms of infection control?

MS BELL: So we do not have evidence from unions that that planning was taking place, and I think, you know, it's been heard throughout the Inquiry that, following Exercise Cygnus, recommendations around pandemic preparedness within the social care system were not acted on, and I think we see this as a sign of the

low pay, the high turnover in staff, insecure work, and that sick pay issue was an issue as well, equally. So, as became clear as the pandemic unfolded, there was no planning or provision in respect, it would appear, to inspection of care home -- in the health and social care sector in particular in respect to care homes.

If I can just say, in another reflection of, you know, the impact of austerity, the Health and Safety Executive Northern Ireland would appear to have been badly under-resourced when it came to looking at and assessing risks going forward, although care homes particularly are -- specifically weren't their concern. But across the broader industrial employment landscape, the fact indeed that the Health and Safety Executive, even though it's allowed under statute to have three trade union representatives on its board, had none, meant that it was devoid of any vital evidence and intelligence which may have been possible for a workplace representative to provide to it.

MS BLACKWELL: Is there anything that you would like to add in terms of infection control and prevention and how that was being manifested within the care sector in Northern Ireland, in the run-up to the pandemic?

MR MURPHY: I have no evidence to offer in respect to that. I simply don't have -- we have nothing from our trade --

Cinderella status of the social care sector, that it had been underfunded and ignored throughout.

I thought it was very striking the evidence that was heard from Emma Reed showing that the Department for Health and Social Care had not prioritised plans prior the pandemic to augment adult social care and community care during the pandemic; and of course when the pandemic hit, recognising that this is outside the scope of this Inquiry, efforts to source PPE for staff working in social care homes were very difficult, and we saw some of the devastating consequences of that for staff and patients.

MS BLACKWELL: Is there anything that you would like to add in terms of the information that has come to you about the social care system in Wales, and in particular on any pandemic planning that was present or that should perhaps have been increased in terms of social care in Wales?

MS BELL: I don't have the evidence in front of me on Wales right now.

MS BLACKWELL: All right.

Coming to you, Mr Murphy, is there anything that you would like to add in terms of what was happening in Northern Ireland and were they facing similar issues?

MR MURPHY: The issues were virtually exactly the same. The

from our affiliated trade unions and nothing from our interactions with the Northern Ireland Executive at that time either.

MS BLACKWELL: All right.

Well, I'm going to return to Scotland momentarily, and ask that we look again at Ms Foyer's witness statement, in relation to which she says:

"In 2019 the Fair Work Convention published their report on social care in Scotland, *'Fair work in Scotland's Social Care Sector'*. The report outlined the main challenges in social care including the undervaluing of social care work, low pay and problems with recruitment and retention. The report reflected on the impact of austerity on the sector:

"'It is widely accepted that the social care sector is facing severe challenges due to austerity. It is also working to meet the needs of an ageing population that is living longer, but with more complex needs. Evidence taken by the social care working group was that 200,000 people receive adult social care services annually, with 100,000 people receiving half of the total health and social care budget: most are accessing many different aspects of the health and social care system'.

"19. Further the report detailed the complexities

in the mixed market economy of social care, the changed role of local authorities in delivering care and the challenges in commissioning and procurement where both voluntary and private providers reported budget pressures due to procurement processes. These factors led to a variety of challenges including a 'disconnect between strategic planning, service commissioning and procurement approaches' and a system that 'creates and relies upon competition has, according to some stakeholders, accelerated a "race to the bottom" as providers compete to win contracts'."

All right, thank you, we can take that down.

I want to move on to touch upon information that has come to your attention about gaps in PPE planning.

Ms Bell, the Inquiry has heard evidence about the pandemic stockpile and PPE will be the subject of more detailed analysis in a later module, but you deal in your witness statement with the lack of planning for PPE across sectors other than health and social care, and I would like to deal with that, please.

In particular, you touch upon the need for PPE amongst Royal Mail staff and the fact that several workers made contact to say that the planning for PPE in relation to that sector was substandard.

What do you have to tell the Inquiry about your

information in relation to that regard?

MS BELL: So our kind of evidence on the lack of planning for PPE beyond the healthcare sector is really evidenced by the experience during the pandemic. So we can't say -- it's difficult to talk about the absence of something.

MS BLACKWELL: Yes.

MS BELL: But the evidence we have from during the pandemic suggests that there was a lack of planning across other sectors. So, as you mentioned, our witness statement sets out the Communication Workers Union.

MS BLACKWELL: Yes.

MS BELL: They were receiving numerous accounts from Royal Mail staff that sourcing PPE was next to impossible, and of course they'd been designated as key workers who needed to continue working during the pandemic.

We also had evidence from the Prison Officers' Association. In March 2020, they warned their members that the Prison Service was planning to ration supplies --

MS BLACKWELL: Well, we --

MS BELL: Is that straying in --

MS BLACKWELL: We're straying in.

All that really you can assist my Lady with in this module is information that has come to your attention

about the lack of planning. If we're straying into Module 2, then I think we need to leave that until that module begins.

Is there anything that you would like to add, Mr Murphy?

MR MURPHY: Apart from the fact that we weren't consulted at any time about planning or PPE, the provision of PPE in the run-up to the pandemic.

MS BLACKWELL: All right. I think it's right to say that in her witness statement Ms Foyer confirms that the Scottish TUC received reports from trade unions at a very early stage in the pandemic about lack of planning of PPE. So that appears to be a general theme across all the nations. All right.

I want to now turn to the extent of the engagement between the government and various trade unions with respect to civil contingency planning. So I'm going to come to you first, Ms Bell, to see, from information which you have received from your members, to what extent did the government seek the views or draw on the expertise of your organisations, the TUC and the Welsh TUC, or indeed individually some of your members.

What information can you give my Lady about that?

MS BELL: So to the best of our knowledge there was no consultation or attempt to engage with trade unions or

the TUC regarding civil contingency planning.

MS BLACKWELL: At all?

MS BELL: Not as far as we're aware of.

MS BLACKWELL: Mr Murphy, what's your experience in that regard?

MR MURPHY: My experience unfortunately is exactly the same as that of my colleague. There was no attempt to engage as far as we are aware, no attempt to engage at Irish Congress of Trade Unions level or with individual trade unions.

MS BLACKWELL: All right.

Returning to you, Ms Bell, what, first of all, could the TUC have provided to the government by way of advice and assistance in relation to civil contingency planning?

MS BELL: I think we could have brought the voice of our workforce, who of course hold considerable expertise across the areas which are covered by that civil contingency planning. So of course we represent workers in the key sectors which are involved, and I think -- you know, hindsight is a wonderful thing but I hope we would have been able to bring their expertise to bear on some of the issues we've been talking about today: so, the pressures that those staff were already under, and perhaps their lack of capacity to respond to another

emergency; I hope that we would have been able to raise the fact that those workers -- workers beyond the health sector were likely to face an impact, recognising that healthcare workers travel to work, need to use community services; and to recognise the interrelationships between those workers, which is of course a core issue of the TUC.

And I think, you know, our experience is that the process of dialogue with the workforce, as is common in many other areas of public life, is one that normally reveals issues and the expertise of the workers on the frontline, and we hope that we would have been able to provide some of that insight and information.

MS BLACKWELL: All right.

And Mr Murphy?

MR MURPHY: Very much the same, and I think what I probably could add would be intelligence to that as well. I think it might have been extremely helpful to the Northern Ireland Executive to have had the insight from people on the ground, you know, who were providing the services directly. And I don't mean those managing, I mean, you know, at a level -- at levels below that. It would have been extremely helpful -- for example, you -- PPE was mentioned earlier, I think it would have -- the absence of PPE would have become apparent

much quicker had the actual workforce been involved in the preparing for the pandemic.

MS BLACKWELL: In terms of future preparedness, to what extent, Ms Bell, have things improved up until today's date in terms of consultation with the government and the TUC? Or what do you suggest might take place from today going forwards, and does the TUC recommend any particular areas in relation to which the government might reach out to you?

MS BELL: Certainly. So I think to start with that point about consultation and dialogue, we think that the process of social dialogue and regular consultation with trade unions should be a key part of how government does business normally, and that should include the process of planning for future emergencies, and we hope that the experience of our members throughout this pandemic, terrible experience for many of them, might be used to learn future lessons.

In terms of some of the lessons that we might bring to bear during that period, if I can go on to that, I guess the impact of cuts to funding on resilience, the impact on staff morale, resilience, their health, their mental health and their ability to respond to an emergency; the impact of a decade of cuts on those services we think is something they would bring to bear.

MS BLACKWELL: All right, but in terms of a joined-up, perhaps more formal level of contact between the TUC and the government, is that something that you can see working?

MS BELL: Absolutely. So there are some, still, social dialogue institutions within the UK where we have that formal process. I mentioned the Low Pay Commission. There are -- there is a health workforce forum which could provide one opportunity to do that. There may be other workforce forums, but we would imagine at the national level there should be a structured process of dialogue with unions and employers.

MS BLACKWELL: Can you explain to us how the workforce forums are set up and how the government might be involved in that?

MS BELL: So normally that would be a situation where the government meets on a regular basis with representatives of the trade unions. The TUC would normally suggest which unions might, you know, represent workers within the sector that's of particular relevance, and I guess the key points are regular meetings, a spirit of openness and collaboration, and a clear process for how government and unions themselves will act on those findings.

So that's the key -- the key system of a kind of

process of social dialogue that we would want to see in the context of emergency planning as well.

MS BLACKWELL: I think you've described how those forums are beneficial in other areas that the TUC looks at on behalf of its members. Is this something which is difficult to organise? Is it something which the TUC could assist to facilitate?

MS BELL: I don't think it's difficult to organise but the TUC exists, you know, to provide that kind of representative and that mediating function between government and unions, and, you know, it's absolutely our job and something we're very willing to do, to provide that forum to ensure there is access to representatives of the workforce.

MS BLACKWELL: Is there anything to suggest that your members would not be prepared to engage in workforce forums of that nature?

MS BELL: No.

MS BLACKWELL: No, all right.

Coming to you, Mr Murphy, do you agree with Ms Bell's suggestions, and is there anything in addition to that that you foresee as being beneficial in connecting the government to your organisation in terms of future civil contingencies planning?

MR MURPHY: I absolutely agree with Ms Bell that a formal

social dialogue mechanism to facilitate co-operation and joint working, if you like, between government and the trade unions is essential. Indeed, in Northern Ireland such a body was established in 2005 by the then Secretary of State, Paul Murphy. Unfortunately it didn't meet after 2016.

We campaigned and have continued to campaign pretty relentlessly on this subject. We think it would be extremely useful. It worked very well for our Welsh counterparts, it works very well for our Scottish counterparts, it works very well across mainland Europe in various countries, and we think it would work perfectly well for us.

There was a glimpse of how it might work at the very beginning -- and I'm hopefully not straying into Module 2 -- at the beginning of the pandemic, with the establishment of the Northern Ireland Engagement Forum, which was able in two weeks -- two weeks -- to produce two very important documents which then became the bedrock of the Northern Ireland Executive response in terms of workers and workforce.

MS BLACKWELL: Yes.

MR MURPHY: So there is examples of how it could work.

MS BLACKWELL: All right, thank you very much.

My Lady, I'm being invited to take a short break at

this stage. I appreciate it's slightly earlier than we would normally do so, but may we have our mid-morning break now, please.

LADY HALLETT: So when you said short break, you're talking about the usual break?

MS BLACKWELL: Yes, please.

LADY HALLETT: All right. 11.45, please.

MS BLACKWELL: Thank you.

(11.30 am)

(A short break)

(11.45 am)

LADY HALLETT: Ms Blackwell.

MS BLACKWELL: Thank you, my Lady.

Just before the break, we spoke about ways in which the government can connect with your organisations, both in terms of the TUC and in terms of the individual organisations that make up your membership, and we discussed the possibility of workforce forums.

The Inquiry heard on Thursday of last week from Melanie Field of the Equality and Human Rights Commission, who confirmed that, in her experience, during a crisis was not the best time to try and get everything right and have systems in place, and mechanisms, and indeed relationships, which can be used to connect and engage one with the other.

What other areas or procedures exist for there to be the provision of information from the TUC and your organisations to the government on issues of civil contingency planning, and is there anything in place at the moment that can be adapted in order to assist in matters of civil emergency, or are there any additional procedures that you think should be considered to make sure that there is a close connection between the government and the TUC and your member organisations?

MS BELL: To the best of my awareness, there are no procedures around civil contingency planning in particular. There may be some around the fire service and the ambulance service, but I don't have details of those now.

I think the normal ways in which government engages with us are through a formal process of consultation --

MS BLACKWELL: Yes.

MS BELL: -- where they will ask us to provide written evidence, perhaps to come to some meetings. But, in our experience, the best way to have continued and effective engagement is through the establishment of dedicated forums where the ability to not just provide information but to build relationships of trust and confidence can also be put in place.

MS BLACKWELL: I think before the break you also suggested

that another way in which the TUC could assist is telegraphing to the government the particular organisations that might be important in certain respects of civil contingency planning. Is that something that exists in other areas of the TUC's work, and do you find that to be an effective use of the TUC's time and energy?

MS BELL: Absolutely. So the TUC will often play a convening role, and I think, you know, the purpose and one of the benefits of having a peak level organisation of unions is that we do have that cross-economy view: we understand how transport workers may relate to health workers, or the particular needs of aviation workers with respect to emergency planning. And I think we're very willing -- you know, we exist to play that convening role and that's something we've done before and are very happy to do again.

MS BLACKWELL: Thank you.

Mr Murphy, is there anything that you would like to add?

MR MURPHY: Just to say I agree again with what Kate's after describing there. We, in Northern Ireland, had an opportunity, I believe, with the 2016 programme for government, which, as I referenced earlier, you know, was built around co-design, co-production, but

an explicit statement of outcomes. I think if and when we see a return to government in Northern Ireland, if that pathway was maintained with those principles in place, that would be extremely helpful. But we still need the formal mechanism to facilitate social dialogue between not only the trade union movement and the Northern Ireland Executive, but also broader civic society and indeed the employers.

So those two things -- and of course it would be essential that adequate funding would be put in place to facilitate that. We're not going to be able to achieve any of that if we continue to pursue this failed doctrine of -- sorry, that's straying into politics here, but --

MS BLACKWELL: Well, please don't stray into politics --

MR MURPHY: -- if we're going to continue with austerity.

MS BLACKWELL: -- Mr Murphy.

MR MURPHY: Yes.

MS BLACKWELL: All right.

My Lady, that concludes my questioning of both of these witnesses.

My Lady has provisionally provided permission for five minutes of questioning each from Scottish Covid Bereaved and also Covid Bereaved Families for Justice Northern Ireland.

So if that still persists, may I invite Claire Mitchell King's Counsel to put her questions on behalf of Scottish Covid Bereaved first. Thank you.

LADY HALLETT: Ms Mitchell.

Questions from MS MITCHELL KC

MS MITCHELL: I'm obliged.

We've heard evidence about the well-being of health workers this morning. You've talked about the additional stress that was caused by the ten years of austerity.

I want to ask you more broadly about workers perhaps with vulnerabilities, and we've heard in your evidence this morning about zero hour contracts, insecure work and the effects that they have on sick pay.

I would like to ask each of you: did the ten years of austerity pre-pandemic disproportionately affect the health of workers who had vulnerabilities, making the vulnerable more vulnerable when the pandemic arrived?

Perhaps if I can ask Mr Murphy first.

MR MURPHY: I think that's absolutely correct. What ten years of austerity did was it exacerbated existing inequalities right across society. So the working people, the families of working people and communities as a whole who were already suffering from economic inequality, health inequality, educational inequality,

and -- you know, all of those things were exacerbated as services receded in the face of government cutbacks.

MS MITCHELL: Can I ask the same question to yourself, Ms Bell?

MS BELL: Yes, absolutely. I think the extent of insecure work is something that had been highlighted frequently in the years in the run-up to the pandemic. You will remember the UK Government commissioned a report into the quality of work called the Taylor report, and widespread evidence was provided during the period of that work of the impact of poor quality work on people's health.

So the report states the quality of people's work is a major factor in helping people to stay healthy. That's also been highlighted in the evidence from Professor Marmot.

And I think our evidence on the extent of insecure work, well over 3 million people in some form of insecure work, shows that that has a particular impact on those already vulnerable in the labour market. So, to give you one example, our research then finding black workers twice as likely to be on zero hours contracts as white workers. So that quality of work issue exacerbating inequalities, which we know then lead to health inequalities in the wider population, which leads

to reduced resilience.

MS MITCHELL: Thank you.

LADY HALLETT: Thank you, Ms Mitchell.

Who is asking questions for -- Mr Fegan?

Questions from MR FEGAN

MR FEGAN: Yes, my Lady, Conan Fegan on behalf of the Northern Ireland team.

My questions are for more Mr Murphy and they relate to co-operation generally between the Northern Ireland Executive and the government of Ireland.

At paragraph 46 of your witness statement, Mr Murphy, you said that:

"The level of co-operation between the Executive and the government [of Ireland] was inconsistent and sporadic ..."

The first question relates to -- we've heard a bit about it this morning, about civic -- our civil dialogue, and what I would like to ask you is: do you think that the all-island civic -- or an all-island civic dialogue forum would support co-operation between the Northern Ireland Executive and the government of Ireland in addressing pandemic preparedness, and if so how?

MR MURPHY: Well, first of all, I do believe that an all-island civic forum would be extremely helpful or

would have been extremely helpful in preparing for a pandemic. There were existing and there are indeed existing areas of co-operation in the area of health on an all-island basis, children, pancreatic cancer services -- or children's -- sorry, paediatric cancer services being one example.

There's co-operation in the area of the provision of emergency services along the border in particular, and indeed along the border again there were example -- there was a short-term experiment around the provision of services by GPs.

So that was all helpful.

The Strand 2 elements of the Good Friday Agreement provide an architecture which would allow for the building of provision on an all-island basis, all of which would have been extremely helpful.

As the pandemic unfolded, there were what we describe as sporadic attempts to align, if you like, the response in the two jurisdictions. That wasn't entirely possible: there were different stages of lockdown, there were different stages of restriction, there were different processes at play at different times, and indeed different responses to data being produced as well.

So I think the short answer to your question is yes,

and the provision of such a forum would be extremely helpful and possibly one of the learnings that we may take from this.

MR FEGAN: Thank you, Mr Murphy.

The second question that I have relates to how trade unions across the border could co-operate, and it is: how have the trade unions in Northern Ireland and Ireland been involved in promoting co-operation on pandemic issues?

MR MURPHY: Pre-pandemic there wasn't any work to any significant degree in that area. Over the course of the pandemic and post-pandemic, that has improved. We are now about to see, for example, the unfolding of a very significant health project involving Unison and Fórsa, which is the second largest public service trade union in the Republic of Ireland.

So there definitely is scope for the trade unions to move into that space. It isn't possible or it wasn't possible pre-pandemic, but I think we've all learnt now that closer co-operation has to be, you know, something that we factor into how we prepare for civil emergencies, or pandemic, in the future.

MR FEGAN: Just to take up that theme, the final question is: how could co-operation between the Northern Ireland Executive and the government of Ireland be improved in

the future, in particular regarding pandemic preparedness and response?

MR MURPHY: Co-operation between the government in the Republic and the Executive in Belfast is a political question. I'm not going to go there, if you'd like --

MR FEGAN: You're declining, then, Mr Murphy?

MR MURPHY: But from a trade union point of view, I think the social dialogue mechanism that I referred to earlier is well established in the Republic of Ireland through the LEEF process. So I think we could borrow from them in that respect, and apply in the north, and that would, I think, greatly assist not only with the work of the trade union movement but would allow for increased levels of working across the economy as a whole.

MR FEGAN: Thank you, Mr Murphy, and thank you, my Lady.

LADY HALLETT: Thank you, Mr Fegan.

MS BLACKWELL: My Lady, that completes the evidence of Ms Bell and Mr Murphy.

LADY HALLETT: Thank you both very much indeed for your help.

MR MURPHY: Thank you, my Lady.

MS BELL: Thank you.

(The witnesses withdrew)

MR KEITH: My Lady, the next witness is Professor Philip Banfield of the British Medical

Association council, please.

PROFESSOR PHILIP BANFIELD (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

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

A. Yes, I'm Philip James Banfield.

Q. Are you in fact Professor Banfield, that's one of your qualifications?

A. Yes, it is.

Q. Thank you very much for your assistance and for the provision of your witness statement dated 12 April, INQ000205177, which you've signed, dated and affirmed to the truth thereof.

Professor, you are the chair of the British Medical Association UK council. What is the BMA council in the context of the British Medical Association?

A. So the UK council is the Executive body of the BMA, the BMA is both a professional association and a trade union.

Q. Have you in fact sat on the UK council since 2012, and were you before then a representative in the British Medical Association of BMA Cymru, Wales, for many years?

A. Yes, I have been.

Q. You are chairman of the board of directors, but you are by profession a consultant obstetrician and

gynaecologist; is that correct?
A. Yes, I am.
Q. You're an honorary professor in the Cardiff University School of Medicine?
A. Yes, I am.
Q. Now, you have prepared a witness statement in which you express views on the part of the BMA. Could you just make plain, please, the extent to which these views are not just your own personal views or not just your personal views alone but reflect the corporate view of the BMA as well as information and views which have been collated by the BMA through lessons learned exercises, the publication of a number of reviews which you have carried out, as well as trackers and surveys which you have conducted and call for evidence between November and December 2021. To what extent have you sought to engage your membership in the views which you express in your statement?
A. Yes, so I've been chair of council since July 2022. Previous to that I was the chair of the BMA Welsh consultants committee. All of the different specialities within medicine have committees that feed into the BMA centrally, within all the four nations. So, for example, consultants, public health medicine, occupational health medicine, ethics committees. And

these have done work in different areas that are relevant to this Inquiry and we have collated their work for this witness statement.

The BMA also commissioned, throughout the Covid pandemic, surveys of its members, as you have described, and then a call for evidence, because it was quite clear from our membership that they wanted early investigation of exactly what had gone on during the pandemic, not just for them but for the wider population.
Q. Does the BMA membership cover the whole breadth of medical practice, so, for example, it includes medical academics, medical students, as well as the particular specialities to which you made reference?
A. Yes, and of course it, you know, quite crucially involves our colleagues in general practice as well.
Q. The tracker or the survey which the BMA carried out, is that a process which started in April of 2020 and then initially involved a fortnightly survey and then, latterly, monthly and then a triannual survey?
A. Yes, it was quite clear that there was a need for information about what was actually happening on the shop floor, so the BMA undertook to do those surveys and in fact actually we were able to act on the information coming back.
Q. For the purposes of the statement which you've provided

to this Inquiry, have you spoken to other organisations in the medical field, not just members of the BMA?
A. Yes, so other organisations were involved in compiling the five Covid inquiry reports that the BMA have issued themselves.
Q. Did those reports address topics such as how well protected the medical profession was on the impact of the pandemic, what the impact was on the delivery of healthcare, what the government's public health response was, and so on and so forth, those sorts of themes?
A. Yes, they do.
Q. All right.

Now just turning to the broad functions of the BMA, do its functions include calling for, in a general sense, improvements in healthcare and also for improvements in the health of the population, alongside the various other more specific functions which you perform?
A. Yes. So we advocate for high quality healthcare and we advocate, therefore, for the population that we serve.
Q. Turning to the specific issue of pandemic preparedness, do you in your witness statement identify three broad reasons why it is the BMA's view that the United Kingdom entered the pandemic significantly underprepared? Are they: firstly, the fact of too great a focus on

influenza pandemic planning; secondly, the lack of sufficient thought given to a proper strategy to detect and contain the spread of the prospective virus; and, thirdly, what is said in your statement about the levels of resourcing and the consequential impact on a lack of resilience in the healthcare and social care sectors? Are those the three broad headings?
A. Broadly speaking, those are the headings, but when we talk about the UK not being prepared, of course there was a local resilience community within public health medicine locally that was fully prepared for a pandemic. That's their bread and butter expertise.
Q. Yes, all right. Well, starting then with the first theme, that is to say the focus on influenza, you'll no doubt be aware of the significant amount of evidence which has been given about the policies and the guidance and particularly the 2011 strategy from the government which focused on pandemic influenza planning, as well as the evidence from politicians and administrators who have spoken of the strategic flaw or flaws contained in that strategy.

To what extent was the BMA cognisant of the government's strategy and its approach to pandemic planning at the beginning of that decade?
A. Well, it had replied to that preparedness and it had

raised concerns especially with regards to PPE and in regards to making sure that things were going to be joined-up in the event of a pandemic. In fact we raised concerns at that time that changes proposed to public health by effectively dismantling the current situation in 2012/13, because that was being planned ahead of time, would threaten the ability to mount an effective pandemic response in the future.

Q. Are you referring there to the primary legislation, the Health and Social Care Act, or are you referring to something specifically concerned with that 2011 strategy?

A. So at the point at which the 2011 strategy was issued, the contents of the Health and Social Care Act were known and, therefore, the proposed reorganisation of public health was also known, and the BMA commented specifically about the risk that was involved in effectively disengaging the regional directors of public health from the NHS.

Q. Coming back to the strategy itself and the focus on influenza pandemic planning, to what extent was the BMA aware of the growing academic and scientific knowledge concerning the risks of coronaviral attack? So the consequences of the SARS outbreak and then subsequently the MERS outbreak. Did that raise concern on the part

of the BMA, and if so was that a concern that was raised by the BMA with the government?

A. Well, I'm not sure we raised it directly as such. We would assume that any pandemic preparedness would effectively prepare for other types of pandemic as well. So it's slightly misleading to say that it's solely because it was influenza pandemic planning that was taking place that it was therefore not applicable to actually what happened subsequently.

Q. The strategy itself proclaims that it is applicable to non-influenza pandemic, of course, and you'll no doubt be aware of the great deal of evidence which has addressed the topic of the extent to which that strategy could have been utilised for non-influenza pandemic planning.

But was the BMA aware of the growing debate about whether or not that was a strategy that was suitable for a coronavirus pandemic, for example MERS or SARS? Was that a debate with which you engaged?

A. As far as I'm aware, there was no specific debate.

Q. You say in your statement that little consideration appears to have been given to strategies to detect and contain the virus. What do you mean by that? Is that a reference to what Mr Hancock might wish to describe as -- or have described as the Hancock doctrine: the

failure to try to stop catastrophic consequences, as opposed to managing catastrophic consequences which have already ensued?

A. Well, the pandemic planning exercises that took place took a worst-case scenario, so it started with the premise that there would be a large number of deaths with a large number of the population being infected, and of course it is basic health prevention and infection protection and control to stop the pandemic from getting to that point in the first place, so to identify, to test and to contain, so that you don't get into the situation.

Of course that was what had taken place during the SARS and MERS outbreaks, and I suppose this is why the public health community, you know, at a ground floor level, seems quite vociferous about criticism of the early management of the pandemic.

Q. You mentioned exercises there in your answer. Is the BMA an entity which regularly takes part in national, that's to say cross-United Kingdom, exercises or simulations?

A. No, it's not.

Q. Have you been able to look back and see to what extent the BMA was involved at all in any of the exercises of which we've heard evidence?

A. Yes, we've had instances where elected members have been part of the exercise or have been involved with commenting -- especially for Exercise Cygnus, we gave ethics advice.

Q. How did that come about? Was that because you were approached directly by one of the participants or observers to those exercises, or was it because the BMA itself had been engaged in the exercise?

A. Yes, the BMA itself was not engaged, these were people who were approached for their individual expertise who had major roles within the BMA.

Q. Having been approached, was any consideration given to formalising the involvement of the BMA, in particular requiring it to become an observer or participant in future exercises?

A. No, that invitation wasn't forthcoming.

Q. Did you ask, though, Professor?

A. Well, I wasn't there at the time, so I --

Q. Did the BMA ask?

A. Not as far as I know.

Q. All right. So if it was an invitation that was not forthcoming, it certainly wasn't one that had been sought?

A. I can't comment on that.

Q. All right.

Has the BMA or did the BMA have any understanding of the extent to which recommendations and lessons which were the result of exercises were being implemented? Do you know or did you know then to what extent recommendations were being acted upon?

A. Yes, we did, and we raised concerns about them not being acted upon.

Q. How did you find that they were not being acted upon? What was your level of knowledge corporately?

A. Corporately, it was feedback from the exercises. I mean, obviously Cygnus we didn't have very much feedback about at all. In fact that wasn't released publicly.

Q. So how did you get to know what the recommendations had been of the various exercises, and therefore be in a position to know anything about the extent to which those recommendations had not been implemented?

A. Well, the early ones, because there was a review, for example, of the 2009 swine flu pandemic by Deirdre Hine, so -- and she made a number of recommendations, particularly about making sure that services were joined-up, that -- you know, were still exposed during other exercises like Alice.

Q. Was that because you became aware of the later exercises and were therefore able to see the extent to which

recommendations from Dame Deirdre Hine's review had not been put into place?

A. Yes. And in particular there was an ongoing discussion with the ethics department, because the ethics department was giving expertise to the discussion around mass casualties and population triage.

Q. Are you able to say in what other broad areas the BMA had expressed concern about a lack of implementation? So, for example, in relation to surge capacity or PPE stockpiling or training in the use of PPE and so on. Keeping it at that level, can you identify what other areas you'd expressed concern about?

A. So not directly to pandemic preparedness, but the BMA for a number of years has been highlighting the issue of capacity within the health service, to all four governments. The number of beds has been falling, the number of staff has been falling, and therefore we have been raising concerns prior to the pandemic that we were not coping with the capacity that was needed to run the health service as it was, we had raised concerns that social care did not have the capacity that it needed to help the health service create capacity, and therefore that there would be no surge capacity if a pandemic happened.

But, in general, the everyday occurrence of our

members was trying to get the job done that was in front of them rather than planning.

Q. In essence you were focused upon, for obvious and good reason, the lack of operational resources, if you like, so a lack of surge capacity or a lack of PPE or a lack of respirators, as opposed to making perhaps the rather drier point that a lack of operational resource was inevitably going to be the result of a lack of prior adequate planning?

A. Yes. So, for example, we were raising concerns and we had had concerns by our members in all four of the nations about intensive care capacity for routine elective and emergency work prior to the pandemic, and we had been, you know, mounting campaigns -- or the intensive care consultants had been mounting campaigns to get expansion of intensive care beds to deal with the increasing demand from the routine business of the NHS at that time.

Q. One important, very important, operational area concerns of course the availability of respirators in order to be able -- and ventilators -- to be able to deal with the transmission of whatever virus it is which forms the basis of the pandemic.

I don't want to go into the operational side of this issue, but was the BMA aware of whether or not there had

been any planning for or preparation for the debate about the extent to which a future pandemic may be caused by a virus which was more transmissible than other viruses, in particular because it may be transmitted by aerosol transmission as opposed to droplet transmission? Was that a debate or an issue in which the BMA engaged pre-pandemic?

A. So the BMA discussed that within the public health community and within its own public health committees, because the local public health teams will have been practised and exercised in infection control measures.

Q. Are you aware of the extent to which persons on the inside of government were debating the consequences of there being a pandemic which had a high degree of aerosol transmission? Do you know whether that is something that was being addressed?

A. No. There was no discussion and the general feeling is that there was a disconnect between anything that was going on in central government and the local public health teams.

Q. Now turning to the third broad area which you've identified, which is the capacity and health of the public health systems and the identification of a lack of resource being relevant to a lack of preparedness by virtue of the impact upon resilience -- and avoiding

contentious or overly political epithets such as "Tory-led austerity cuts", of which we've heard I think quite enough in evidence -- why is level of resourcing relevant to resilience in a public health or healthcare system?

A. Well, at the moment public health is funded for business as usual. Clearly in any sort of infection outbreak you need to be able to escalate things like testing for the disease, contact tracing, being able to isolate or quarantine, and having expertise, as the local public health teams do, in this is incredibly important, and what has been eroded is their ability to plan and scale up rapidly, and that's what we saw.

So, for example, they would have expected testing to have become more widely available more quickly, they would have expected the NHS -- 44 NHS labs to be available and brought into use, and the point at which that didn't happen and testing was taken into the private sector and into the Lighthouse labs, we started to get a disconnect of information because the IT systems were just not compatible.

Q. To what extent is it possible to say that that lack of resource in the public health testing system, for example, is the result of lack of resourcing and the lack of -- or reduction in levels of funding in prior

years, as opposed to a combination of lack of funding and a lack of administrative focus, that is to say a deliberate step to ensure that those resources and that testing structure are put in place by way of preparedness? How can we ever assess whether it is just the result of funding decisions as opposed to a failure to focus on the particular need?

A. The split of public health from NHS into Public Health England, which took health protection and some of health improvement into government, effectively, split, then, the health improvement and the public health assessment of the care needs and the health needs of the local population. By doing that, it split the resource, because you now had the local health protection function diluted. The terms and conditions were different in local authorities than in government. So you started to have more medically-focused personnel centrally, more non-medical locally, and you started to lose some of the resilience and expertise in managing local outbreaks.

So, for example, where that expertise was retained, an example would be Ceredigion in Wales, they managed to contain and had very low rates of Covid for a lot of the pandemic.

Q. So just taking a step back, then, what you're saying is that the -- one of the direct impacts of the Health and

Social Care Act and the transfer of the public health functions, if you like, away from the NHS to local government was not just changes in the funding and the resourcing, which was then a matter for local government, but there was a direct impact in terms of the level of speciality or the medical experience or the skill sets of public health officials in local government thereafter?

A. That is correct.

Q. Turning your attention to the adult social care sector, putting aside resourcing, what changes were brought about, as the BMA sees it, in the social care sector by virtue of the fact that that is a matter run primarily by local government?

A. I'm not quite sure that I understand the question.

Q. Yes. In terms of the resilience of the sector, what impacts, if any, are there of the fact that the social care sector is run essentially by local government, on what we've heard is quite a fragmented approach, with only an indirect central government control?

A. Well, part of the problem with social care, and in fact actually we saw it as well with public health, was that there is no consistency of record. So there are no data that can be shared, no one knew what the state of

social care was within the locality.

The advantage of having local public health teams is that they know their local population, so they know what works. The cutbacks in general with social care remove resilience. And part of the planning that goes into a pandemic is what happens when you start to lose staff, either because they are ill or they're removed because, you know, in the case of Covid, they were shielding, or they have caring responsibilities.

So going into a pandemic with a lack of resilience because of pressures on staffing does invite there to be a problem from the start.

Q. There has been clear evidence to the fact that there was a lack of understanding at DHSC level of the number of care homes, the number of providers, the number of staff, the numbers of the workforce, as well as the number of persons receiving care, as well as the numbers of those persons who required care but who were not receiving it.

Does the BMA have a view on the general state of data gathering of the adult social care sector? Is it a system which historically has been -- I can't think of the correct word -- it's simply not been amenable to any proper Understanding of what its moving parts consist of?

A. We don't have a particular and specific view about that. But, for example, we went into the pandemic without the Department of Health and Social Care having an up-to-date list of the regional directors of public health.
Q. What is your view on that?
A. Well, I'd -- it shows that we were not prepared for the pandemic that was coming, and it showed the disconnect between the front line and the people who were responsible for planning.
Q. Turning to the question of inequalities, again, an issue which you address in your witness statement, what is the BMA's view as to the extent to which pre-existing non-clinical inequalities were taken into account and planned for pre-pandemic?
A. Well, a number of instances had arisen, for example when talking about respiratory protection, about the need to have close-fitting filtering face piece masks, for example, and this wasn't taken into account. It did occur at some stage during the pandemic as people started to do this fit testing more appropriately and to take it more positively and more proactively.
Q. What is the link between fit testing and ethnic or societal --
A. Because one mask does not fit all. You know, different

people have different size faces, so it was predominantly a male face that masks were built for, for example.
Q. So this isn't a question so much of inequalities as of ethnic differences failing to be taken account of in the context of mask fit testing?
A. Yeah.
Q. What about generally in relation to the government's approach to identifying those persons who may suffer from non-clinical inequality and who therefore may need to have especial attention paid to their needs in the context of pandemic planning? Is that something on which the BMA has expressed a view?
A. Well, it has expressed a view. I mean, if you are referring to, for example, the way that the letters were sent out for the extremely clinically vulnerable, for example, there was a presumption that people could read and write; the way that information was given didn't include sign language, for example, so -- you know, there were also inequalities in the social gradient. People went into this pandemic very vulnerable because of their health inequalities that had been getting worse over the previous ten years.
Q. Drawing the threads together from the various topics which you've just addressed, do you set out in your

witness statement a number of lessons which the BMA believes are required to be learnt for future pandemics and other whole-system emergencies?

If you agree, say "yes", Professor, rather than nodding, so the stenographer can pick it up.

A. Yes.
Q. Do these include ensuring in future that recommendations are, from pandemic planning exercises, properly implemented?
A. Yes, it does.
Q. Highlighting existing responsibilities under health and safety law. Why are health and safety legal requirements relevant to proper pandemic preparedness? What do such legal structures provide which, if implemented correctly, can assist with pandemic preparedness?
A. Well, there is a legal duty on behalf of the employer to the employee to make reasonable attempts to protect that employee, and we feel very strongly that the information that was available prior to the pandemic wasn't heeded. So the Health and Safety Executive, for example, in 2008 had its own investigation of fluid-resistant surgical masks, and showed that virus was behind each of the masks tested. So these were not protective of the respiratory tract. And we had seen a lot of comment --

everyone that comments about the influenza pandemic and future influenza pandemics talks about how unpredictable the pandemic might be in both its virulence and how severe it might be.

So, you know, there should be a health and safety duty to take a precautionary approach, and that wasn't taken. We think that that's because occupational health medicine has collapsed in this country, effectively.
Q. So are you saying that if health and safety workplace law and guidance were properly to be implemented and enforced, there would be a greater attention to detail and therefore, by implication, it would be less likely that that sort of risk assessment process would be overlooked and less likely that flaws in, for example, the use of respirators and the systems for their use would be allowed to go unchallenged? Is that the nub of it?
A. It is the nub of it, yes.
Q. All right.

A third area that you alight upon is the need to maintain an adequate rotating stockpile of PPE. I don't wish to go into the detail of the operational side of PPE -- and procurement, which is a matter for subsequent modules, but to what extent did the planning for the future use and availability of PPE oblige those persons,

who held on to stockpiles and who made them available, to rotate them, to make sure that they were up to date, to make sure that they were fit for purpose?

A. Well, I mean, there is an obligation to review stockpiles. The reality was that there was a conscious decision to reduce stockpiles since 2009 up to the pandemic, so the stockpiles were, my understanding, about 3% of what they were or should have been planned for, especially with respect to respiratory protection and respirators.

Q. All right, well, that's an issue that -- the degree of availability of PPE is something that will be looked at in a later module.

But is the BMA aware of the degree of planning and the guidance and the policy material which underpinned the position with PPE? Is that something that you've looked at?

A. No.

Q. All right.

Improving health and care data, you've referred to this already. The government has, it's plain, sought to review its provision of health and care data and has started to look at ways in which the accumulation of data in the health and social care sectors can be improved.

Has the BMA contributed to any post-pandemic review of data or assisted in any way in which the processes can be improved?

A. Not that I'm aware of.

Q. Do you know, have you been approached at all to assist the government in this way or not? Do you know --

A. Not that I'm aware of.

Q. You then say that in future consideration of inequalities must be central to pandemic preparations and must be closer to the heart of what is required to be done in preparation for pandemic.

What do you mean by that in practice? Do you mean that planning documents, planning approaches, plans have to have the needs of sectors of the population and consideration of inequalities far more clearly identified? They need to be at the forefront of all planning; is that what you're suggesting?

A. Yes, it does, but it's not just about the population and patients we have, but it's about our staff as well.

Q. In what practical ways do you suggest that the needs of your staff and of the population who suffer from inequalities and of inequalities generally need to be better highlighted? Does that mean there needs to be a focus on those issues and it needs to be at the forefront of future planning?

A. Well, I mean, reducing health inequalities and -- and health in all policies is one of our highlights that we wish to see government introduce. You know, the reality is that if you are in an environment where a portion of your population is sicker than another one and it's due to, you know, social determinants of ill health, then unless you tackle those a specific area and subset of your population will be more vulnerable to a pandemic or another flu pandemic, which will come, you know, it is almost inevitable, and we are duty bound to be prepared for that.

Q. So, in essence, it's not really a question of planning, it's a question of ensuring that inequalities are reduced and the health of the population, in particular those who suffer from ill health, is improved, so that we are all better off for the next pandemic?

A. I mean, that's partially true, but when it comes to, for example, inequalities within our healthcare and social care workforce, we are still in a situation where the recommendation is for fluid-resistant surgical masks, which of course are not protective against aerosols at all. So that advice is affecting disproportionately those with inequalities.

And ventilation within our NHS estate and social care isn't -- hasn't been addressed either.

So the risk assessments and the assessment of hazards is still being poorly done, and it affects certain members of both our patients and our staff disproportionately.

Q. So that's not so much an issue concerning health improvement of the population as a whole or for those who suffer from inequalities as much as a need to focus on societal and ethnic differences in the particular context of ensuring that, in future, respiratory facilities, respirators and so on and so forth, are fit for purpose?

A. Correct.

MR KEITH: All right, well, we can leave it there then.

Professor, thank you very much, I've no further questions for you.

My Lady, I believe you have granted permission prospectively to Bereaved Families for Justice, ten minutes.

LADY HALLETT: I have been. I've got Mr Weatherby. Ms Munroe, it's you, is it?

Questions from MS MUNROE KC

MS MUNROE: It is, my Lady, good morning.

Good morning, Professor Banfield. My name is Allison Munroe and I ask questions on behalf of Covid Bereaved Families for Justice UK.

There are a few matters, some discrete topics, I'd like to ask you about, some of which you have already touched upon in your evidence, so I will try and tailor the questions to the answers you've already given.

The Inquiry, Professor Banfield, has heard evidence obviously that the UK was preparing for an influenza pandemic at the exclusion of other pathogens, and in your statement at paragraph 17 you say this:

"This narrow focus was an oversight ..."

You go on at paragraph 18, you have been taken to the start of that paragraph, where you said:

"Little consideration was given within pandemic planning policies of strategies to detect and contain the spread of disease, but rather the emphasis was on how to respond in a situation where there was already significant mortality and morbidity."

But the rest of that paragraph you say this:

"For pandemic planning policies to be comprehensive and effective, both strategies need full consideration. This relatively limited focus on disease containment within the UK's pandemic preparations may explain why the UK Government was slow to implement public health and occupational hygiene measures when Covid-19 arrived."

So in that context, Professor Banfield, a relevant

issue is whether the UK could have even contained an outbreak of an emerging infectious disease of the proportions envisaged by the National Risk Register at the time.

Now, firstly, were you aware -- in your position and as the BMA as an organisation, would you have been aware and conversant with the National Risk Register during this relevant period?

A. Yes, we would. So we would have been aware that pandemic flu was the risk register's number one risk.

Q. Thank you. In that case, I won't bring up the document, but, my Lady, for reference, it's the 2019 National Risk Register, annex B, INQ000185135, pages 4 and 8.

Were the BMA, Professor Banfield, aware that that 2019 National Risk Register contained a planning assumption for an emerging infectious disease outbreak of 2,000 cases and 200 fatalities in addition to the pandemic influenza scenario?

A. Not specifically.

Q. Well, I'll come on to the next question, then. It sort of follows from that.

Dr Michael Prentice from NHS England -- again, no need to bring up his statement. He has provided a statement, hasn't given evidence to the Inquiry, but for reference, my Lady, it's INQ000177805,

paragraph 181.

He talks about the number of airborne high-consequence infectious disease units located in the country, and he says in that paragraph airborne HCID units are located at Guy's and Saint Thomas' NHS Trust, adult and paediatric services; secondly, Royal Free London NHS Foundation Trust with a paediatric service provided by Imperial College Healthcare and St Mary's. Then Liverpool University Hospitals NHS Foundation Trust, with a paediatric service provided at Alder Hey Children's Hospital, and, finally, Newcastle upon Tyne Hospitals NHS Foundation Trust, both adult and paediatric services. Each centre routinely provides two beds, eight in total, for airborne HCID. Specific service specifications outline the care pathway and unit requirements.

Was the BMA aware that there were only four units in England for airborne HCIDs, with two beds each?

A. Yes.

Q. Well, firstly, those figures, those are the bald facts and figures from both the National Risk Register and the number of HCID units; would you agree that eight beds for an airborne HCID is woefully inadequate to contain 2,000 cases?

A. Yes, I would.

Q. These are figures that the BMA would have been aware of at the time. You've said it's woefully inadequate.

I mean, in terms of your concerns as an organisation, did you raise these at the time to those who were planning? Because you've spoken about the need or the possibility to plan up and scale up rapidly. They would have to scale up very rapidly, wouldn't they? Was this something that was part of the dialogue or the discussions that the BMA were having with -- amongst yourselves, but more importantly outside of the organisation?

A. No, no, they were not, but they had been the subject of the review after Ebola, and one of the exercises that took place is quite striking because it ended up with three cases being admitted to Newcastle, and them using something like 70 members of staff to treat those three cases and removing 18 care beds from the system.

So the reason I say that is for those particular high virulent high mortality situations that capacity was not enough. When it comes to the Covid pandemic, the issue of capacity and the need to create effective isolation either within single rooms or then cohorting was very quickly appreciated by the medical profession, because we were getting feedback from China and from colleagues in Italy, and there was a sudden realisation

within the medical community of what was coming our way, and it was all hands to the pump trying to plan where our intensive care beds would be, because we had half the number of beds of the European average, a quarter of the intensive care beds that Germany had for example, and I've never seen doctors so worried about how they were going to cope with the influx of seriously sick patients to the extent that, you know, we had intensive care consultants doing physics calculations of oxygen flow through pipes to see whether we could get more oxygen round the hospitals.

We knew that this was unprepared for, we had no idea what was coming our way, we were suddenly in a position where not only patients were going to die but our colleagues and ourselves were in a position where we might die because we felt so unprepared. And, as was referred to earlier, the surveys that we did with the medical profession continued in that vein for some time into the pandemic.

Q. That sudden realisation by the medical profession of what you were faced with, could that and should that have been planned for and prepared though?

A. Sorry?

Q. Could that and should that have been planned for and prepared for?

A. Yes, and we feel that the disconnect between central government and the realities of the shop floor was one of the recommendations that was consistently not addressed during any of the exercises.

Q. Then finally, on the question of exercises, you've told us already in your evidence, Professor Banfield, of the limited involvement that your organisation, the BMA, would have had in those exercises, both in terms of before, planning them, being part of them and finding out what happened as a result of those exercises.

Surge capacity. There was a report on the Ebola preparedness surge capacity exercise from 2015.

Again, I won't bring it up but for reference it's INQ000090428.

Was that a report from 2015 that you were aware of at the time?

A. Not me personally, but the BMA --

Q. The BMA would have been aware of.

Now, it took place in March of 2015 and that exercise indicated that even a small outbreak of a contact -- high-consequence infectious disease such as Ebola could overwhelm existing plans and provisions and effectively overwhelm the NHS.

Was that something that was very much at the forefront of the BMA's mind at the time when you saw

that review, or that report?

A. We've been quite consistent in trying to highlight the lack of capacity, and the disjointedness of the expertise that lies within local public health provision and the central planning, because the best defence is to test and isolate quickly so that you don't get the kind of spread that you're discussing.

Q. So as an organisation, being concerned -- and you've said you highlighted -- in practical terms what did you do as an organisation or what were you able to do as an organisation to highlight this?

A. Well, we have consistently pushed back at government and escalated to central government about the lack of preparedness, but most of that has come really with the onset of the pandemic, because, like so many other people, I think we were concentrating on getting on with the everyday day job rather than the planning of what may or may not happen because, you know, we're under such pressure -- or our members are under such pressure every day, we're working constantly on the premise that, you know, our system may tip over at any moment.

MS MUNROE: Thank you very much, Professor Banfield.

My Lady, thank you, those are my questions.

LADY HALLETT: Thank you, Ms Munroe.

MR KEITH: My Lady, that concludes the evidence of

Professor Banfield, and in fact this morning's evidence. We are actually one witness ahead.

LADY HALLETT: Thank you very much indeed, Professor Banfield, thank you for your help, really grateful.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Very well, I will return at 1.55, please.

MR KEITH: Thank you.

(12.55 pm)

(The short adjournment)

(1.55 pm)

MR KEITH: Dr Dixon, the chief executive of The Health Foundation, please.

DR JENNIFER DIXON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY

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

A. Yes, Jennifer Dixon.

Q. Dr Dixon, thank you for your provision of a witness statement to this Inquiry. It's dated 14 April. There it is, INQ000183420. I believe that you've signed the last page and signed the declaration of truth that the statement contains.

Dr Dixon, whilst you give evidence, could I ask you

to keep your voice up, so that we may clearly hear what you have to say, and also try to speak as slowly as you can in order to assist our stenographer.

You are, we believe, the chief executive of The Health Foundation. I'll come back to what that is in a moment, but it's a position that you've held since 2013. Before that, were you the chief executive of The Nuffield Trust, a post you held from 2008 to 2013?

A. Correct.

Q. A director of policy at The King's Fund, and also a policy adviser to the chief executive of the NHS between 1998 and 2000?

A. Correct.

Q. By training, you are a medic, you hold a masters in public health and a PhD in health services research from the London School of Hygiene and Tropical Medicine.

A. Correct.

Q. Are you also a non-executive board member of the United Kingdom Health Security Agency, a position to which you were appointed in April 2022?

A. Correct.

Q. But you give evidence today, so that we may be clear about it, solely on behalf of The Health Foundation?

A. Correct.

Q. So what does The Health Foundation do?

A. The Health Foundation is an endowed independent charitable foundation and we have a mission to improve health and healthcare for the UK population. We do that --

Q. Slow down, please, Dr Dixon.

A. Sorry.

We fund projects and research to try to improve the health and care for the people of the UK, and we carry out research also.

Q. We are most interested in the research that you do, because much of your witness statement is concerned with the provision of facts and figures which we wish you to talk about.

To what extent does the foundation commission and use evidence? Is that the majority of your work? Are you, I suppose, what might be called a "think tank", insofar as you provide to the public information and data about the structure and operation of our healthcare structures?

A. More than half of our work is commissioned and carried out in research, but we give out other funds to, for example, improve -- for fellowships and suchlike.

Q. When you commission research, are your researchers and your experts in-house or do you commission external

analysis?

A. Both.

Q. Are those reports and is that analysis directed at the public or is it directed at government or to the healthcare systems themselves?

A. It's to both, to -- it's all three, but mostly it would be to leaders and policymakers.

Q. May I ask, are you a respected organisation to whose views the government pays particular attention?

A. We are a well respected organisation because we are known to be impartial, do high quality work and are entirely independent. And on the question of whether the government listens, whether we have influence, that's variable.

Q. You are obviously independent, but to whom is the foundation accountable? So is there a body or are there individuals to whom you are accountable as an organisation?

A. Yes, we are accountable to the board of trustees, which is an entirely independent board, and we receive all our money from -- our income from the endowment, with a small amount extra coming from commissioned work.

Q. Are you therefore regulated by the Charity Commission as well?

A. We are, yes.

Q. All right.

The Inquiry doesn't believe, from your witness statement, that the foundation had a role or exercised a role in relation to the pre-pandemic preparedness system, so you didn't engage with the government when it drew up its relevant plans and procedures for pandemic planning, and nor, I think, did any of your work focus on the state of the preparedness of the United Kingdom pre-pandemic?

A. That is correct.

Q. But where you are able to provide specific detail is in relation to, bluntly, the facts and figures relating to the state of the health and care systems in the United Kingdom as it entered, as they entered the pandemic, and now, and also facts and figures relating to the general health of the population, and in particular the impact on those who suffer from inequalities in terms of the receipt of health and social care?

A. Yes, that's correct.

Q. All right. Let's look then at those two areas, dealing with the health and care systems first.

In the decade leading up to the pandemic, so in the decade prior to January 2020, what can The Health Foundation say in relation to the reductions in the

levels of spending on public services generally in the United Kingdom?
A. So public services per person reduced by 13%, of the order of 13%, over that decade.
Q. You've provided us with that headline figure. Is that a figure drawn from research and analysis and no doubt a series of papers and projects which the foundation prepared over time?
A. Yes.
Q. You haven't just produced that figure as a result of a request from the Inquiry that you address that particular topic?
A. That's correct.
Q. That was a question revolving exclusively around the level of spending on public services. But what about the NHS? The Inquiry has received evidence already that parts of the NHS spending were protected, and there's obviously a divide between money that is spent on day-to-day services within the NHS as well as money spent on infrastructure and the like. So, dealing with those areas in turn, was core NHS spending protected to any extent during that decade prior to 2020?
A. Core NHS spending was protected relative to other public services, but over that decade the NHS received about half or slightly less than half than it would have

normally expected to receive per annum compared to a long-run average.
Q. That's an average of spending, annual spending in the United Kingdom, is it?
A. Yes, real terms growth on average, long run, is 3.6%. The NHS grew 1.4% over that decade.
Q. When you say it grew, you mean the spending grew as opposed to the NHS growing in size?
A. The spending grew, yes, by 1.4% real terms per year.
Q. The comparative figure that you provide, that is to say the amount of spending or the amount of increase that it could have gone up annually but did not, is that a figure which necessarily takes account of any demand in the receipt of healthcare services?

So presumably the NHS budgets, on the basis that there is a demand for its services and there is a cost to providing or meeting that demand on the part of the population across the United Kingdom, did that level of spending, constrained as it was, keep pace with the demand in the population for NHS services?
A. No, and normally the increases given to the NHS are made irrespective of demand, and there has not been long-term projections of demand in order to assess how much spending is required.
Q. So it would be wrong to assume that the NHS, as

a healthcare organisation, tries to receive enough by way of its budget to meet a projected demand; it has to make do with whatever it receives?
A. That is correct. It's more linked to the state of the economy.
Q. During that time, were there changes in the pressures placed on the NHS operationally? That is to say, changes in the demand for NHS services, demands for improvements in its infrastructure, demands in terms of the specific health services which the NHS provides? So, for example, cancer treatment and the like.
A. Yes. So the pressures on the National Health will be growing because of increases in population size, changes in population structure with the ageing of the population, with --
Q. Slow down, sorry, Dr Dixon. If you can start that sentence again.
A. So the pressures on the NHS will be growing because of increases in the population, because of changes in the composition of the population because of the ageing of the population, and also the changes in the ill health of the population, which were all growing over that period.

There will also be what we call supply-side pressures coming from price increases, but also in terms

of needing more technologies to improve care.

So the kinds of figures that the -- the growth that the NHS received over that decade was not enough to modernise the NHS nor indeed to keep pace with demand.

And you see this very clearly -- we might get on to this -- with capital spend as well.
Q. We'll come to that in a moment.

So although NHS spending then was protected, and although there were increases in real terms year by year, because of the particular demands of the NHS, the need to modernise, the need to keep up with the demand from the population, the amounts of the increase could not be enough to match those demands?
A. No, they were not.

And if I may, just to give a comparison, if we had spent per capita in 2019 the same as France, the NHS would be receiving an extra £40 billion per year, and if we'd compared ourselves with Germany we'd be spending another £70 billion a year. That's on a roughly £150 billion budget.
Q. Now, it's self-evident, of course, that those sorts of political choices are not for this Inquiry or for --
LADY HALLETT: Sorry, just before we go on -- sorry, can you come back to that, Mr Keith?
MR KEITH: Yes.

LADY HALLETT: You say if we'd spent as much as France per capita. How do you equate a system in France, which is very different from an NHS in England? How do you get the figures of what's spent?
A. We just look at total spending in France, whether it's public or private, and we look at public or private spending in the UK, and we divide by the population size.
LADY HALLETT: So when you talk about we'd be spending an extra £40 billion a year on the NHS, that is funding in France that would be both private and public funding?
A. Yes.
LADY HALLETT: Right.
MR KEITH: It must also follow, Dr Dixon, that those sorts of figures are provided on the basis of an assumption of a single overarching budget --
A. Yes.
Q. -- for the NHS. So in addition to my Lady's point, it may well be that sources of funding in Germany, for example, come in part from central government, in part from federal government and in part from state government?
A. That's true.
Q. All right.
So the point I was going to make to you is those are

self-evidently political choices that have to be made, and of course they don't take account of and they're not meant to take account of different sources of funding and the state structures which may be in place in each country.
But evidence has been received by the Inquiry, in particular from Jeremy Hunt, which you may have seen, that over that period in fact the number of doctors and nurses in the NHS went up significantly. It may seem very obvious and is self-evident, but is that because -- or, rather, your figures are what they are notwithstanding that there can be significant improvements in some parts of the system, by way of additional or extra expenditure on doctors and nurses, but other parts of the system may be relatively constrained or may indeed suffer reductions in levels of funding, which is why overall there may be a reduction across the system as a whole?
A. Yes, there were workforce increases, but over the decade full-time equivalents of NHS staff grew only 1% across that period, and in fact the number of fully qualified GPs, for example, fell over that period. So we were coming from a very low base, and if, again, if you compare us with other European countries, we have many fewer doctors per thousand population, fewer nurses,

fewer everything, to be honest. So although it may be true that the absolute rise was there over that period, it was low and it was on a very low base.
Q. The two rises in fact of which Jeremy Hunt spoke in particular were rises in two particular years. You of course are producing figures over a whole decade?
A. Over ten years, yeah.
Q. Right.
Turning to adult social care, what can you say in general terms over the decade about the levels of funding across the system as a whole, and the levels in the workforce across the system as a whole?
A. Yeah. So the funding per capita, which is the best, probably, measure, reduced by 12% over that decade, funding in social care, and the shortages remained pretty static over that period, and they're --
Q. Workforce shortages you mean?
A. In social care, at 120,000, which is around 10% of the workforce.
Q. Now, addressing your two answers in order, the first answer, the level of funding over that time and the reduction in the funding per person, is that an objective level of funding? Is that an objective number, or is it a number which is adjusted to take account of the additional needs of persons in the

social care system, and in particular the fact that our population is ageing generally?
A. This will just be a per capita figure. If you adjust for the needs of the population, then the reductions will be greater.
Q. Is that because in these calculations it's implicit that if the population has greater demands, it's going to cost more to meet those demands?
A. That's exactly right. And again, like in NHS funding, overall the overall funding in the decade was less than half of the longer run average.
Q. How was The Health Foundation able to compute figures about the levels of workforce in the adult social care sector and on the amount of funding per capita given the evidence the Inquiry has already heard about the fragmentation in the system and the sheer difficulty of trying to quantify the various moving parts in the adult social care sector?
A. So there will be central figures on funding which will be collected and we will use those figures, we won't directly collect the figures ourselves, they'll be from official sources. And similarly with the workforce, that is true, there are organisations that collect information such as Skills for Care on the overall numbers of the workforce.

Q. So you haven't sent researchers out to each care home in order to find out how many people work there and how many people receive care; there are central government supplies of data?

A. There will be central government supplies. Although, as I think other witnesses have said, there is significant churn in this sector, so the numbers will be estimated.

Q. Evidence has been given of what has been termed the fragmentation of the health and care -- the adult social care system in particular. What do you understand that phrase to mean?

A. Well, in the social care system, unlike the NHS, there is no centralised authority, it's not a national care service. So there will be 150 local authorities that will be commissioning care, and there's upwards of 14,000 different social care providers, many of whom will be very small. So I suspect that's what they mean by fragmentation.

Q. When you say there are upwards of 15,000 organisations providing care, does that mean -- does that include nursing homes and care homes?

A. It's both, yes, indeed.

Q. They are the providers of social care to the persons in those homes?

A. In the homes, and then there will be domiciliary care as

well, provided by a range of different agencies.

Q. Are those domiciliary carers included in your figures of 15,000-odd?

A. Yes, they will be.

Q. How do the governance and accountability arrangements work for the adult social care sector? Are they split between a number of different entities in government?

A. There are three government departments that deal with social care, and 150 local authorities. So there's no one overarching department. I suppose the lead department would be the Department of Health.

Q. And Social Care?

A. And Social Care, yes, sorry.

Q. In your statement at paragraph 19, you say that:

"Data availability and quality was a significant barrier to the pandemic response in some areas, for instance, the lack of a care home register; difficulties in identifying care homes residents in routine data; and lack of reliable data presented difficulties for local authorities ..."

Without going into the operational response of the sector, do those difficulties reflect the absence of a well ordered, well organised, pre-existing pre-pandemic system for the collation of data?

A. Yes, and in particular this is the case in social care,

where you can imagine, as you can see, thousands of providers each with care home residents, each -- where the residents are not necessarily -- could be churning over themselves in terms of, you know, a certain level of throughput, and staff as well, 40% turnover in a year. So very hard to track both staff and patients, and there's no national care record for social care. There isn't actually even a national minimum data set, although there is work that is ongoing to develop that.

Then linking social care data with NHS sources of data is also immensely difficult.

Q. Are you able to say to what extent the systems for the supply of data have significantly changed since the pandemic or been the subject of updating or review by the government?

A. No. I think work is being done to try to get a minimum data set together. It's still ongoing. But just as in the NHS, the social care sector will be undercapitalised in terms of the money available to -- or spent, I would say, on developing IT systems that can track individual patients. And --

Q. Sorry, just pause there.

Is it implicit in that answer that any improvement in the data systems has to be funded out of money in the adult social care system or the NHS system itself, as

opposed to coming from an external source of funds?

A. So I -- it doesn't necessarily follow. I mean, clearly there will be local authority funded patients in care homes and there will be privately funded patients, and care homes -- many of them are -- some of them are large enough to be able to afford such infrastructure, so it's not necessarily the local authority's role to do that, but the smaller ones simply won't have the money and there will be many three, four-bedded care homes who cannot afford detailed IT or the staff to analyse or indeed enter the data.

Q. So the nub of it is that a sensible and well ordered overarching system of data supply is going to have to be funded by central government or at least non-care home providers, perhaps local government, and it's got to be imposed centrally as opposed to being something that can be requested of individual care and nursing home providers?

A. Well, I think there would have to be some more incentives to encourage or, indeed, mandate providers of social care to collect data.

Some social care providers are owned by some very large businesses who will have the capital funds to be able to do that, but maybe they need incentives or, indeed, regulatory apparatus to encourage them to do so.

Q. All right, thank you, that's very helpful.

Turning to the second part of your statement and the part that deals with population health and inequalities, you say:

"... staying healthy depends on much more than healthcare: people's health is shaped by the circumstances in which they are born, grow, live, work and age -- often referred to as the 'wider determinants of health'."

Does it follow, Dr Dixon, that in order to improve resilience for the future it is necessary to improve the general health of the population as long as dealing on a micro level with whatever may be done in terms of preparedness and planning?

A. Yes, I think the resilience of the -- as we saw in the pandemic, certain groups were more affected and more vulnerable, and that will be a feature not just of their levels of exposure but also their levels of underlying health. And we know that in the decade before the pandemic that life expectancy was stalling more in Britain than in other countries apart from the United States, and that there were significant inequalities with some areas of the country -- some populations, their life expectancy actually reducing.

Q. Beyond the self-evident concern that that statistic

gives rise to, why does a fall in mortality rate -- why does a fall in life expectancy matter in the context of resilience and planning and preparedness? Is it because if life expectancy is reducing and health inequalities are worsening, there is more to be done, there is a greater step to be navigated before those parts of the population can be put into a state of proper resilience?

A. Yes, I mean, I think people will be more vulnerable to any external sort of infectious disease if they're in a more vulnerable state. For example, if you have chronic diseases, obesity and so on -- and as we know obesity has increased, chronic diseases have increased in the population -- so individuals with those will be more susceptible, as we saw with Covid-19. So it is important to try to reduce avoidable ill health for the long term if we want to build resilience here.

Q. You refer in your statement to something you describe as long-term conditions, LTCs; what are they?

A. They will be conditions that are non-infectious, for which there is no particular cure, but they are rumbling and chronic. So hypertension, for example, diabetes, chronic respiratory disease, would be an example, heart disease, and in poorer groups in society those chronic disease begin when people are in their early 50s and in the wealthiest parts of our society they begin 20 years

later, in people's early 70s. So you can see that particularly people in deprived -- socio-economically deprived groups will have more susceptibility to all sorts of illness, including infectious disease, if they begin with chronic disease that early.

Q. Are LTCs also more prevalent in some ethnic minority groups?

A. Yes, they are. Well, it depends what it is, but, for example, diabetes is more common in the South Asian community.

Q. So in order to improve resilience, one has to first or one has to also improve health in a general sense, address these comorbidities of the pandemic, the long-term conditions, and recognise that they are more prevalent in some parts of society than others?

A. Yes, that's absolutely right.

Q. Turning then to public health funding, the Inquiry's received quite an extensive amount of evidence about how public health is provided to the population, which parts of local government, indeed, and directors of public health are concerned with public health services.

Are there figures in existence which show general levels of funding at central and also local government level for public health services?

A. Yes, there are such figures.

Q. Over the last decade what do they show?

A. They show -- well, our figures show that in the last decade public health funding was reduced per head by 22% and those are the overall headline figures.

Q. That's in relation to -- is that central government or central government and local government?

A. I think it's both. I'll check, but I think it's both.

Q. Is that -- that's an overarching figure for the whole of the last decade?

A. Yes.

Q. So from beginning to end it's reduced by 22%?

A. It has, yes.

Q. All right.

A. And more in deprived areas than not.

Q. You conclude your witness statement by setting out a number of lessons for future pandemics and/or public health emergencies, which lessons you frankly acknowledge can only have been formulated with the benefit of hindsight.

Are all the lessons and the points that you seek to make related in some shape or form to the evidence that you've given about the reduction, general reduction, in levels of funding and the need for greater resilience, greater health improvement and a particular focus on those parts of society where there have been the

greatest reductions in both funding and in health?
A. More or less. I would say that our -- the statement, and indeed today's conversation focused a lot on what I would call tangible assets that are important for resilience, but there are also a lot of intangible assets that need to be there, and by that I mean the kind of expertise, relationships that need to be built, skills, data, staff to analyse the data, all those -- public trust, there's a whole set of intangibles that I think it's worth looking at. Indeed, those relationships can be disrupted and skills can be disrupted by reforms, the 2022 -- sorry, 2012 reforms, for example, and also, not that my statement refers to this, but Brexit as well.

So if you have a constant reform agenda, that can disrupt quite a lot of relationships that you need to have built and stable in order to be resilient in the face of shocks.
Q. Those references in the main, for example to the impact of preparations for a no-deal exit or perhaps from Brexit itself, but we're not going to go into that, the intangibles of lack of a pre-existing and effective data supply system, the reductions in the overall levels of funding and so on and so forth, are all in the past, they're all retrospective. Do you in your statement try

to identify areas going forward where work can be done in order to try to bring about a more resilient United Kingdom?
A. Yes. So obviously we talked about investment, I think that's important. To avoid excessive distracting reforms that can disrupt relationships and skills and form attrition of experienced staff. I think much more support for social care, investment in particular. We really do need a serious cross-government strategy to improve health and reduce inequalities in the way that we simply haven't over the last ten, 15 years. A lot more investment in data and infrastructure and the analysts to support them. There was -- in some cases we had data that NHS England and the Department of Health did not have during the pandemic, because of a lack of investment. And work on public trust, I think those are some of the biggest areas: public trust in authority of handling the pandemic but also in -- in -- confidence in using data and linking it correctly to respond to threats.
Q. That last or that penultimate topic, public trust, is not something that features to a great extent in your statement. Why is the maintenance or the promulgation of trust in public bodies relevant to the health of a population or health improvement or to dealing with

the inequalities in society and the health determinants that you have described? Why does it matter that there is trust in government?
A. Well, I think in a pandemic situation you want people to be able to take notice of information that may help them reduce their risks, and also you really want to encourage trust in vaccines and to reduce vaccine hesitancy where that's based on misinformation, so you need trust and authority in both those counts.
Q. Is that relevant to a system of preparedness and planning as well as to a system of vaccine provision?
A. It's absolutely part of the building up of intangible assets which lead to resilience.
MR KEITH: Thank you very much.
THE WITNESS: Thank you.
MR KEITH: My Lady, I don't believe that there are any applications for Rule 10 questions for Dr Dixon, so that concludes her evidence, unless you have any questions.
LADY HALLETT: No, I don't have any questions.

Thank you very much indeed, Dr Dixon, for your help.
THE WITNESS: Thank you.

(The witness withdrew)
MR KEITH: My Lady, the next and, in fact, final witness of fact is Michael Adamson, the chief executive of the British Red Cross.

MR MICHAEL ADAMSON (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY
MR KEITH: Good afternoon. Could you give the Inquiry your full name, please.
A. My name is Michael Adamson.
Q. Mr Adamson, whilst you give evidence, could you remember to keep your voice up, please, and also speak as slowly as you can so as to aid our stenographer.

You have kindly provided a witness statement dated 28 April 2023. There it is at INQ000182613, and I believe that you've signed it and declared its truth at page 20.

Mr Adamson, you are the chief executive of the British Red Cross. Are you also currently the co-chair of a partnership called the Voluntary and Community Sector Emergencies Partnership?
A. Yes, I am.
Q. Dealing firstly with the British Red Cross, we understand that it was founded in 1870. It received its royal charter in 1908, and I think it received a further royal charter in 1988, which was subsequently revised in July 2003. It's a very well known organisation with around about 12,000 volunteers and 4,000 staff.

What is the British Red Cross's primary aim?
A. Our primary role is to support people in emergencies or

at their lowest ebb in crises, both here in the UK and around the world.

Q. Is it a government or a non-governmental organisation or something quite different, and indeed completely independent?

A. We are a completely independent organisation, registered as a charity, committed to the principles of humanity, impartiality and neutrality.

We are also, though, a -- we are also an auxiliary to government, which means that we work in partnership with government on issues like international humanitarian law and, indeed, in emergency response. But we're entirely independent.

Q. When you say you are an auxiliary to government, is that obligation, which is what it is in effect, something mandated by your charter?

A. Yes. Our role is to work alongside the authorities to provide support to people in emergencies, but we do that based on our own assessments of the needs in those emergencies, and we make choices about the support that we'll provide based on the assessment of that need, but we'll always do it in a way that is cognisant of our partnership with the authorities.

Q. So give us, if you would be so kind, some examples of crises or emergencies in recent years with which you've

assisted, firstly in the United Kingdom and, secondly, abroad?

A. For example, we were very active in the response to the Grenfell Tower fire, and supported the local authorities in the establishment of a rest centre, and then were present on the ground for six weeks supporting the response to the community.

We have also supported people who have been arriving, for example, most recently from Sudan, meeting people at -- who were evacuated -- the British citizens evacuated from Sudan, meeting around two and a half thousand people at airports and then working in partnership with others to ensure that they had a pathway to get the support they need to settle back here in the UK.

Q. In the particular context of the pandemic and mindful of the fact that the response for the pandemic is for future, did the British Red Cross help by way of, for example, the delivery of medicine and food packages, the loaning of medical devices, patient transport and the like?

A. Yes. We were active from the earliest days of the pandemic, as you say, in providing food support, cash to people who had no access to funding, providing support to help people get in and out of hospital, to provide

support around the delivery of medication.

We also mobilised support to vaccine -- vaccination centres and, indeed, mobilised vaccination hesitancy campaigns through social media and mainstream media.

Q. Turning then to the VCSEP, when was that created?

A. The VCS Emergencies Partnership was created in the aftermath of the Grenfell Tower fire, where we recognised that both resilience and recovery from an emergency are activities that require many agencies and organisations, both in the -- in all three sectors, not for profit sector, private sector and public sector --

Q. Slow down, Mr Adamson.

A. In the not for profit sector, private sector and public sector to work together to enable a community to get back on its feet again, and we formed the emergency partnership in the period between 2018 -- after 2018, and then it grew and expanded to its current scale during Covid.

Q. How many partners or entities are there within, now, the Voluntary and Community Sector Emergencies Partnership?

A. We now have 250 or so partners signed up, 70% of which are local organisations who would not normally think of themselves as first responders in an emergency, but who have realised that when both the day-to-day emergencies,

the floods, the fires, and so on, take place, actually it's local communities that respond, and then when bigger emergencies come along, like a pandemic, that actually they're also very active.

The other thing that's distinctive about the VCS Emergencies Partnership is that it also includes government departments, and indeed representatives of business through business in the community.

Q. So can you tell us which government departments are included within the emergency partnership?

A. The Civil Contingencies Secretariat --

Q. Within the Cabinet Office?

A. Within the Cabinet Office, and the resilience and emergency directorate within what is now the Department for Levelling Up, Housing and Communities, local government, and also the Department for Culture, Media and Sport.

Q. When you say they are part of the emergency partnership, that means presumably that the partnership communicates with them, they attend meetings, and no doubt a whole host of issues are explored week in, week out with them?

A. That is correct. We would have, for example, a monthly network call with all of the partnership and they would be part of that, and attending it.

We also have a strategy steering group that meets

once a quarter, which is a smaller group of around 23 or 24 organisations, and that would include those government departments.

Q. Now, just a series of questions, if I may, about what the perceived need for the emergency partnership was.

Presumably the majority of the organisations within the partnership pre-existed the foundation of the partnership. Why, if they were already providing planning services and resilience and also response capability in local emergencies, was it necessary to have a partnership for them to continue to discharge those functions? If they were already playing their part in the EPRR system, why is this partnership an improvement on what went before?

A. Many of those local organisations would not have seen themselves as having a role in emergencies before we created the emergency partnership.

Q. Just pause there. What do you mean by "they wouldn't have seen themselves as having a role"? They do things, they exist, and they exist locally. So why would they have not seen that?

A. Because their primary purpose was to support people in, you know, disability or in the environmental work or in other sports work or other charitable work at local level, and they would have seen their primary purpose --

or to address poverty in their local community. They would have seen their primary purpose as that. But what we have learnt around the world from our work is that it is always the community that responds first, and we've also learnt that in an emergency it's much better to have the relationships in place in advance of the emergency rather than have to make friends, as it were, during the emergency.

Q. So, in essence, the various entities already existed to provide services and help and support to various parts of the population, those for example who may be disabled or those who suffer from health inequalities or so on and so forth, but no one had brought them together for the specific purpose of planning for local emergency and to respond to local emergencies, whatever they may be?

A. That's correct.

Q. Right.

Why is it necessary for the emergency partnership and the entities which make up the partnership to do the jobs that they now do in terms of local planning, local resilience, local response? Why are local authorities and central government not fulfilling those tasks or doing those jobs themselves so as to require your partnership to step into the breach?

A. I think it's fair to say that the dominant thinking in

the world of emergencies would be based around command and control structures, around gold, silver and bronze, and for -- for example, to put out both the actual or the metaphorical fire. But the preparedness for -- to prevent the fire or the flood or to be better ready for it in advance, or to respond and help people to recover is a -- involves a lot of different activities that are very people-focused and not about infrastructure, not about command and control, they're very relational. And actually bringing organisations together in advance of when these things happen allows us to secure better outcomes for people.

It's not a criticism of the National Health Service or a local authority that actually there is a need for the Voluntary and Community Sector Emergencies Partnership. What we need to, though, ensure is recognised is the importance of that partnership to the outcomes for people in emergencies before they happen, and that those are -- that is recognised at national and local government level.

Q. In essence, local and central government and the emergency services have to provide the overarching structure in which a pandemic or any emergency may be both planned for and responded to, but when it comes to the delivery of food to a household, or the supply of

a vaccine, or shielding facilities, or replacing household goods and providing somewhere to sleep in the event of a flood, recourse has to be had to the sorts of organisations, entities, whom you represent, because they're the ones who deliver on the ground; is that a fair summary?

A. That is partly a fair summary, in the sense that some of those things were actually done very well during the pandemic, in terms of a mass vaccination programme, for example, that we were able to, for example, mobilise volunteers to provide support at vaccine centres and, indeed, to then work around trying to identify who are the people who are not likely to come forward for a vaccine, why might they be vaccine-shy, as it were, and what are the barriers to them coming forwards, be that around disability or, for example, a lack of confidence in their legal status that meant they were reluctant to really -- you know, to reveal themselves, as they saw it, to the authorities. So we might work in that kind of way.

But if you also look at the recovery from flooding or fire, or indeed the arrival of people from Sudan trying to settle and get back on their feet again, they need to be accompanied. Because you think of the trauma that they have been through, if you lose your home,

whether it's fire, flood or indeed because you were coming from Sudan, you think of the emotional impact of that: you don't know your way around the system, you don't know where to get help, you don't know where to get legal advice, you don't know whether you're insured, your insurance company will pay out. You need people who will accompany you and think of you as a whole person, and indeed sometimes think of a whole community and the community cohesion that can be -- and actually whether that has been undermined by the events.

Organisations like ours, and indeed local community organisations, can work alongside people for the medium term to help them re-establish the connections that actually help them to be more resilient for the next emergency.

Q. In plain English you provide, at a local level, individual help to specific people?

A. We provide individual help to -- we and others. We, as the Red Cross, provide individual help to specific people. We work with other organisations in a community to identify who might be being missed in the -- as the -- as we think about the response and the recovery, and how do we help connect them into the support they need for the medium term.

Q. All right.

A. But it's very -- it's rooted in that individual support, that person-centredness.

Q. I think, if I may say so, I then did summarise it moderately accurately.

The Inquiry's heard evidence about the way in which the current EPRR systems operate and in particular the existence of local resilience forums. Are the British Red Cross and the Voluntary and Community Sector Emergencies Partnership part of the local resilience forum structure already?

A. Yes, in many places, but not necessarily everywhere.

Q. Why are they not plugged in to the local resilience forum structure everywhere?

A. Local resilience forums are not consistent in the way in which they work with and engage with the voluntary and community sector and community organisations. There are a range of models across the country, and some of that variation is completely understandable because a densely populated urban environment is very different to a more sparsely populated rural area, for example, and may indeed have differences in the emergencies with which it's potentially threatened and indeed about the organisations that are around in those places.

Q. So they differ, they may have to deal with different emergencies, and of course they will exist in different

parts of the country, urban, rural and all in between, and therefore have different demands made of them; is that fair?

A. That is correct, but it's only part of the story, because there is also -- I think all of those local resilience forums would benefit from having deep relationships with the voluntary and community sector in order to achieve some of those both individual and community outcomes that I talked about earlier, and they're not equally committed to that way of working.

That said -- can I just complete the point?

Q. Yes, please.

A. I think there's been a significant development in the orientation of willingness to engage with the voluntary and community sector coming out of Covid, because we all lived through it, you know, for the best part of two years, and relationships were forged. The question is: what do we learn from that for the future, and what needs to be put in place to ensure there is that consistency of intentions around the outcomes that can only be secured in partnership between statutory and voluntary and community sector organisations for the long run? How do we make sure that that is secured for the future?

Q. That was to be my next question, Mr Adamson.

What can be done to make local resilience forums better aware of what the voluntary and community sector has to offer? Must it be done by way of the imposition of a legal obligation, changes to the Civil Contingencies Act and the nature of Category 1 and Category 2 responders, or changes to the working relationship between local resilience forums and DLUHC, or what? How can local resilience forums be made to engage your sector better in the future?

A. Well, local resilience forums are not standard legal entities anyway. They --

Q. We -- the Inquiry is aware of that.

A. Yeah. But that means that it's hard -- I'm not sure the answer is legislation, but I think that the UK resilience framework creates the opportunity to set out a much clearer set of expectations about the characteristics of an effective local resilience forum, including the way in which it engages with the voluntary and community sector, and the kind of models and structures that work in different places, and to spread best practice, and also to use peer review and audit as tools to establish what is working well and what is working less well, and then be prepared to talk about those that are working well and those that are working less well.

LADY HALLETT: Forgive me. Who decides on the member ship of the LRF?
A. That is decided amongst the -- I think primarily among the Category 1 responders in a -- in whatever the designated area is, sometimes which is a local authority boundary and sometimes it may be across a number of local authority boundaries. But other boundaries will also be taken into account, for example police boundaries or health service boundaries. So there is quite a lot of variability about the way in which they work.
MR KEITH: Is the position, Mr Adamson, that because the local police force will generally be the de facto chair of the local resilience forum and because the main attendees are the police and the blue light services, they generally get to decide who will attend those meetings? Is that how it works in practice, in your experience?
A. I don't think I would have expressed it like that. I think the police do sometimes take the lead, there's no question about that, but I think it's more variable, and perhaps post-Covid even more so, because it's recognised that actually the issues in responding to and recovering from something like a pandemic are so much more about community than they are about policing and

security.
Q. The Civil Contingencies Act part 1 provides that Category 1 responders are, amongst the many duties imposed on them, obliged to liaise with the voluntary and community sector. So there's no shortage of legal obligation to connect with your sector, the issue lies in relation to how it's carried out in practice; would you agree?
A. Yes, I would.
Q. You refer also to the national resilience guidance. By that, did you mean the national resilience framework, in particular the document which was published by Mr Dowden, the Deputy Prime Minister, and the Cabinet Office in December of last year, the national resilience framework? Is that the sort of guidance you had in mind when referring to the existence of a structure or a guidance required to place expectations upon your sector as to what it can do?
A. Yes. We see the UK resilience framework that was published in December 2022 as a step forward in setting out a whole-society approach to the way in which we think about resilience, that recognises -- that brings people much more into our thinking about resilience as opposed to just about infrastructure, important though that is.

The challenge for the UK resilience framework is actually that the strategic implementation plan or, you know, the roadmap is incredibly high level, and we would like to see a much more detailed roadmap or strategic implementation for all of the different components of the UK resilience framework that we could develop in partnership with the Cabinet Office, and indeed the resilience and emergencies directorate, to really live that whole-society approach from now about what needs to be in place to enable people better to -- to be better prepared for emergencies in the future and to better recover from them.
Q. So you would say that the national resilience framework does not go far enough in setting out what can be done, what the expectations are, reasonably, upon your sector and in identifying a route map going forward to bring about practical change?
A. I would frame it more positively, in the sense that the UK resilience framework came out in December 2022, we're now in July 2023, now is the time for a detailed roadmap of what is required.
We think that the quality of conversation has improved since, you know, its development.
We also welcome the development of a kind of split of the role of the director of the Civil Contingencies

Secretariat from the director of resilience, because we think that resilience has been the poor relation of emergency preparedness and response for too long, so it is welcome that there's a director in charge of that.
We would like to see that go further, we would like to see a minister for resilience, because at the moment resilience is the responsibility of --
Q. Slow down, please, Mr Adamson.
A. We would like to see a minister for resilience, because at the moment those responsibilities fall to the Paymaster General, and we don't -- whatever the qualities of the Paymaster General, we don't think that signals a serious commitment to national resilience, particularly when the Paymaster General has a range of other responsibilities.
Q. I'm going to pause you there, because my Lady has heard a great deal of evidence from Cabinet Office witnesses about that, and from politicians, about the need for a minister to be in charge of resilience unencumbered by other obligations.
LADY HALLETT: I'm not sure they all agreed on "unencumbered by other obligations", Mr Keith.
MR KEITH: I stand corrected. That is correct, there was a variety of views expressed across that topic.
LADY HALLETT: What would be you recommending?

A. We think 2017 was a watershed year with the Grenfell Tower fire and the terror attacks, we've then had Covid, we've then seen the way in which international emergencies in Afghanistan, Ukraine and Sudan have had deep ripple effects back into the UK in a way that international emergencies did not previously have. And therefore we think that the -- we as a nation need to be much more prepared for a world of multiple simultaneous emergencies that will affect us in the future, and that therefore there is a requirement for a minister who is fully committed to thinking through: what is a resilience strategy for the nation? And that required -- the risk, if you like, the risk profile has changed.

LADY HALLETT: Thank you. So fully and solely committed?

A. Yes.

LADY HALLETT: Yes.

MR KEITH: Mr Adamson, a few moments ago I asked you some questions about the legal obligations in part 1 of the Civil Contingencies Act 2004, and I noted in my question to you that Category 1 responders are required to have regard to the activities of certain voluntary organisations. I think that's regulation 23, and I'm very grateful to those behind me for reminding me of that.

Do you have a view as to whether or not the current terminology in that legal obligation -- that is to say the requirement upon Category 1 responders to have regard to activities of certain voluntary organisations -- should be strengthened?

I ask because I think you were asked this very same question in the context of the Inquiry into the Grenfell fire, the Grenfell Tower fire, and you answered yes, if I can remind you, to that question when it was put to you in that Inquiry.

A. We would -- we still believe that that would be desirable. The reason -- we do, though, think that the new UK resilience framework is very helpful in setting out strategic intentions around a whole-society approach to how we build resilience and the ability to respond to and recover from emergencies, that means that there is an implicit strengthening of the "have regard to" phrase. But of course we would welcome phraseology in law that was stronger than that phrase of "have regard to".

Q. The framework itself, as you know well, makes reference repeatedly to activities which the government is already undertaking to carry out, as well as to specific activities and acts which are due to be complete by, respectively, 2025 and 2030.

So it would seem, Mr Adamson, that there isn't room in the current framework for the additional sort of plans of action or route maps of which you've spoken, because the framework is already committed to a particular timetable which doesn't include the matters that you've spoken of.

So would you also welcome a tightening up of that national resilience framework and a further, more detailed commitment to the sorts of changes of which you've spoken?

A. Yes, we would. We have chosen to interpret the word "framework" in a positive way, which is -- and that there is a framework set out, of action, but we think that a much more detailed roadmap and implementation plan is required to deliver what is set out there.

Q. All right.

A further discrete topic, if I may. To what extent does the voluntary and community sector, and in particular the emergency partnership, take part in national exercises or simulations for civil contingencies emergencies? Do you attend exercises? Are you invited to attend them? Do you attend as participants or as observers, or --

A. As both -- with both my Red Cross hat on and VCS Emergencies Partnership hat on, yes, we are part of

exercises and have been for many years, and indeed most recently took part in the Mighty Oak exercise, which was looking at the impact of a complete power outage on the ability of the nation to cope.

What I would observe is that -- and this is very relevant to the UK resilience framework -- is to ask the question of whether anyone is taking account of, when we look at the risk register, which is -- and we welcome some of the updating of the National Risk Register -- are -- and you look at the mix of local and national exercising that's taking place, is that a proportionate response to the National Risk Register against which we're planning? And is that covering the whole country against the kind of risks that different parts of the country might face? And indeed, in relation to your question, are the voluntary and community sector being properly integrated into those exercises?

So my answer is: yes, we are included, but I think that the reflection of the change in the risk profile that we face, that I described earlier, means that we should also be making sure that the exercising we're doing, locally and nationally, is being done in the right way and relating to the risk profile we now face.

Q. You mean the role that you play currently in national exercises and simulations needs to be better thought

about and better targeted, the risks for which the exercise exist need to be thought about to a greater degree, and your role in the meeting of those risks needs to be thought about also to a greater degree?

A. Yes, I do.

Q. Finally, in your statement at paragraph 57 you identify a number of key areas where lessons should be learnt from the pandemic for the future. Are they advanced not by way, in fact, of specific steps that can be taken but more by way of general principles that ought, in your opinion, to be applied?

A. That's correct.

Q. Devolving power from central government to local government and better co-ordination of preparedness and response at a local level, the first one; strengthening the relationships with the voluntary and community sector, at both national and local levels, in advance of civil emergencies so that resources can be better deployed in times of need; thirdly, it's important to look beyond initial emergency response and plan for longer term recovery and build that into your planning procedures so that, bluntly, we're taken less by surprise in the event of an emergency; and, fourthly, do you also, as with many others, say there needs to be greater focus on understanding, thinking about and

planning for the impact of emergencies on those persons who suffer from pre-existing inequalities and vulnerabilities, and would you wish the Inquiry to consider all those worthy principles?

A. Yes, we would, and they are a connected set of principles, because if we work through the scenarios for the different kinds of emergencies we face, coming -- arising from the risk register, and the human impacts of those different types of emergencies, and the vulnerabilities that may arise.

So, for example, and I'm sure you've heard considerable evidence about: while this was treated as -- Covid was treated as a health emergency, actually its impact on vulnerability was multifaceted and could only really be interpreted at local level.

So these considerations that we're suggesting for the future are connected.

National scenario planning, a more human approach to the risk register that's pulling out the different vulnerabilities in different scenarios, different emergencies, and then allowing local -- you know, emergency response is essentially a local activity, because that's where people are.

So local authorities and their partners, including the voluntary and community sector, need to be empowered

with the information necessary to respond, but having been stretched and challenged around those scenarios and thinking through who is most likely to be forgotten in the response to these emergencies.

Q. A whole-society but individual approach?

A. Exactly.

MR KEITH: My Lady, those are all the questions I have for Mr Adamson.

LADY HALLETT: I don't think there are any other questions?

MR KEITH: I believe not.

LADY HALLETT: Mr Adamson, thank you very much indeed. Extremely thoughtful and extremely interesting; you've bee very helpful, thank you.

THE WITNESS: Thank you so much, and can I also just express my condolences to all those who lost loved ones in the emergency during this period.

LADY HALLETT: Thank you, Mr Adamson.

(The witness withdrew)

MR KEITH: My Lady, that concludes today's evidence and indeed all the evidence, expert and factual, in Module 1. There remains only to hear, importantly, from four witnesses tomorrow on the part -- on behalf of the Covid bereaved family groups.

LADY HALLETT: Yes, so anybody who is planning to watch tomorrow, they should know -- or listen or attend

tomorrow -- they should know that the morning will be spent listening to people who have suffered bereavement during the pandemic.

MR KEITH: Indeed.

LADY HALLETT: Very well. Thank you very much. 10 o'clock tomorrow.

MR KEITH: Thank you.

LADY HALLETT: Thank you.

(3.08 pm)

(The hearing adjourned until 10 am on Tuesday, 18 July 2023)

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