

Wednesday, 19 July 2023

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2 (10.00 am)

3 LADY HALLETT: Mr Stanton.

4 Submissions on behalf of the British Medical Association by
5 MR STANTON

6 MR STANTON: My Lady, the closing statement to Module 1 on
7 behalf of the British Medical Association, the BMA, is
8 as follows: after six weeks of hearings it is clear that
9 the UK entered the pandemic with critically
10 under-resourced and underfunded health and public health
11 services, and that there were repeated failures in
12 pandemic planning and preparedness, including in
13 relation to the PPE stockpile, and the implementation of
14 recommendations and learning from previous pandemic
15 planning exercises.

16 These failures gravely hampered the pandemic
17 response and placed doctors, other healthcare workers
18 and patients at increased risk when the pandemic hit.

19 This statement highlights four key areas of
20 deficiencies in pandemic planning and resilience.

21 First, the failure to ensure that doctors and
22 healthcare workers were adequately protected when
23 responding to a pandemic.

24 Second, the lack of capacity and resourcing
25 available to provide an effective response.

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1 were not provided. It was in April 2020, whilst wearing
2 inadequate PPE, that I caught coronavirus from
3 a patient."

4 Tragically, there are doctors and healthcare workers
5 who died because of Covid-19 infection acquired in their
6 workplace, and significant numbers are suffering from
7 long Covid. The BMA has very recently, on 4 July 2023,
8 published a report about the impact of long Covid titled
9 *Over-exposed and under-protected: the long-term impact*
10 *of COVID-19 on doctors*, which is informed by a survey of
11 over 600 doctors suffering from long Covid.

12 The report establishes that lack of preparedness for
13 a pandemic and poor risk management in health services
14 contributed to many doctors contracting Covid-19 at
15 work.

16 A key finding of this report is the lack of access
17 by staff to FFP3 respirators, which are the type of
18 filtering face piece respirators that provide maximum
19 protection from infection transmitted by aerosol.

20 77% of the respondents to the BMA survey who
21 acquired a Covid-19 infection in the first wave of the
22 pandemic believe that they were infected while at work,
23 and only 16% of respondents had access to these more
24 protective FFP3 respirators at the time they were
25 infected.

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1 Third, the specific failure to ensure there was
2 an adequate test and trace response.

3 And, fourth, the government structures and processes
4 in place for civil contingencies.

5 Dealing first with the issue of the provision of PPE
6 to doctors and other healthcare workers. The Inquiry
7 has heard repeatedly in this module that the planning
8 for PPE including stockpile was inadequate for
9 a pandemic event. This, coupled with the distressing
10 accounts of healthcare workers about the circumstances
11 in which they were required to work without adequate
12 protection while exposed to a deadly disease, is damning
13 evidence.

14 Right from the outset of the pandemic, there was
15 a huge concern within the BMA's membership about this
16 issue, with doctors describing how they were instructed
17 to remove their masks, accused of scaremongering, and
18 others expressing concern at the absence of
19 FFP3 respirators and the inadequate consideration given
20 to the risks of aerosol transmission.

21 One GP from England told the BMA that:

22 "We were seeing patients who had Covid, but because
23 of the advice that was behind the curve they were deemed
24 to be low risk. We needed proper protection with
25 FFP3 masks, but these were not considered necessary and

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1 There is evidence before the Inquiry that this lack
2 of availability of FFP3 respirators was because cost
3 considerations were prioritised ahead of safety, leaving
4 doctors and healthcare workers inadequately protected
5 while delivering healthcare.

6 It's not just a question of volumes of PPE. There
7 was also a failure to ensure that there was PPE
8 available to suit a diverse range of facial features,
9 including for smaller, often female, face shapes, for
10 staff from some ethnic minority backgrounds and for
11 staff who wear a beard or hair covering for religious
12 reasons.

13 Respondents to BMA surveys during the pandemic were
14 more likely to report failed fit testing of respirators
15 if they were from ethnic minority backgrounds, as these
16 were usually manufactured for white male face types.

17 Clara Swinson, director general at the Department of
18 Health and Social Care, accepted that these issues were
19 not adequately considered as part of pandemic planning
20 prior to Covid-19.

21 The BMA's position is that the adequacy of the
22 PPE stockpile is firmly within the scope of Module 1 as
23 a matter of planning and preparedness. However, it also
24 recognises that PPE is a cross-cutting issue, with
25 relevance to Modules 2, 3 and 5, and that in these

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1 circumstances you will not yet be able to make final
2 findings and recommendations about where responsibility
3 lies and why the stockpile remained deficient for so
4 long in the knowledge of the risks posed to healthcare
5 workers.

6 Nevertheless, it will be important in the BMA's
7 submission that this appalling failure to protect
8 doctors and other healthcare workers is reflected within
9 the Inquiry's Module 1 report.

10 Similarly, healthcare workers including those more
11 vulnerable to Covid-19, for example due to factors such
12 as age, ethnicity, sex or underlying health conditions,
13 did not receive timely and adequate workplace risk
14 assessments which could, if undertaken and acted upon,
15 have prevented the death and long-term illness of some
16 workers.

17 The UK Government failed to ensure that employers
18 met their responsibilities under health and safety law,
19 and did not provide sufficient guidance or support for
20 employers to undertake risk assessments.

21 The BMA raised concerns on multiple occasions that
22 these legally required risk assessments were not being
23 undertaken within healthcare settings. However, it was
24 not until 24 June 2020, three months into the pandemic,
25 that NHS England issued a letter reminding employers to

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1 Covid-19 pandemic.

2 These have included Professor Heymann, who noted
3 that preparedness is not just about a strong public
4 health system and discussed the need for NHS surge
5 capacity. One of the key recommendations from
6 Professor Whitworth was to have sufficient reserve
7 capacity within the health system.

8 Dr Marmot and Professor Bambra talked about how the
9 funding of healthcare has been inadequate since 2010,
10 and waiting times have doubled.

11 Dame Sally Davies commented that there was no
12 resilience in the NHS and that, compared to similar
13 countries, the UK was bottom of the table on numbers of
14 doctors, nurses, beds, intensive care units, respirators
15 and ventilators.

16 Jeremy Hunt, the former Secretary of State of
17 Health, told the Inquiry that he had become convinced at
18 Health Secretary that the NHS needed more capacity.

19 Rosemary Gallagher from the Royal College of Nursing
20 spoke about how workforce resilience is essential in
21 order to deliver healthcare services, and that the UK
22 went into the pandemic 50,000 nurses short, which put
23 staff at risk when seeking to surge capacity.

24 Nigel Edwards, of the Nuffield Trust, told
25 the Inquiry that some hospitals had to make very major

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1 undertake risk assessments for their staff.

2 In these circumstances, the BMA felt compelled to
3 develop its own risk assessment tool for healthcare
4 environments and the fact that it was required to take
5 this step is clear evidence of the failure to plan and
6 prepare to keep healthcare workers safe in their place
7 of work.

8 In relation to capacity and resources, the Inquiry
9 has been told that, in addition to adequate planning, it
10 is necessary to have the resilience and the resources to
11 implement the plans and to pivot and adapt in response
12 to changing circumstances.

13 On Monday, in his evidence, the current chair of the
14 BMA's UK council, Professor Banfield, told the Inquiry
15 that the BMA had for a number of years been highlighting
16 the issue of capacity within the health service to all
17 four governments and raising concerns that, prior to the
18 pandemic, there wasn't the capacity needed to run the
19 health services as it was.

20 He is not alone in this regard, and over the course
21 of the hearings the Inquiry has heard from numerous
22 witnesses across a range of fields of expertise that
23 public health and health services in the UK are
24 suffering from a lack of resources, equipment and
25 capacity, which impacted their ability to respond to the

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1 engineering and structural changes to accommodate high
2 flow oxygen at the outset of the pandemic, a point
3 echoed by Professor Banfield in his evidence on Monday.

4 This, he said, indicated a broader issue about the
5 way hospitals have been designed and built in the UK,
6 which is to strip out any kind of redundancy, to
7 compress spaces that are available, to save money where
8 that is possible by reducing to the lowest tolerance
9 that sits within the guidance.

10 Mr Edwards also said that many health systems, but
11 the UK in particular, have traditionally run with very
12 low margins of spare capacity, which means that having
13 a plan for how to deal with a sudden surge or emergency
14 is very important, but it also limits the scope of that
15 plan because the level of spare capacity in the system
16 is relatively low.

17 Dame Jenny Harries referred to a 40% reduction in
18 the funding of Public Health England in real terms over
19 the course of its life, and Sir Jeremy Farrar, the
20 Chief Scientist at the World Health Organisation, sets
21 out in his witness statement that public health,
22 clinical care, care homes, health services and the NHS
23 were chronically underfunded for what they were expected
24 to deliver during the period 2010 to 2020. Efficiency
25 was the singular focus, and spare capacity, resilience

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1 and support for the staff within the NHS and all allied
2 services was neglected. He said this was a system that
3 was not really coping with normal pressures, and there
4 was no spare capacity when a crisis hit.

5 The Inquiry has also heard about specific concerns
6 that the public health system was hindered in their
7 pandemic response because of the continuing impact of
8 the structural reforms introduced in England by the 2012
9 Health and Social Care Act, which fragmented the system
10 and fractured links between public health and NHS
11 colleagues, and of the subsequent years of budget
12 reductions and funding cuts.

13 As early as 2011, prior to the implementation of
14 these reforms, in response to the consultation on the
15 government's influenza pandemic preparedness strategy,
16 the BMA had raised concerns that the proposed
17 reorganisation of the NHS and the public health system
18 which would result from the Act jeopardised
19 a co-ordinated and integrated approach, and asked the
20 government to consider the knock-on effects of these
21 reforms on the strategy.

22 In the same response, the BMA also called for the
23 involvement of public health doctors with specialisms in
24 health protection, to be enshrined in the pandemic
25 response system.

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1 Health England that they had been reluctant to engage
2 with private laboratory testing facilities, is
3 instructive in this regard.

4 He said:

5 "... I think that in the UK case it's a slightly odd
6 criticism because the UK has a significant sequencing
7 public capability within the NHS and it also has
8 significant sequencing capabilities within the
9 university sector, of which Public Health England were
10 naturally aware because they were working with all of
11 these laboratories prior to the pandemic ...

12 "It's very interesting to see the NHS capabilities
13 perhaps not being used as strongly as some observers
14 would have wanted them to be used in 2020."

15 Similarly, there was significant expertise and
16 capacity to carry out contact tracing within local
17 authority public health functions, which again wasn't
18 properly utilised.

19 Professor McManus, President of the Association of
20 Directors of Public Health, told the Inquiry why it was
21 so important to engage with directors of public health,
22 who were trained and expert in contact tracing and knew
23 their local areas and local communities. He said they
24 have capabilities that should have been shaped rapidly,
25 like on test and trace, which improved markedly when

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1 Duncan Selbie, the former chief executive of Public
2 Health England, agreed with Dame Jenny Harries that
3 there was a difficult transition and that the links
4 between NHS staff and public health specialists became
5 fractured and affected community infection prevention
6 and control. He told the Inquiry that one of his
7 greatest regrets was that strengthening the relationship
8 between public health and local government came at the
9 expense of having removed that capability and experience
10 from the NHS.

11 Moving from resourcing to planning, the Inquiry also
12 heard evidence about the dual failure to adequately plan
13 for a coronavirus-type pandemic and separately to plan
14 to prevent the spread of the disease rather than simply
15 manage its impact.

16 A major consequence of these failures was that there
17 was no contingency to carry out mass testing and
18 tracing, leading to the abandonment of contact tracing
19 on 12 March 2020, which left the UK without any
20 effective measures for controlling the pandemic at this
21 critical time.

22 However, the UK did have existing diagnostic
23 capability within 44 NHS laboratories that simply was
24 not fully utilised, and Dr Kirchhelle's evidence to
25 the Inquiry, when asked about criticisms of Public

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1 local directors of public health and local authorities
2 became involved. However, at the start of the pandemic,
3 the United Kingdom Government did not even have
4 an up-to-date contact list for all the directors of
5 public health.

6 Finally, turning briefly to government systems and
7 processes for ensuring resilience and preparedness, the
8 BMA's position is that there is an urgent need for clear
9 accountabilities and responsibilities to be established.
10 The process by which learning from expert reports and
11 exercises is implemented is woefully inadequate. Over
12 the last six weeks, the Inquiry has questioned many
13 witnesses about the failure to implement
14 recommendations, and there are too many instances to
15 mention in the time available, save to say that concerns
16 and recommendations about the need to ensure adequate
17 PPE, risk assessment processes, test and trace
18 capability, and adequately resourced and staffed public
19 health and health services have been raised repeatedly
20 since at least 2003, following the SARS outbreak, and
21 yet by the time the pandemic struck, almost two decades
22 later, they had still not been properly implemented.

23 These failures are partly explained by the vacuum of
24 responsibility for the implementation of
25 recommendations. Public Health England told the Inquiry

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1 that they just ran the exercises but were not
2 responsible for implementing their recommendations.
3 Similarly, there was no clear process by which those who
4 commissioned and instigated exercises knew whether and
5 how recommendations had been put in place, an example of
6 this being Exercise Alice, instigated by the then Chief
7 Medical Officer in 2016 in response to MERS.

8 The quality of decision-making, such as the
9 composition of the PPE stockpile, which was dictated by
10 considerations of cost rather than safety, is also
11 a serious cause for concern, particularly when
12 considering the views expressed by Oliver Letwin, who
13 told the Inquiry that the revolving door of ministerial
14 and official appointments tends to undermine experience,
15 efficacy, and the ability of ministers and officers to
16 be able to do the job with which they are tasked.

17 In this regard, the Inquiry has heard about
18 a concerning lack of knowledge and awareness at senior
19 levels within lead government departments, including in
20 relation to key documents such as the 2011 UK Influenza
21 Pandemic Preparedness Strategy.

22 The Inquiry has also heard about failures to engage
23 and to share information with key stakeholders,
24 for example the Exercise Cygnus report, which was only
25 published in 2020 following a judicial review challenge

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1 who make up its 48 member unions and who span a wide
2 range of sectors profoundly affected by the Covid-19
3 pandemic.

4 In this module, the TUC is working in partnership
5 with the Wales TUC, the Scottish TUC, and the Northern
6 Ireland Committee of the Irish Congress of Trade Unions.
7 Together we seek to represent the interests in this
8 Inquiry of a great many unions all listed in our written
9 opening right across the four nations of the UK.

10 Of particular concern to our affiliated unions is to
11 understand the causes and learn the lessons of those of
12 working age who died of Covid-19. They numbered
13 over 15,000. Many suffered in a myriad of ways,
14 including those who continue to live with long Covid.

15 My Lady, in this module concerning pandemic planning
16 and preparedness, what we have learnt in respect of
17 a plan for a pandemic such as Covid-19 has been
18 surprisingly straightforward. Quite simply, there was
19 no plan.

20 Planning was, as Dame Sally Davies put it,
21 monomaniacally focused on pandemic flu. Even then it
22 was focused on managing the dead, rather than protecting
23 the living. No doubt there are many important lessons
24 to be learned. That might include reframing our
25 thinking around emergency planning so that we plan not

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1 brought by a doctor.

2 Add all of this together, the failure to implement
3 learning, the lack of clarity around roles and
4 responsibilities, concerns about levels of knowledge and
5 experience, cost-cutting, and a tendency towards
6 unnecessary secrecy, and it was inevitable that there
7 would be failures to plan and prepare properly.

8 Sir Jeremy Farrar told the Inquiry that we are
9 living in a pandemic age, and before the next pandemic
10 inevitably hits there is an urgent need to establish
11 clear and coherent decision-making processes,
12 responsibilities and accountability. In addition, it is
13 imperative that key public services, in particular
14 health and public health services, are safe working
15 environments and are adequately resourced.

16 Thank you, my Lady.

17 **LADY HALLETT:** Thank you very much, extremely helpful,
18 Mr Stanton, thank you.

19 I think next is Mr Jacobs.

20 **Submissions on behalf of the Trades Union Congress by**
21 **MR JACOBS**

22 **MR JACOBS:** Good morning, my Lady. I appear on behalf of
23 the Trades Union Congress, the TUC, with
24 Ms Ruby Peacock, and instructed by Thompsons Solicitors.

25 The TUC brings together 5.5 million working people

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1 only for what is foreseen as the likeliest emergency,
2 but also for the emergency with the most severe
3 potential consequence. It might include lessons such
4 as -- as to the structures for emergency planning, such
5 as there being a dedicated minister and perhaps
6 an agency specifically focused on such matters.

7 The Bereaved Family groups yesterday afternoon made
8 a number of suggestions as to necessary reforms for the
9 structures for pandemic planning, and they seem to us to
10 carry some significant force.

11 We say that the Inquiry should robustly reject the
12 narrative suggested by some that the events in the
13 pandemic were unforeseeable and all that could really be
14 done was to react as it unravelled.

15 Perhaps the one area in which we were world leading
16 during the pandemic was in the development and
17 distribution of vaccines. My Lady, that was not built
18 on plucky British resolve in response to adversity as it
19 arose, it was built on research and development,
20 investment and the application of clinical expertise
21 through the establishment of the Vaccine Network.

22 As Dame Sally Davies explained, it was the only
23 thing we had resilience in. It was an instance of
24 foresight and action and a welcome escape from
25 short-term-ism.

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1 So we have learnt, my Lady, not only that there was
2 no plan, but also that preparedness really matters.

3 Our particular focus and concern through Module 1
4 has been on the resilience of public services and on the
5 disproportionate impact of a pandemic upon certain
6 vulnerable and protected groups. The unavoidable
7 context for considering the resilience of services going
8 into the pandemic is austerity. In our opening
9 submission, we expressed this to be a central theme of
10 the evidence which rested on a simple but inescapable
11 truth: that no matter what planning is put in place,
12 public services stretched to breaking point by over
13 a decade of budget cuts will be severely impaired in
14 their ability to cope with the shock of a national
15 emergency such as a pandemic.

16 What we described as a striking feature of the
17 evidence, that so many will consistently describe
18 austerity's disastrous consequences, has proven to be so
19 in the oral hearings.

20 The only real exception has been the evidence of
21 Mr Cameron and Mr Osborne. To us, their evidence had
22 the feeling of having come from a distant island in
23 which NHS staff numbers were high, NHS satisfaction was
24 high, and the output of public services had the good
25 fortune of bearing no relation to budgetary input.

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1 but also the ability to continue to provide healthcare
2 to the population generally and to be able to return
3 within a reasonable timeframe to something resembling
4 an effective health service.

5 Given the gaps in planning, it is a real credit to
6 the commitment, skill and determination of those in our
7 health service that we did not run out of intensive care
8 beds.

9 The real price has been longer term: in respect of
10 the impacts more generally on the ability of the NHS to
11 meet needs for healthcare. Quite shockingly, as of the
12 start of this year, the number of people on an NHS
13 waiting list for hospital treatment has risen
14 to 7.2 million. As Kate Bell of the TUC described in
15 her oral evidence, that number can be compared with
16 the 4.2 million patients on waiting lists at the
17 beginning of the pandemic.

18 That is a huge long-term cost to patients of the
19 lack of resilience and capacity in the NHS. It is also,
20 of course, an unfair demand on the workforce, who, burnt
21 out from the demands of battling a pandemic in
22 an under-resourced system, now face the pressures of
23 managing and responding to enormous and growing waiting
24 lists.

25 As Ms Bell highlighted in her oral evidence, in

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1 It was not a picture we recognised, nor does it
2 appear one recognised by any other witness in this
3 module.

4 The Chancellor, for example, was at least prepared
5 to recognise that, as Secretary of State for Health and
6 Social Care, he had been concerned in the years prior to
7 the pandemic as to the resilience and capacity in our
8 health and social care services. Indeed, he described
9 the fact that he was unable to secure a long-term
10 funding settlement for the social care sector as one of
11 the regrets of his time as Secretary of State for Health
12 and Social Care.

13 This Inquiry has made clear that it cannot and
14 should not express a ruling on the merit or otherwise of
15 austerity as a fiscal policy, but it is its duty to be
16 full and fearless about its findings about the
17 consequences of drastic cuts to public spending.

18 We have heard evidence about resilience and capacity
19 in our healthcare services. For a health service that
20 has perennially faced the existential question of
21 whether it can cope with the next winter flu, we didn't
22 really need to be told that it didn't have the
23 resilience and capacity for a global pandemic.

24 Resilience in the face of a pandemic includes not
25 only the ability to treat the urgent cases in its peak,

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1 a survey by the TUC of 1,000 NHS staff, 69% said that
2 reductions in staffing and resources were putting
3 patient care at risk. The issue is not, therefore, only
4 one of waiting times, but of patient safety.

5 We have also heard evidence about resilience in
6 social care. In our opening, we suggested that in
7 social care the problem has been not so much one of
8 repeated restructuring and reorganisation, but one of
9 neglect. There has been no attempt to structure at all.

10 We observed that adult social care in England is now
11 provided by around 18,000 organisations. We observed
12 that the overall workforce is larger than in the NHS,
13 yet there is no equivalent to NHS England seeking to
14 provide some strategy and direction to the sector. We
15 pointed out that the TUC has repeatedly called for
16 a national social care forum to bring together
17 government, unions, employers, commissioners and
18 providers to co-ordinate the delivery and development of
19 services, including the negotiation of a workforce
20 strategy.

21 We also suggested that co-ordinating a national
22 effort across a hotch potch of private organisations is
23 impossible.

24 My Lady, all of those observations have been
25 underlined by the evidence you have heard. On being

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1 asked about funding and the difficult picture facing the
2 social care sector, Mr Osborne pointed out that the cuts
3 in local authority funding were not secret but were
4 publicly announced as part of a programme of trying to
5 reduce government expenditure. No doubt they were, but
6 an openness as to cuts in funding does not make the
7 challenges faced by the social care sector any less
8 difficult.

9 There are huge challenges facing the workforce.
10 The Inquiry has received evidence that in the year going
11 into the pandemic there were care worker turnover rates
12 of around 40%, in the region of 115,000 staff vacancies,
13 and around one quarter of its staff were working on
14 zero hour contracts.

15 Bruce Mann described the UK Influenza Pandemic
16 Preparedness Strategy from 2011 as very slim on the
17 social care aspect. From the Department of Health and
18 Social Care's own operational response centre lessons
19 learned reviews, it is clear that there was confusion
20 within the department regarding whether it even had
21 responsibility for social care pandemic planning. It
22 states:

23 "Some commented that emergency planning had assumed
24 care providers would be responsible for their own
25 response, and a centralised government role had not been

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1 capacity in social care. The Inquiry cannot seek to
2 recommend the solutions to those problems in this
3 module, but it should be moving forward towards a future
4 module in social care with a sense of conviction that
5 fundamental change is needed.

6 My Lady, you've committed to understanding and
7 making findings as to the unequal impact of the
8 pandemic. It is widely recognised that the pandemic
9 disproportionately impacted certain protected and
10 vulnerable groups. It is important for this Inquiry to
11 understand the drivers of that disproportionate impact
12 and to understand, crucially, how planning for future
13 pandemics can mitigate those impacts.

14 As a starting point, it was foreseeable that
15 a pandemic would have a disproportionately adverse
16 impact upon lines of socio-economic disadvantage and
17 along the intersection of such disadvantage with
18 precarious work, with ethnicity, disability, age,
19 gender, caring responsibilities and poor health.

20 As explained by Professors Marmot and Bambra, the
21 historic and global experience of a range of
22 whole-system shocks, whether it be a financial crisis,
23 extreme weather events or indeed pandemic flu, is that
24 such shocks expose and amplify pre-existing health
25 inequalities.

23

1 anticipated."

2 The Inquiry has of course received significant
3 evidence from witnesses, including
4 Sir Christopher Wormald, that key recommendations in
5 respect of social care following Exercise Cygnus were
6 not implemented before the pandemic.

7 Perhaps a scarcity of detailed planning is
8 unsurprising when viewed in light of the complete lack
9 of visibility and centralised oversight in social care
10 as an undoubtedly fragmented sector. The Inquiry has
11 heard that going into the pandemic there was no central
12 government understanding as to how many people were
13 receiving or needed adult social care, nor how many
14 registered homes were providing such care. This is
15 a glaring omission, given the complexity of the sector.

16 The Department of Health and Social Care described
17 in its opening statement the fact that social care is
18 managed across 152 local authorities and is made up of
19 around 25,800 registered social care establishments.

20 The reality, as described to the Inquiry, is that
21 a complex and fragile sector, upon which so much of
22 pandemic response relies, went into the pandemic without
23 even the most basic of preparations.

24 The Inquiry should move forward from Module 1 with
25 some pretty stark findings as to preparedness and

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1 The examples are numerous, but perhaps among the
2 most striking, given its timing, is that in the 2009
3 swine flu pandemic the mortality rate in the most
4 deprived 20% of England's neighbourhoods was over three
5 times higher than in the least deprived 20%.

6 It is evident that the uneven impact is not unique
7 to Covid-19.

8 It is also evident that these matters were not
9 considered in the UK's pandemic planning. The evidence
10 is that such consideration relating to unequal impacts
11 of a pandemic as there was, was limited to clinical
12 vulnerabilities. That was acknowledged by both
13 Sir Christopher Wormald, in evidence given on behalf of
14 the Department of Health and Social Care, and by
15 Katharine Hammond, in evidence given on behalf of the
16 Cabinet Office.

17 The Module 1 evidence establishes, then, that the
18 disparate impacts were foreseeable and were not
19 considered. Those have been important points to
20 understand, but they also give rise to, in a sense,
21 a rather more important and certainly more difficult
22 question: how should planning for a pandemic address
23 these matters?

24 An important aspect is no doubt having appropriate
25 structures for planning. Of course we urge a departure

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1 from the arrangements we described in opening as
2 something resembling a bowl of spaghetti. But this
3 Inquiry must also, we suggest, always have in mind what
4 it considers should be in a pandemic plan -- or, perhaps
5 more helpfully described by the Department of Health and
6 Social Care in its opening, what should be in the
7 toolkit of capabilities to respond to the many different
8 possible characteristics of a future pandemic.

9 Whilst it may be hugely important, for example, to
10 recommend that there be a minister with sole
11 responsibility for emergency planning, this Inquiry will
12 not have done its job effectively if that minister is
13 not left with a concrete understanding as to the
14 practical requirements of an effective pandemic plan.

15 To an extent, those concrete measures will be
16 revealed in future modules, but we do not believe we are
17 getting ahead of ourselves in considering them now.
18 These issues should be at the forefront of the Inquiry's
19 consideration throughout, and it is in part necessary to
20 have them in mind to ensure that the Inquiry is
21 continuing to look at the right issues.

22 It appears to us that the lessons to be learned,
23 certainly in relation to Covid-19 in the workplace,
24 really fall into two baskets. The first relates to the
25 health generally of our nation and the extent of the

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1 the labour market and employment practices. One
2 challenge is rates of pay, with more people in poverty
3 now being in work than out of work. Insecure work has
4 increased. One aspect of that is zero hour contracts.
5 In 2010 there were 168,000 people working on zero hour
6 contracts --

7 **LADY HALLETT:** I think, with respect, Mr Jacobs, you're
8 straying beyond the powers that I'll have in this
9 Inquiry to tackle such issues.

10 **MR JACOBS:** My Lady, I quite agree, and in fact that is
11 a point which I am going to come on to, which is that
12 part of what we have learnt in this module, my Lady, is
13 that unless we become a healthier, fairer and more equal
14 society, then a future pandemic will again see
15 a disproportionate impact on disadvantaged groups.

16 What we say, it is important that the Inquiry makes
17 appropriate findings as to pre-existing structural
18 inequalities and their relevance to uneven impacts, but
19 it may also be, my Lady, that the answers to a point lay
20 beyond this Inquiry. It comes, ultimately, to questions
21 such as the value we as a nation put on matters such as
22 fair work, access to core services, and public health.

23 The Inquiry itself cannot answer those questions,
24 but we do say it must make crystal clear findings as to
25 the consequences of not addressing those sorts of

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1 growing structural health inequalities. The evidence is
2 that the UK entered the pandemic with increasing health
3 inequalities and with health among the poorest people in
4 our society in a state of decline, as it has been
5 since 2010. One of the starkest features of that health
6 inequality is the vast difference in life expectancy
7 between the most and least deprived areas.

8 As the Marmot and Bambra report describes, the
9 health picture coming in to the pandemic was stalling
10 life expectancy, increased regional and
11 deprivation-based health inequalities and worsening
12 health for the poorest in society.

13 One of the key determinants of health is work.
14 Being in good employment is protective of health and, as
15 Professors Marmot and Bambra describe, good work is free
16 of the core features of precariousness, such as lack of
17 stability and high risk of job loss, lack of safety
18 measures and the absence of minimal standards of
19 employment protection.

20 Insecure and poor quality employment is also
21 associated with increased risks of poor physical and
22 mental health.

23 My Lady, unemployment is relatively low, but, as
24 described by Professor Marmot in the *10 Years On* report,
25 there have been some profound shifts in many aspects of

26

1 matters.

2 But it is also, my Lady, crucially a question of
3 planning. Adequate planning can at least mitigate the
4 uneven impacts of a pandemic. This, my Lady, is the
5 second basket of lessons that we say are to be learned
6 relating to uneven impact of the pandemic in the
7 workplace, and in contrast, my Lady, they absolutely can
8 and should be answered by this Inquiry.

9 A number of witnesses and organisations have put
10 forward suggestions as to the lessons to be learned in
11 respect of pandemic planning and mitigating the uneven
12 impacts of the pandemic.

13 Of course in a sense we welcome all ideas, but we do
14 say that many, particularly when focused on how to plan
15 to address inequalities, have tended to be rather
16 nebulous in nature, and it is not at all clear how they
17 would lead to concrete and meaningful action. Some have
18 been, to take an observation of yours during the public
19 hearings, my Lady, and in fact just a minute or so ago,
20 noble but beyond the scope of your Inquiry.

21 So what does the Inquiry do about that, my Lady?

22 We say that ultimately, in considering uneven
23 impacts at least in the workplace, the Inquiry must not
24 ignore some simple truths. During the Covid-19
25 pandemic, there was a continued need for us to travel

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1 and to eat, there was a need for food retail staff to
 2 attend work, for transport workers to attend work, for
 3 food processing workers to attend work, and many others.
 4 There was a need, more broadly, to keep the economy
 5 going. And the burden and risk of continuing to attend
 6 work falls not on the professional occupations but on
 7 those professions who need to attend work in person and,
 8 in doing so, expose themselves to risk, and, my Lady,
 9 that pattern will inevitably repeat itself in a future
 10 pandemic.

11 Moreover, the burden falls, therefore, not on
 12 a cohort -- sorry, the burden falls on a cohort of
 13 working people, a great many of whom are in low paid and
 14 insecure work and who suffer from structural health
 15 disadvantages. Unless there are some fundamental
 16 changes in our society as to the labour market and
 17 factors driving health inequalities, the unequal impact
 18 will repeat itself too. But the Inquiry will hear in
 19 future modules, if it seeks the evidence, that the
 20 mitigations in those sectors where there were frontline
 21 and key workers were pretty hopeless.

22 What all of that means is that one crucial aspect of
 23 planning to mitigate uneven impact is, quite simply,
 24 planning to keep frontline occupations safe.

25 My Lady, that requires pandemic planning across
 29

1 workers are faced with a choice between not
 2 self-isolating or self-isolating but not having the
 3 money to live and eat.

4 The TUC has raised repeated concerns about the
 5 limitations of statutory sick pay and repeatedly raised
 6 it during the pandemic in connection with the
 7 effectiveness of self-isolation as an NPI.

8 As Ms Bell described in oral evidence, our evidence
 9 shows that those on zero hour contracts are much less
 10 likely to have access to decent sick pay. Around
 11 a third of those on zero hour contracts don't earn
 12 enough to qualify for sick pay when they fall sick.

13 Fundamentally the TUC believes it would be better
 14 for fair rather than insecure work to be embedded in the
 15 labour market, but at the very least, and when it comes
 16 to pandemic planning, there must be proper provision for
 17 pay and support during self-isolation and it needs to be
 18 planned for.

19 My Lady, these, ultimately, are the sorts of
 20 concrete measures that need to be seen in pandemic
 21 planning, and which will help ameliorate its uneven
 22 impact in key and frontline sectors.

23 Of course those sorts of measures will mean little
 24 in practice without an effective health and safety
 25 regulator with sufficient resources and powers of

1 a range of workplaces. In our opening, we said that
 2 pandemic preparedness across the whole range of
 3 workplaces was not so much a theme that is emerging but
 4 a theme that we are concerned is not emerging, and,
 5 my Lady, we still wait in hope for the Inquiry to
 6 address these issues.

7 Planning across the necessary range of workplaces
 8 and sectors must clearly include an adequate plan for
 9 PPE. It must include planning for PPE across a range of
 10 sectors. What will the provision and guidance be in
 11 advance of the next pandemic for PPE in a processing
 12 plant, in a supermarket, or on a bus? Will that be
 13 government stockpiles or will it be for employers to be
 14 able to cater for that in meeting their health and
 15 safety obligations? If the latter, are those health and
 16 safety obligations adequately clear and well understood?
 17 These questions remain unanswered, but they are
 18 important.

19 The relevance of PPE across a range of settings was
 20 a point stressed at least in the written report of
 21 Professors Marmot and Bambra.

22 Planning across a range of sectors must also include
 23 ensuring that those in the relevant occupations have the
 24 financial support to be able to self-isolate when poor
 25 pay, insecure work and a lack of sick pay means that

1 inspection. We fear becoming a broken record on this
 2 point, but it is important, and we still cannot see that
 3 it is being addressed.

4 To place an emphasis on health and safety and health
 5 and safety regulation may not be a glamorous answer to
 6 these problems, but ultimately it is important. The
 7 severe cuts to the UK Health and Safety Executive and
 8 its Northern Ireland counterpart, particularly following
 9 2010, were accompanied by a dangerous narrative that
 10 dismissed workplace health and safety as unhelpful
 11 red tape that did nothing but frustrate businesses and
 12 the economy. But that is a reckless approach and the
 13 inevitable consequences have come to pass. To a worker
 14 sitting on a processing plant who may already be
 15 suffering the disadvantages of low pay, insecure work
 16 and suffering the associated poorer health outcomes,
 17 an effective health and safety regulator may be the
 18 difference between working in an environment with or
 19 without adequate measures such as social distancing and
 20 PPE. We have reiterated on a number of occasions the
 21 inability of the HSE to respond to the pandemic.

22 Delivering a plan which achieves measures across
 23 a range of workplaces also requires an approach of
 24 partnership in consultation with the relevant
 25 industries, including both employers and unions.

1 Ultimately, if preparedness is needed across a range of
2 workplaces, then there needs to be engagement of
3 frontline workers across the necessary range of sectors.
4 The answer must lie in the responsible action of
5 employers, supported by government.

6 As Gerry Murphy, assistant general [secretary] of
7 the Irish Congress of Trade Unions, stated during oral
8 evidence, a formal social dialogue mechanism to
9 facilitate co-operation and joint working between
10 government and the trade unions is essential.

11 As Mr Murphy explained, formal engagement fora have
12 worked in the devolved nations and in counterparts
13 across unions, and the TUC, the Welsh TUC, the Scottish
14 TUC and the Irish Congress are, of course, in a position
15 to provide a representative and mediating function
16 between government and unions.

17 As Ms Bell explained, the key points are regular
18 meetings, a spirit of openness and collaboration, and
19 a clear process for how government and unions themselves
20 will act on those findings.

21 My Lady, our key points on pandemic planning for the
22 workplace may be summarised relatively shortly.
23 Pandemic planning needs to consider health and safety
24 measures across a range of workplaces. It needs to be
25 supported by an effective and funded health and safety

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1 **MR ALLEN:** My Lady, as you know, I represent the Local
2 Government Association and the Welsh Local Government
3 Association, and both organisations thank you and
4 the Inquiry team for the efficiency and thoroughness of
5 the process to date.

6 They also thank you and the Inquiry team for the
7 opportunity to participate in this module. They know
8 that you will carefully consider the two chief
9 executives' separate and joint witness statements and
10 the answers given to them and those of Ms Allen, no
11 relation, chief executive of NILGA, in their oral
12 examination on 12 July.

13 Their teams and I, having listened intently to the
14 examination of other witnesses, are preparing a written
15 closing submission which you will receive in due course,
16 and this will say more than I can in this brief oral
17 closing.

18 Today, I will focus on the very heart of the
19 association's concerns. I must start by emphasising
20 again the importance of local government in pandemic
21 planning. You will have learnt during this stage of
22 your Inquiry, to the extent that it was not already
23 apparent to you, that to bring a country through the
24 scourge of a pandemic requires multiple efforts across
25 civil society, and that means not just from the NHS,

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1 regulator. It should be achieved in partnership with
2 employers and workers via representative unions, and
3 doing those things will preserve lives of those at work
4 and will help ameliorate some of the uneven impacts of
5 the pandemic.

6 Although this is the closing submission for
7 Module 1, aspects of what we say is needed in pandemic
8 planning and preparedness really look forward to what we
9 say is necessary in future modules.

10 We say respectfully that we have not in this module
11 seen the necessary consideration of preparedness in
12 sectors beyond health and social care, but we also say
13 that with the hope and expectation that the issue is
14 going to be the subject of detailed evidence in future
15 modules.

16 My Lady, we have been grateful for the opportunity
17 to contribute to this Inquiry thus far. We again
18 commend the Inquiry for its endeavour for getting to
19 this point in this timeframe, and we look forward to
20 some timely findings and recommendations. As ever,
21 my Lady, we stand ready to assist.

22 **LADY HALLETT:** Thank you, Mr Jacobs.

23 Mr Allen, I think I can see you back there.

24 **Submissions on behalf of the Local Government Association
25 and Welsh Local Government Association by MR ALLEN KC**

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1 but, as I've already emphasised, from all of the
2 1 million-plus local government officers across England
3 and Wales.

4 They have been at the heart of the work by: finding
5 and tracing those actually or potentially affected or
6 particularly vulnerable; stopping the spread of the
7 virus through assisting with quarantine; helping to
8 maintain social distancing; enforcing lockdowns and
9 creating vaccine centres; supporting and caring for
10 those who are particularly frail or vulnerable;
11 providing adult social care; looking after families when
12 schools are closed or they're otherwise in need; and, at
13 death, doing what they can to provide a dignified
14 departure from this world; maintaining as much of
15 ordinary life as possible, including administering
16 business loans to help keep business going, then and
17 later; and, in due course, helping with the process of
18 recovery.

19 The association's two chief executives have been
20 examined about local government's preparation for these
21 roles. Their engagement with the local resilience fora
22 as Category 1 responders, their engagement with the
23 Cabinet Office and the way in which the Civil
24 Contingencies Act had worked during the Module 1 period.

25 You have already heard some extraordinary facts, how

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1 the planning was focused on a pan flu and ignored the
2 possibility of a respiratory virus pandemic, how there
3 was no preparation for quarantine, social distancing or
4 lockdown, how there was no planning for cross-border
5 working between England and Wales, and how the
6 associations were excluded from full participation in
7 Operation Cygnus and were not even informed of its
8 recommendations until they were disclosed in the autumn
9 of 2020, long after the pandemic had begun, and how
10 Operation Alice was conducted with no engagement with
11 local government.

12 And, I must add, my clients simply do not understand
13 the evidence of former Secretary of State for Health
14 Mr Hancock, who stated that only two councils had plans
15 for pandemic flu, a suggestion they do not believe to be
16 accurate at all, and, my Lady, we refer you to the
17 survey conducted at the request of the Inquiry team
18 attached to the joint witness statement of the two chief
19 executives, and, similarly, they believe the department
20 had and has far more levers to understand, oversee and
21 to shape social care provision than his evidence
22 suggested.

23 To find out the extent of adult social care
24 provision, all he had to do was to speak to the Care
25 Quality Commission, with which providers must be

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1 government is at the core of all future resilience
2 planning.

3 My Lady, between 2009 and 2020, councils, as
4 Category 1 responders, prepared, in line with the
5 government's risk assessment and planning, for
6 an influenza pandemic. Yet, as the Inquiry has already
7 heard, the pandemic that councils had to respond to was
8 different to the one that had been planned for, meaning
9 plans had to be changed or started from scratch. So for
10 the future, government must recognise that any national
11 response works best when it is built from the local
12 level upwards, co-designed with local government rather
13 than imposed, and regularly tested and exercised with
14 local government and not in isolation.

15 Important work has already been started by the
16 Welsh Government in considering its response to the 2023
17 independent report into future structures and
18 arrangements for civil contingencies in Wales. The
19 Welsh Local Government Association emphasises that the
20 response needs to be wide-ranging and to address the
21 whole system with local government involved from the
22 outset in any system re-design.

23 By contrast, much more is necessary in England,
24 where details of the new UK Government Resilience
25 Framework remain limited. Jointly, the two associations

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1 registered, or with directors of adult social services
2 who commission care services.

3 My Lady, I will move now to emphasising the
4 overarching conclusions that these two associations ask
5 you to include in your report on this module of the
6 Inquiry. These points are short and pithy, but I submit
7 they are vital if your report is to address fully what
8 is now known to be needed to prepare for the next
9 pandemic, and they concern the vital role that their
10 member councils play.

11 I shall summarise them first and then say a little
12 more about each of them. There are three.

13 One, we must learn from the failures in preparing
14 for Covid to design a better approach to pandemic
15 planning and to ensure that local government is at the
16 core of all future resilience planning.

17 Two, in this process, local government must be
18 treated as a trusted and equal partner by central
19 government.

20 Three, local government preparedness has been
21 impacted by austerity, but this cannot be allowed to
22 occur again.

23 So, turning to the first, that we must learn from
24 the failures in preparing for Covid to design a better
25 approach to pandemic planning and to ensure that local

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1 submit that the civil contingencies system needs to be
2 treated and managed as a single system, from top to
3 bottom, from central to local, and from strategic to
4 operational. They say that for emergency events,
5 whether of a national or global scale, there has to be
6 a joined-up and co-owned planning system between
7 the UK Government and the devolved governments, with
8 local government fully engaged in this.

9 This must lead to comprehensive and inclusive
10 national planning arrangements to build preparedness for
11 emergency events of such scale and length. These plans
12 should be maintained and be reviewed and tested at
13 regular intervals by all agencies in the whole system.

14 The testing processes must have sensible and
15 workable lead-in times, allowing local areas to
16 co-ordinate their local testing approaches. Planning at
17 all levels should be inclusive of the third sector, and
18 they should give the opportunity for stakeholders and
19 representative bodies, for instance those who might be
20 vulnerable or have protected characteristics, to give
21 advice and insight.

22 Arrangements should be put in place so as to give
23 the public proper assurance about preparedness through
24 access to information and media coverage.

25 As part of planning, protocols and arrangements

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1 should be put in place for clear, timely and
2 co-ordinated public information in the event of a major
3 emergency. These protocols and arrangements should be
4 intergovernmental to avoid public confusion across the
5 home nations.

6 The systems for national data modelling for the
7 reach and impacts of a national emergency, including the
8 worst-case scenarios for a pandemic or other incidents,
9 should be transparent and well understood.

10 In preparing for or responding to an actual
11 emergency, the data analysis should be shared within and
12 flow through the civil contingencies system in a timely
13 way.

14 A peer review system for the local resilience fora
15 should be introduced to provide external insight and
16 local assurance about plans.

17 Preparedness and resilience need to be reviewed in
18 several key areas of high sensitivity and risk,
19 including: protecting vulnerable people, the protection
20 of dignity in the management of excess death numbers,
21 and the resilience and capacity of the independent
22 residential care home sector.

23 All information within the system, whatever its
24 confidential or sensitive status, should be shared
25 amongst partners within the system, including local

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1 delivery within it. Forget these points and central
2 government will always be in a mess in a crisis.

3 But the key point is that, long before a crisis
4 happens, the best resilience will be built on
5 partnership in which each understands and respects the
6 role of the other, because local knowledge, skills and
7 expertise will always be crucial in addressing complex
8 issues that affect diverse communities in the context of
9 a crisis.

10 Now, while the Welsh Local Government Association
11 recognises that it had a different experience to our
12 English counterparts in preparedness for major
13 emergencies, nonetheless there are lessons there too.
14 Nationally constructed plans for preparedness should be
15 reviewed and updated regularly with the full involvement
16 of all partners, including local authorities and their
17 representative associations.

18 My Lady, my third overarching point is this: local
19 government preparedness has been impacted by austerity,
20 but this cannot be allowed to occur again. We are
21 grateful to Counsel to the Inquiry who have examined
22 numerous witnesses about the facts and effect of
23 austerity. The associations recognise fully the
24 importance of fiscal prudence at their level, so it's
25 not necessary for me to make general submissions in

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1 government and other Category 1 responders. And the
2 principle of subsidiarity, localism, should be
3 understood and honoured, so that planning and action are
4 taken at the most local point possible, but equally
5 there must be local input into those national decisions
6 whose impacts will be most felt locally by local
7 communities. And these plans should be subject to
8 democratic oversight at local and national levels,
9 including democratic oversight of the system of
10 preparedness through, for instance, local council
11 scrutiny committees and also Parliamentary committees.

12 Now, turning next to our second overarching theme,
13 local government must be trusted as an equal partner by
14 central government. I said at the outset in my opening
15 remarks that central government must take active steps
16 to ensure it fully understands how local government
17 works and the complex systems within which it operates.

18 The evidence that you have received has shown just
19 how little trust and understanding there has been, and
20 also some of the consequences of this.

21 So my clients want to emphasise in their closing
22 submission that local authorities are not merely
23 delivery bodies, they are democratic representatives of
24 their local communities and they are repositories of
25 expertise and knowledge about their locality and service

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1 closing about the effects of the decade or more of
2 austerity on the UK as a whole.

3 The two associations do, though, want to ensure that
4 you know that they most certainly have a view about the
5 effects of cuts to resources on planning for a pandemic.

6 In short, it has impacted on councils' ability to
7 plan and prepare effectively, and the focus on
8 protecting the NHS services has meant larger cuts
9 elsewhere in the public sector, including both public
10 health and emergency preparedness.

11 Reductions in spending have also affected the
12 resilience of public services and influenced the social
13 and economic conditions that impact on people's health
14 in the short and long term.

15 So what can be said about resources and planning for
16 the future? Well, my Lady, in short, we ask you to say
17 that continued budget cuts will undermine the resilience
18 and capacity of councils to respond to pandemics. If
19 we -- ordinary people, like all of us in this room, able
20 to get out and about -- if persons such as we are to be
21 assured of local governments' capacity to cope and
22 respond to any future emergency of scale and duration,
23 then the budgets for local government must be protected.

24 Yet we have a duty to look further than us. Such
25 events will, as you have heard, affect those who are

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1 less able to get out and be seen and heard, the most
2 vulnerable, those with pre-existing ill or fragile
3 health or comorbidities, those in poor quality housing
4 or who cannot easily shield because they live in larger
5 families or crowded housing. They are likely already to
6 have suffered the worst effects of austerity, and when
7 it comes to planning for a pandemic their particular
8 vulnerabilities must be part of the preparation. They
9 are less able to be resilient on their own. It is not
10 right that they should be expected to shoulder the same
11 burden of austerity measures as or so who are in
12 a better place and more capable of being resilient.

13 So, my Lady, there should be a greater focus in
14 planning on supporting people with a wider range of
15 health and socio-economic vulnerabilities compared to
16 those who are in a better place and more capable of
17 being resilient, relying on their own resources.

18 So while direct funding to local resilience fora
19 should be maintained, the government must also recognise
20 that operational capability rests with the responders
21 themselves and they must be adequately funded and
22 resilient.

23 So finally in this oral submission, my Lady, may
24 I remind you that in my opening submission I set out
25 13 requests for each association. The evidence that you

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1 **Submissions on behalf of the Government Office for Science**
2 **by MR HILL**

3 **MR HILL:** My Lady, thank you.

4 The Government Office for Science is grateful for
5 the opportunity to contribute to this module of the
6 Inquiry. You have heard evidence from two former
7 Government Chief Scientific Advisers, Sir Mark Walport
8 and Sir Patrick Vallance. These brief closing
9 submissions, which will be supplemented in writing, are
10 a distillation of the key aspects of their evidence and
11 identify the key issues they would invite the Inquiry to
12 address when formulating its conclusions and
13 recommendations in relation to future pandemic
14 preparedness.

15 There is a fundamental overarching issue to which
16 everything that follows is subject, and that is the
17 extent to which we, as a society, wish to devote
18 resources to purchasing insurance against future
19 pandemics.

20 Although choices on allocation of resources will
21 always remain political ones, this module of the Inquiry
22 provides an opportunity to reflect on the value of
23 insurance against future risks that have the capacity to
24 cause a large number of deaths and profound social
25 upheaval.

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1 have received has, we believe, more than demonstrated
2 the good sense of those proposals. I will not repeat
3 them here because I'm confident that the Inquiry team
4 will already have them well in mind.

5 I ask you, therefore, on behalf of my two clients to
6 note the width and depth of local governments' tasks and
7 responsibilities, to adopt the three overarching points
8 as headline but essential points, and to consider and
9 conclude that my opening two times 13 points are indeed
10 good points to be included in your report as steps that
11 must be taken forward in all future civil contingency
12 planning.

13 My Lady, I thank you in advance for the report that
14 you propose to deliver on the issues we have discussed
15 in Module 1, and we respect the fact that there is a lot
16 of hard work for you ahead.

17 Thank you.

18 **LADY HALLETT:** Thank you, Mr Allen. On that note, I think
19 it may be time for a coffee break. I shall return at
20 11.25.

21 **(11.08 am)**

(A short break)

23 **(11.25 am)**

24 **LADY HALLETT:** Mr Hill.

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1 In some areas, the value of insuring against future
2 risk is well understood and Sir Patrick gave the example
3 of the armed forces. He observed that money spent on
4 that aspect of the nation's security is not regarded as
5 wasted if there turns out to be no need to fight a war.
6 The effective protection of society from natural hazards
7 requires a similar mentality and an understanding that
8 natural hazards can be just as devastating as security
9 threats.

10 In particular, when planning for a future pandemic,
11 it needs to be understood that you may not need
12 everything that you pay for. Innovation, whether
13 scientific or technological, inevitably comes with
14 failure, and that has to be priced in and accepted as
15 part of the process. The success of the development of
16 vaccines and the Vaccine Taskforce has been referred to
17 by many witnesses and indeed was referred to by
18 Mr Jacobs earlier today. In respect of that undoubted
19 achievement, Sir Patrick made the telling observation
20 that it was only by the approval of funding,
21 notwithstanding the very significant risk of failure,
22 that success was achieved.

23 In the field of pandemic preparation, the concept of
24 value for money has to be broader than traditionally
25 used by government. The conventional analysis, as

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1 exemplified by the National Audit Office and the Public
2 Accounts Committee requires revision when applied to the
3 building up of effective resilience against future
4 pandemics.

5 Turning to the issues of planning and resilience, it
6 is our submission that the approach to risk planning for
7 future pandemics, as reflected in the NSRA and more
8 broadly across government, requires fundamental
9 structural change in at least two respects.

10 First, the focus should be on capabilities and
11 scenarios, and not specific plans for specific types of
12 pandemic. The response to the emergency that eventuates
13 will inevitably need to be targeted, but the preparation
14 needs to be broad. Predicting the next pandemic with
15 any sort of precision is impossible. There are too many
16 variables. There is little value, we would suggest, in
17 asking whether previous iterations of the NSRA foresaw
18 the right sort of pandemic.

19 Similarly, there were some suggestions floated
20 during the course of evidence apparently predicated on
21 a belief that it is our powers of prediction that need
22 to be improved. One is that drugs and vaccines
23 effective against Covid-19 should have been stockpiled
24 and would have been with a little more imagination. Yet
25 nobody knew which drugs worked until extensive clinical

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1 capacity will we require, and where is that capacity
2 held?

3 Fifth, diagnostics. The same questions arise,
4 together with the imperative of preserving that which we
5 have now built. How can we ensure that everyday
6 healthcare in this country uses a domestic diagnostic
7 capacity so that it can be pivoted to emergency pandemic
8 response at short notice when required? What support
9 and partnerships do we need to develop with industry?

10 Sixth, international co-operation. What networks
11 will we be able to call upon and plug in to?

12 Seventh, vulnerable groups. Where within society
13 are the effects of a pandemic likely to be felt most
14 acutely, and what measures are available to mitigate
15 that impact?

16 These are the questions of general application that
17 should underpin the NSRA and should, if approached
18 correctly, provide answers that would be adaptable to
19 the next pandemic. They do not depend for their success
20 on correctly guessing what the pandemic will look like.
21 They will lead to a better balance between prevention,
22 mitigation and response. They will identify in advance
23 areas of strength and areas of relative weakness so that
24 they can be addressed before the pandemic, rather than
25 during it.

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1 trials had taken place, and you cannot stockpile a drug
2 or vaccine which does not yet exist.

3 But what you can do is to assess and build your
4 capability to research, trial and roll out existing
5 treatments when faced with a new hazard. You can invest
6 in your capacity to discover, invent, manufacture and
7 distribute a new treatment or vaccine at speed. You can
8 ask what capabilities will be required to deal with
9 future pandemics, whether those capabilities exist, and
10 how they can be scaled up quickly.

11 In the particular context of a future pandemic, and
12 based on recent experience, the key areas to address in
13 this analysis include the following:

14 First, data. Which data will be required, who holds
15 them, how can they be obtained and analysed?

16 Second, testing and tracing. What capability will
17 we require, and what infrastructure do we have to
18 provide it?

19 Third, equipment. What will we require, and where
20 will we source it from? What can we realistically
21 stockpile and what industrial manufacturing capacity
22 will we be able to call upon?

23 Drugs and vaccines. How do we preserve excellence
24 in our scientific research base? How do we translate
25 that research into manufacturing? What manufacturing

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1 The second point we make about planning and
2 resilience is an inevitable consequence of the first.
3 The effective formulation and delivery of a resilience
4 plan of the type that I have just described cannot
5 simply be allocated to a single government department on
6 the existing NSRA model. Pandemics require
7 an integrated cross and intergovernmental response.
8 They present funding challenges which cannot be met by
9 a single department, with a single budget from which to
10 meet all of its day-to-day requirements. Nor can the
11 effective oversight and delivery of a plan of this
12 nature be fragmented across the various branches of
13 government with an interest in its constituent elements.
14 It is essential that there is a senior and authoritative
15 single point of accountability and responsibility within
16 government, to drive resilience and implement plans.

17 To take the example of Exercise Alice, this did
18 address containment and mitigation and did provide
19 an opportunity to develop capabilities that would have
20 been valuable when the pandemic struck. But there is
21 simply no point in running exercises like this without
22 having someone responsible for co-ordinating and
23 overseeing the response, and being responsible for
24 ensuring that actions are followed through.

25 A clear structure of accountability and

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1 responsibility will address the tendency to believe
2 that, as long as the report has been written, the
3 problem has been resolved. It will create
4 an institutional memory and repository of relevant
5 information which will be preserved when officials and
6 ministers inevitably move on. It will ensure that
7 documents and plans relating to resilience are kept
8 under regular review and remain within their sell by
9 date rather than being allowed to drift into
10 obsolescence.

11 Crucially, from a science perspective, it will
12 provide a clear docking point within the government for
13 scientific advice during normal times.

14 Both Sir Mark and Sir Patrick spoke of the need for
15 scientific advisers to be proactive and go beyond simply
16 answering the questions set by government. That
17 approach will only be effective if there is a clear and
18 direct route by which such advice can find its way to
19 the right person's desk.

20 There is, therefore, a need for reform and
21 improvement in the structures for planning, preparation
22 and resilience.

23 In contrast, the existing structure for the delivery
24 of science advice during an emergency is clear and fit
25 for purpose. COBR commissioned SAGE, and the GCSA

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1 These structures work well, and we would invite
2 your Ladyship to reject any suggestion that they should
3 be changed further. In particular, adding mandatory
4 representation of all the devolved nations' Health CSAs
5 to the CSA network would risk actively harming a body
6 that has developed organically into a highly effective
7 means of cross-governmental collaboration and one that
8 concerns the full spectrum of science advice, not just
9 health. We would urge your Ladyship to resist any
10 invitation to stray into areas beyond the pandemic to
11 try to fix that which is not broken.

12 In addition to these two structural matters relating
13 to the mechanics of pandemic planning and building
14 resilience, there are three broader issues that we would
15 invite the Inquiry to consider.

16 First, Sir Patrick advocated the establishment of
17 an academic institute for pandemic preparedness. He
18 envisages a hub and spoke model where experts from
19 across relevant fields could bring together their
20 expertise and identify further areas for research. The
21 model would allow for an exchange of ideas from
22 epidemiologists, virologists, clinicians, behavioural
23 scientists, data scientists, engineers, economists,
24 educationalists, and others. The UK has a rich and
25 active research base, an institute for pandemic planning

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1 provides the link between SAGE and COBR. During the
2 pandemic, SAGE could commission sub-groups such as SPI-B
3 and SPI-M to undertake specialist pieces of work. Each
4 department has or should have its own CSA, and each
5 devolved administration should have its own
6 Government CSA. They have a direct line of
7 communication with the UK GCSA who supports them and
8 leads the CSA network.

9 The SAGE model allows for flexibility and a tailored
10 response to the emergency that is being faced. It
11 enables the right people to be assembled from the
12 appropriate disciplines. Many other countries adopted
13 similar models in recognition of the effectiveness of
14 the UK's arrangements and the Inquiry will recall in
15 particular the evidence of Sir Jeremy Farrar in this
16 regard.

17 This is not said complacently, and the Inquiry has
18 heard of the ongoing work within the Government Office
19 for Science to strengthen and improve SAGE's processes.
20 We also see the force in ensuring that representation of
21 the devolved -- sorry, representatives of the devolved
22 administrations are invited from the outset to
23 SAGE meetings where emergencies concern them. SAGE is
24 the appropriate forum for this link rather than the
25 CSA network.

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1 could draw from its full breadth and depth.

2 Second, the role of public health infrastructure in
3 prevention and mitigation. As Sir Mark explained, and
4 as some of the expert evidence commissioned by
5 the Inquiry has illustrated, the lack of priority
6 accorded to public health over several decades has meant
7 that much of the traditional infrastructure for the
8 control of infectious diseases has been lost. As
9 a result, when the pandemic struck, the capacity for
10 testing, tracing and isolation had to be built largely
11 from scratch. The UK could not, for example, replicate
12 the initial South Korean response to the pandemic
13 because it had not made the investment South Korea had
14 made in its public health systems.

15 A better developed, better funded public health
16 system, delivered at a local level and including a large
17 cohort of community health workers, would have a double
18 benefit in this context. During peace time, it would
19 improve the health and access to healthcare of the
20 general population, including vulnerable and
21 marginalised groups. In the event of a pandemic it
22 would provide a readymade infrastructure and workforce
23 that could pivot to testing and tracing.

24 The Inquiry has made clear its concern about the
25 important issue of inequality of impact and outcome, and

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1 rightly so. That is not an issue that can be addressed
2 during the course of a pandemic. It has to be dealt
3 with at a structural level in advance. A high quality
4 and properly resourced public health system is essential
5 to achieving this.

6 Finally, whilst there are plainly steps that we can
7 take at a national level to improve our planning and
8 resilience, it has to be kept in mind that the effective
9 response to a future pandemic will inevitably be
10 an international endeavour. The 100 Days Mission is
11 centrally important in this regard in respect of
12 inventing and manufacturing diagnostics, vaccines and
13 therapeutics. Other areas of co-operation are also
14 required, notably in surveillance and initial public
15 health response. It is important that any structural
16 changes made at national level dovetail with the work
17 that is being done on the international plane.

18 Although the hearings in respect of Module 1 are now
19 at a close, we appreciate that the work of the Inquiry
20 on the issues of resilience and preparedness will
21 continue. The Government Office for Science will
22 of course continue to provide the Inquiry with whatever
23 further assistance and support it may require as it
24 completes this important aspect of its work.

25 **LADY HALLETT:** Thank you very much indeed, Mr Hill, very
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1 comprehensive witness evidence.

2 So far, in relation to Module 1, we've disclosed
3 a significant number of relevant documents to
4 the Inquiry, and supplied a detailed corporate witness
5 statement from the second permanent secretary,
6 Catherine Little, and we have also supported
7 George Osborne, the former Chancellor, to facilitate
8 the Inquiry, receiving detailed written and oral
9 evidence from him.

10 My Lady, we hope it's of assistance to you and all
11 of those following the Inquiry to provide a summary of
12 the Treasury's role in government insofar as it's
13 relevant to Module 1 and to pandemic preparation and
14 resilience.

15 The Inquiry has not heard oral evidence of these
16 matters, and of course it's only core participants who
17 will have seen the written evidence.

18 Catherine Little's statement, as requested, explains
19 to the Inquiry the Treasury's role in governmental risk
20 management and emergency planning, and it sets out the
21 detail of the Treasury's involvement in and engagement
22 with pandemic planning.

23 In summary, the Treasury is the government's
24 economic and finance ministry, responsible for
25 maintaining control over public spending, setting the
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1 helpful.

2 Next is Mr Block. Oh, right back there.

3 **Submissions on behalf of His Majesty's Treasury by**
4 **MR BLOCK KC**

5 **MR BLOCK:** Good morning, my Lady.

6 **LADY HALLETT:** Mr Block.

7 **MR BLOCK:** My Lady, as you are aware, His Majesty's Treasury
8 has not yet addressed the Inquiry. Therefore may
9 I associate the Treasury with the sentiments of the
10 Inquiry legal team and those core participants who made
11 opening statements and offer our sincere and heartfelt
12 condolences to those who lost family members, friends
13 and colleagues, and our sympathy to all those who have
14 been affected by the pandemic.

15 My Lady, no one who heard the moving and courageous
16 evidence yesterday morning can be in any doubt about the
17 profound effects on individuals and families.

18 My Lady, I'm instructed by Robyn Smith of the
19 Government Legal Department, and appear together with
20 Mr Steven Gray.

21 May I say at the outset that the Treasury wishes
22 publicly to reiterate its intention to assist the
23 important work of this Inquiry. It has sought and will
24 continue to seek to assist you as best it can through
25 disclosure of relevant material and provision of
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1 direction of the United Kingdom's economic policy and
2 working to achieve strong and sustainable economic
3 growth.

4 Of course the positions taken by Treasury officials
5 are determined by ministers in accordance with relevant
6 government policy, and the Inquiry has heard and read
7 evidence relating to the Module 1 period from some of
8 those ministers.

9 It's not the Treasury's function in this Inquiry to
10 seek to persuade you of the merits of the
11 United Kingdom's fiscal and economic policy during the
12 relevant period. Indeed, Mr Keith has, for
13 understandable reasons, made clear on a number of
14 occasions during the hearings that the Inquiry is not
15 concerned with the merits or otherwise of government
16 policies, as well as the government's fiscal policy
17 generally, and this obviously includes the policy of
18 austerity, which has been the subject of comment at
19 various points during the module and in particular
20 during yesterday and today's closing statements.

21 The Inquiry is focusing in this module on the period
22 from 2009 to 2020, and the Treasury submits that the
23 evidence shows that, following the global financial
24 crisis, the Treasury acted to strengthen the economy to
25 a level whereby it was able to respond to financial and
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1 other crises.

2 My Lady, I turn now to briefly address you on two
3 issues in relation to this module, firstly the
4 Treasury's role and approach to planning for a civil
5 emergency, in other words the Treasury's plan; and,
6 secondly, the Treasury's contribution more specifically
7 to the United Kingdom Government's planning for
8 a pandemic.

9 Catherine Little's statement addresses both of these
10 issues in detail and, my Lady, for that reason we don't
11 propose to burden you with lengthy written submissions
12 to supplement this oral submission, but we do commend to
13 you her statement.

14 I do intend to highlight certain aspects of the
15 Treasury's general role in government, including its
16 role in the United Kingdom's pre-pandemic emergency
17 planning and also the involvement the Treasury had in
18 that planning. We hope that the following summary of
19 the Treasury's role in cross-government emergency
20 planning and risk management, including pandemic
21 planning and preparedness, is helpful.

22 Emergency preparedness except in the case of
23 a crisis originating in the financial system is not
24 a lead responsibility of the Treasury. However,
25 the Treasury has always engaged with the departments who

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1 the Treasury has a detailed and comprehensive risk
2 management framework, including the Treasury economic
3 risks, fiscal risks and financial stability groups,
4 together with resilience and contingency planning units,
5 which regularly assess, monitor and scrutinise risks to
6 economic, financial and fiscal stability, and they draw
7 on information and data from a wide range of sources and
8 work with other organisations such as the
9 Bank of England, the Prudential Regulation Authority,
10 and the Financial Conduct Authority.

11 The Treasury's work in this regard also has
12 an international dimension. By way of example,
13 the Treasury is the joint chair with the Foreign,
14 Commonwealth and Development Office of the quarterly
15 Global Economic Analysis and Risk Group, and this group
16 works to ensure that there is sufficient focus on and
17 analysis of important global economic issues and risks.
18 It has previously, for example, included the health
19 risks in relation to Ebola.

20 In addition, the Treasury has regularly taken part
21 in G20 discussions on civil emergencies and health
22 threats.

23 The Treasury's risk management framework undoubtedly
24 benefitted significantly from the detailed review and
25 the lessons learned exercise carried out in respect of

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1 are responsible for specific risk planning to provide
2 targeted support in civil emergency preparedness where
3 appropriate.

4 Like other government departments, the Treasury
5 feeds in to the Cabinet Office National Security Risk
6 Assessment, about which you have heard much, and the
7 risks published on the National Risk Register. For the
8 risks where the Treasury is the lead department, namely
9 the economic and financial risks, the Treasury develops
10 scenarios and determines the potential impacts and
11 likelihood of the risk in question, and we've provided
12 detailed statements of that for later modules. That was
13 the case prior to the Covid-19 pandemic, and remains the
14 case.

15 In the context of emergency planning, the Treasury's
16 focus is inevitably, therefore, on economic risk
17 management. Firstly, monitoring and responding to risks
18 to the economy and public finances; secondly, monitoring
19 and responding to risks to the stable operation of the
20 United Kingdom financial system; and, thirdly, setting
21 budgets and applying spending controls for government
22 departments, associated bodies and the devolved
23 administrations, the sober reality, of course, being
24 that there is a finite amount of public money available.

25 As set out in Catherine Little's statement,

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1 the Treasury's handling of the 2008/2009 global
2 financial crisis, the White review, to which you've been
3 referred. This was commissioned in 2011 and it
4 published its findings in 2012.

5 The review made 56 recommendations. By 2014,
6 the Treasury had fully accepted and completed 46 of
7 those, it had partially accepted and completed eight of
8 those, and it rejected only two of those.

9 The implementation of these recommendations
10 materially improved the Treasury's ability to react in
11 a nimble and responsive way to new and fast changing
12 priorities, including the Covid-19 pandemic.

13 In addition, both prior to and during the pandemic,
14 the Treasury's internal risk management framework was
15 supported by the Office for Budget Responsibility, the
16 OBR, which is the government's official independent
17 economic and fiscal forecaster. It's the -- and I hope
18 I'm forgiven one abbreviation -- it is the OBR's
19 statutory duty to examine and report on the
20 sustainability of the United Kingdom's public finances.
21 That's the duty which feeds directly in to
22 the Treasury's fiscal objective to deliver sound and
23 sustainable public finances. The OBR's regular fiscal
24 risk report, introduced in response to recommendations
25 included in a 2015 review by the Treasury of the OBR,

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1 has made a major contribution to the Treasury's wider
2 risk management systems. Indeed, the International
3 Monetary Fund has recognised that those reports "raised
4 the bar on the assessment and quantification of fiscal
5 risks to a new level that other countries should look to
6 meet".

7 In 2017, a new fiscal risks branch was established
8 within the fiscal group to support the Treasury's
9 increased engagement with the OBR on assessing financial
10 risks, and the first report was published in 2017.

11 One of the main lessons to emerge from the OBR's
12 fiscal risk reports, and which has underpinned the
13 government's fiscal strategy and the Treasury's approach
14 to internal risk management, is the need to ensure that
15 public finances are managed prudently during more
16 favourable times to ensure that when economic risks do
17 crystallise they do not put the public finances onto an
18 unsustainable path.

19 There is therefore, to state the obvious, a limit to
20 what can be spent at any one time.

21 It was the Treasury's position prior to the
22 pandemic, and it remains the Treasury's position now,
23 that the uncertain nature of economic shocks makes
24 developing specific granular response plans for every
25 possible contingency ahead of time difficult. We echo

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1 A crucial part of any plan for any economic crisis,
2 such as an economic crisis which may accompany
3 a pandemic, is being able quickly and nimbly to scale up
4 resource or surge public expenditure when necessary and
5 as required to meet the specific economic and financial
6 demands of the emergency.

7 It is that economic flexibility which is also
8 required when an emergency requires the scaling up
9 described by Professor Sir Chris Whitty as being so
10 important in responding to a health emergency such as
11 a pandemic and this pandemic.

12 The Treasury's role in setting budgets and
13 controlling public spending is, in this context,
14 an important part of its remit, and essential to
15 maintaining sustainable and flexible public finances.

16 Departmental budgets are set as a result of the
17 spending review process which is overseen by
18 the Treasury, and Catherine Little's statement explains
19 this process in detail. However, it's ordinarily the
20 Secretary of State for each department, on the advice of
21 their officials, who is responsible for decisions on
22 allocations within a department's budget.

23 While the spending review generally covers only
24 expenditure which can be reasonably planned in advance,
25 the Treasury has always set aside contingency, called

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1 Mr Hill's submissions in that respect. Such plans would
2 need continuous updates and may not ultimately prove to
3 be directly applicable to the shocks that do emerge or
4 crystallise.

5 The OBR published its third report in July 2021 and
6 it's addressed in the statement of Richard Hughes to
7 this Inquiry. That report specifically focused on and
8 considered lessons learned from the pandemic. The OBR
9 recognised with hindsight that the risk of a global
10 pandemic received far too little attention from the
11 economic community.

12 However, the OBR's focus was not on prescriptive
13 scenario planning. Instead, it concluded that fiscal
14 policy needs to be more nimble than previously thought,
15 so as to be able to adapt quickly to the unexpected, and
16 that -- and this is a quote again:

17 "In the absence of perfect foresight, fiscal space
18 [by which I understand in simple terms it means a room
19 for economic manoeuvre] may be the single most valuable
20 risk management tool."

21 Without economic flexibility, it simply is not
22 possible to respond to those risks whose size or timing
23 is too uncertain to explicitly provision for in advance.

24 As George Osborne explained, a plan isn't worth the
25 paper it's written on if it can't be paid for.

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1 the reserve, for genuinely unforeseen, unabsorbable and
2 unavoidable pressures. The Treasury then controls how
3 this contingency is allocated.

4 Catherine Little also explains the funding
5 arrangements for the devolved nations in annex G of her
6 statement, and similarly to the UK departments the
7 devolved administrations receive multi-year funding
8 settlements at spending reviews. The amount of funding
9 provided is largely determined by the long-standing
10 Barnett formula. Devolved administrations can seek
11 access to the reserve and access is judged on largely
12 the same criteria as the United Kingdom government
13 departments, but also considering the additional tools
14 and powers open to them.

15 In the context of its risk management role
16 the Treasury also wishes to assure the Inquiry that it,
17 as no doubt all government departments do, carefully
18 considers the equality impacts of its decision-making in
19 accordance with its legal obligations and its strong
20 commitment to equality issues.

21 My Lady, I now turn to summarise the role that
22 the Treasury played in respect of pandemic preparedness
23 in the period covered by Module 1.

24 Before the Covid-19 pandemic, as you know, pandemic
25 preparedness was led by the Department of Health and

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1 Social Care together with the Civil Contingencies
2 Secretariat in the Cabinet Office. The Treasury was not
3 a lead department regarding pandemic preparedness.
4 However, it did participate in and respond to influenza
5 pandemic planning and the related exercises carried out
6 by those departments with the lead responsibility and
7 when asked to do so.

8 At various points and in accordance with the expert
9 advice at the relevant time, the Treasury undertook
10 economic analysis to understand the impact of a pandemic
11 flu scenario. For example, in 2006 the Treasury
12 produced internal analysis of the impact of a future
13 human flu pandemic on the economy following the avian
14 influenza outbreak.

15 Exercise Winter Willow in 2007, the Treasury
16 actively supported this exercise, and in 2009/10, the
17 swine flu outbreak, the Treasury was involved in
18 reviewing the potential costs that could be associated
19 with the varying degrees of that outbreak. And again,
20 Exercise Cygnus in 2016, the Treasury focused on
21 ensuring that government finances were resilient to the
22 impact of a pandemic on the workforce and amending its
23 processes accordingly in such an event.

24 My Lady, the Treasury's attempts to gauge the
25 potential scale of the economic impact of a pandemic

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1 the Treasury has been receptive to and supportive of
2 requests for funding to develop the United Kingdom's
3 scientific research and development capability, which
4 became is so important during the pandemic for the
5 purpose of developing a vaccine and has been
6 acknowledged by the TUC as at least something that we
7 got right.

8 My Lady, in terms of lessons learned, as
9 Catherine Little's statement explains, the Treasury,
10 along with other departments, has learned much from the
11 pandemic, and is seeking to drive change and
12 improvement, and will listen carefully to the
13 recommendations of this Inquiry.

14 To date, some of the lessons that we've learnt
15 include a need to strengthen and improve the consistency
16 of the Treasury's risk reporting. In autumn of 2021,
17 the Government updated the charter for budget
18 responsibility to require the OBR to produce an annual
19 report on sustainability of and the risks to the public
20 finances, and that permitted the OBR to take a more
21 flexible approach to determining its content and
22 reporting to the Treasury and to government.

23 Thirdly, we've learnt that we need to manage fraud
24 risk, such as through the launch of the Public Sector
25 Fraud Authority in August of last year.

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1 serve to highlight the significant uncertainties in the
2 analysis, such as the severity of the illness, the
3 proportion of the workforce affected, the amount of time
4 individuals might be affected by the virus, and the
5 behavioural response of individuals. These were all
6 identified as factors that resulted in a high degree of
7 uncertainty.

8 This uncertainty highlights both the difficulty
9 associated with the preparation of specific contingent
10 plans for dealing with potential economic shocks and the
11 importance of being able to respond quickly and flexibly
12 when economic shocks crystallise.

13 This economic analysis by the Treasury was plainly
14 not directed towards a global pandemic of the scale
15 which struck the world in early 2020. It did help
16 provide an analytical framework through which
17 the Treasury could rapidly assess, based on very limited
18 or initially very limited scientific and economic data,
19 the potential impacts of the Covid-19 pandemic as it
20 emerged in early 2020.

21 Catherine Little's statement also details the
22 consideration given by the Treasury to funding requests
23 related to pandemic planning. The evidence indicates
24 that the Treasury has been receptive to and supportive
25 of such requests. The evidence also indicates how

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1 Finally, we have learnt the need to make
2 improvements regarding the risk management framework,
3 with a focus on the need to address challenges
4 associated with cross-government decisions and
5 responsibilities, and we seek and will continue to seek
6 to improve our ways of working to discharge our function
7 and protect the United Kingdom economy as best as we are
8 able.

9 My Lady, finally, we're grateful for the opportunity
10 to assist the Inquiry in respect of Module 1 and to
11 address you, and we wish to conclude these submissions
12 by assuring you of our assistance in your future modules
13 and work. Thank you.

14 **LADY HALLETT:** Thank you, Mr Block.

15 Ms Murnaghan.

16 **Submissions on behalf of the Department of Health Northern
17 Ireland by MS MURNAGHAN KC**

18 **MS MURNAGHAN:** Good morning, my Lady. I make this closing
19 statement on behalf of the Northern Ireland Department
20 for Health, which I'll refer to as "the department".

21 My Lady, the purpose of this closing statement is to
22 assist the Inquiry in respect of nine identified issues,
23 which we feel may require further clarification as
24 a result of the evidence which has been given during
25 these hearings.

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1 The first of those issues, my Lady, is that of the
2 updating of the 1967 Public Health Act, and, firstly,
3 the department would like to emphasise that the proposal
4 to pause work on updating the 1967 Public Health Act was
5 made in the context of other priorities and pressures at
6 that time.

7 The updating work had been initially intended to
8 broaden the scope of the Act from having a primary focus
9 on infectious diseases to an all-hazards approach.

10 My Lady will see, of course, that from the
11 contemporaneous emails of Professor Sir Michael McBride
12 that this agreement was only reluctantly given, in light
13 of the more immediate priorities at that particular
14 juncture. Indeed, the subsequent collapse of
15 the Executive would have prevented further work and
16 progress on this in any event.

17 Notwithstanding the decision to pause that work,
18 significant work had been taken forward in
19 Northern Ireland during 2018 and 2019 to develop
20 Northern Ireland clauses for inclusion in a draft UK
21 pandemic flu Bill. This work sought to address the gaps
22 that had been identified in the Northern Ireland's 1967
23 Public Health Act, and indeed this work was extensively
24 drawn upon when the -- and informed the making of the
25 2020 Coronavirus Act.

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1 Further, we would hope that the context and scope of
2 the departmental risk register should be considered.
3 Risk registers are living documents and they comprise
4 identified corporate risks which are considered as
5 having the potential to impact on the department's
6 ability to deliver on its objectives.

7 The risk register of course does not reflect risks
8 that have actually materialised, but rather represent
9 risks which the department has identified that may
10 happen and the high level actions that the department
11 will take to mitigate the risk of same.

12 The departmental risk register is reviewed quarterly
13 at three distinct stages, and is also separately
14 considered by the departmental audit and risk assurance
15 committee, who will advise in turn the
16 permanent secretary on the adequacy of the
17 representation of the risk and the actions to manage and
18 mitigate.

19 At no stage is there any expectation that the
20 minister should review or supervise the risk register.
21 As such, the failure to reiterate risks from the risk
22 register in the minister's first day brief should not be
23 regarded, we say, as a point of criticism, particularly
24 given that the first day brief is extensively elaborated
25 on in the minister's subsequent meetings with the

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1 It is also of course the case that, contrary to the
2 evidence that was given to the Inquiry by
3 Mr Aidan Dawson on behalf of the Northern Ireland Public
4 Health Agency, that amendments to the list of notifiable
5 diseases could be made at any time, and in fact this was
6 the case during the Covid-19 pandemic, when the
7 causative virus was made a notifiable disease.

8 The department would also like to point out that
9 there has been at times during the hearing the
10 perception that there has been a conflation and
11 confusion in relation to the UK Civil Contingencies Act
12 and the Northern Ireland Public Health Act. Of course
13 these are two separate pieces of primary legislation.

14 The second issue, my Lady, that we would like to
15 address is that of potential issues which may remain in
16 relation to the department's corporate risk register.
17 Regrettably, the most recent iteration of the
18 department's risk register, which showed the actions
19 completed, had erroneously not been provided to
20 the Inquiry at the point when our witnesses gave their
21 evidence. This oversight, my Lady, has now been
22 remedied and the department would ask that any
23 recommendations made by the Inquiry would refer,
24 of course, to the most recent and relevant iteration of
25 that register.

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1 respective policy leads in the first few days and weeks
2 of his appointment.

3 The third issue, my Lady, we would like to address
4 is that of the perception that there were concerns that
5 the department had not acted on the Bengoa report.
6 Indeed, a ten-year approach to transforming health and
7 social care in Northern Ireland, which was entitled
8 *Health and Wellbeing 2026: Delivering Together* was
9 launched in October 2016. The Delivering Together
10 project was in response to three significant reports,
11 the first being the Bengoa report, the second the
12 *Transforming Your Care* report, and the third, of course,
13 being Sir Liam Donaldson's report.

14 Work began on that project in November 2016, and in
15 the absence of our Northern Irish Assembly, senior
16 departmental officials continued to provide strategic
17 leadership and oversight in the design, development and
18 implementation of the transformation strategy.

19 In that context, 18 key deliverables were identified
20 for the Delivering Together project, and reports had
21 been published in 2017, May 2019 and June 2021. These
22 18 actions were all considered as being achieved in as
23 far as possible within the decision-making context and
24 the financial constraints of the time.

25 Notwithstanding this, of course, it was always

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1 acknowledged that full implementation of the
2 transformation strategy required both sustained
3 investment and decisions that would rightly fall within
4 the purview of the ministers.

5 The fourth issue, my Lady, is that of the impact of
6 single-year bundles. The department would like to
7 clarify that the evidence of the former health minister,
8 Mr Robin Swann, in relation to single-year budgets did
9 not mean that the department was only able to make
10 short-term decisions in relation to healthcare. In the
11 hiatus period the department was able to make some
12 long-term decisions in respect of major capital
13 programmes, amongst which was the establishment of the
14 critical care building at the Royal Victoria Hospital
15 and the introduction of the largest digital project in
16 Northern Ireland, entitled Encompass.

17 Despite these actions, it is, of course,
18 incontrovertible that the absence of multi-year budgets
19 reduced the certainty with which longer-term planning
20 could take place and created a greater short-term focus
21 than was otherwise desirable.

22 Of course, my Lady, officials operate under the
23 direction and control of the relevant departmental
24 minister. In Health, both officials and the minister
25 have responsibilities set out in statute in the Health

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1 in that they bring together individuals across separate
2 organisations in order to work collectively on aspects
3 of emergency preparedness and planning. These
4 arrangements are, by necessity, complicated and, to the
5 uninitiated, may appear complex. That said, these
6 interactions are considered to be fundamental and
7 necessary to ensure resolved consideration across
8 separate organisations and expert groups.

9 Furthermore, it is considered that there is a good
10 level of accountability for aspects of health and social
11 care, including emergency preparedness. Planning in
12 Northern Ireland is necessarily delegated to boards of
13 arm's length bodies who are in turn accountable to the
14 department through extant arrangements of departmental
15 sponsorship and mid and end-year accountability reviews.

16 Accountability within the department means, in
17 practice, that respective directors and departmental
18 group leads will provide assurance to the
19 permanent secretary. These arrangements are long
20 established and well understood.

21 The sixth issue is that of emergency planning.
22 The Inquiry Counsel at times asserted that the
23 department's emergency response plan was based on
24 outdated and faulty thinking in its focus on pandemic
25 influenza.

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1 and Social Care (Reform) Act (Northern Ireland) 2009.
2 In brief compass, these responsibilities are to effect
3 the health and wellbeing of the population and to secure
4 the continuity of health services.

5 These responsibilities cannot be passive or reactive
6 in nature, but rather must be performed to their full
7 extent to ensure that the public has the protection that
8 they rightly expect and deserve.

9 The fifth issue that I'd like to discuss, my Lady,
10 is that of departmental structures, and the department
11 would like to address issues which arose in relation to
12 the extensive and complex structures for emergency
13 planning and preparedness in Northern Ireland, and the
14 observation that had been made that these could be seen
15 as overly complex.

16 While of course the department is open to better
17 ways of organising these arrangements, it is considered
18 that there is no one ideal structure. The department
19 does not consider that there was a fundamental
20 structural problem. Rather, it considered that what
21 mattered more is that of functionality and that those
22 individuals who operate within the extant arrangements
23 understood their respective roles and responsibilities.

24 In the Northern Ireland context, it is considered
25 that these advisory groups and structures are important,

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1 The department would like to emphasise that this
2 response, the emergency response plan, was not of itself
3 specific to pandemic influenza or even to pandemics, but
4 rather it was designed to allow an appropriate response
5 to be made to an emergency of any sort which impacted on
6 health and social care, including infectious diseases.

7 The health service and the department have
8 long-standing and well rehearsed plans to respond to all
9 emergencies, irrespective of the threat or the hazard.
10 As such, this planning and preparation is agnostic as
11 regards to the cause of the hazard, and is designed to
12 ensure an appropriate and proportionate response at all
13 levels. This could range from responding to a local and
14 contained emergency up to and including an emergency
15 which would require cross-government response and
16 triggering of the civil contingency arrangements.

17 Of course, as the Inquiry has heard over these
18 hearings in recent weeks, it is necessarily preferable
19 to have an approach with flexible capabilities that
20 could be deployed in response to any pandemic. While
21 some of the elements of the UK influenza pandemic plan
22 were beneficial, it clearly had deficiencies in
23 providing a response to the Covid-19 pandemic.
24 Capabilities should be generic enough to allow
25 a response to a range of potential pathogens and modes

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1 of transmission, agile enough to be scaled up quickly
2 enough to contain spread, and specific enough, with
3 tailored control measures, when there is a better
4 understanding of the pathogen.

5 These are all lessons which Northern Ireland and the
6 department can reflect on in future approaches to
7 planning and preparation.

8 Further, notwithstanding the importance of a general
9 pandemic plan, it is nonetheless considered essential
10 that Northern Ireland would maintain a pandemic plan for
11 influenza, given its continued propensity to cause
12 outbreaks with significant morbidity and mortality.

13 The seventh issue, my Lady, is that of the reviews
14 that had been carried out via the silver debrief and the
15 gold independent inflight review in the very early
16 stages of the pandemic in Northern Ireland.

17 In such a high pressurised, fast-moving and dynamic
18 situation, communications are always challenging, and it
19 was in this context that issues were raised about PPE
20 which led to the suggestion that some had failed to
21 appreciate that the emergency PPE stockpile did not form
22 part of the day-to-day supply chain.

23 In his evidence, Mr Pengelly confirmed that no
24 concerns had been brought to his attention about the
25 management of the emergency stockpile of PPE prior to

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1 posed by this pandemic.

2 The Northern Ireland Covid Bereaved Families raised
3 the issue of the limited participation of the
4 department's Chief Scientific Adviser in the UK CSA
5 network. However, it should be noted that the absence
6 of the department's scientific adviser from that network
7 did not mean that the department was unable to access
8 its advice.

9 It is also the fact that the issue of participation
10 is outwith the scope of those in Northern Ireland and,
11 rather, rests at the discretion of the UK Government
12 Chief Scientific Adviser.

13 Indeed, the Department of Agriculture, Environment
14 and Rural Affairs, the CSA for that department in
15 Northern Ireland acted as the single point of contact
16 for Northern Ireland in the network, and he was able to
17 pass papers to Professor Young.

18 It is also, we say, apposite to note the scope of
19 what happened at those CSA meetings. They were
20 informal, regular meetings but significantly were not
21 part of central government emergency planning or
22 decision-making or advisory structures, in preparation
23 to or in response to the Covid-19 pandemic.

24 Additionally, it should be noted that throughout
25 the pandemic Professor Young attended the UK SAGE

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1 the pandemic. The PPE stockpile in Northern Ireland was
2 effectively used during the pandemic to supplement and
3 to support the main PPE supply, not only to trusts but
4 also to social care, primary care and emergency dental
5 services during the early response to the pandemic.

6 The eighth issue I'd like to touch on, my Lady, is
7 that of north-south collaboration. The department's
8 evidence demonstrated the extent of collaboration with
9 its Irish counterparts, but of course it is to be
10 recalled that any formal policy, if it is to encompass
11 a five nation, two-island approach, will be a matter
12 necessarily for the UK and Irish governments, rather
13 than being a matter for the department.

14 The ninth and final issue, my Lady, is that of
15 whether there should be a chief scientific adviser in
16 Northern Ireland, and we say that this is essentially
17 a matter for the Executive Office. However, the
18 department does wish to point out that Professor Young
19 provided input and advice as required and on a number of
20 areas to the Department of Health. The fact that
21 the Executive did not ask Professor Young for scientific
22 advice from 2015 should not be interpreted as inexorably
23 meaning that Northern Ireland was inadequately served by
24 the provision of scientific advice in a way which
25 detracted from its ability to respond to the challenges

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1 meetings and other relevant UK fora. He was able to
2 provide advice to our Chief Medical Officer and the
3 health minister as appropriate. He attended meetings
4 with the Northern Ireland Executive ministers and
5 officials from other departments, participated in
6 communications and briefings to the media, the public
7 and other stakeholders, and established and chaired the
8 department's strategic intelligence group and modelling
9 group.

10 My Lady, to conclude, the department of course
11 recognises that, with the benefit of experience of the
12 Covid-19 pandemic and its particular challenges,
13 Northern Ireland could have been better prepared. It is
14 also mindful, however, that, without this experience, it
15 was very challenging to be ready to meet every
16 eventuality. In a range of ways, very substantial
17 efforts had been made to ensure that the department was
18 adequately prepared, with many of those involved showing
19 dedication and commitment to achieving the best possible
20 outcomes whilst simultaneously addressing very
21 significant non-pandemic issues facing health and social
22 care in Northern Ireland.

23 However, insofar as more could have been done, that
24 is a matter of profound regret. The department
25 reiterates its sincere commitment to learning lessons

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1 from the devastating impact of the Covid-19 pandemic
2 such that it might mitigate the enduring consequences
3 that continue to be experienced by our health service
4 and our community. To this end, the department hopes
5 that the Inquiry will be able to identify learnings and
6 recommendations to help shape future responses,
7 particularly given the ever-present potential that
8 another pandemic may arise, the exact timing and nature
9 of which will be unknown.

10 Finally, the department wishes again to convey our
11 deepest sympathies to those bereaved during the course
12 of this pandemic.

13 Thank you.

14 **LADY HALLETT:** Thank you very much for your help.

15 Ms Studd.

16 **Submissions on behalf of the Cabinet Office by MS STUDD KC**

17 **MS STUDD:** My Lady, the Cabinet Office welcomes the
18 opportunity to make an oral closing statement --

19 **LADY HALLETT:** I don't know, is the microphone on?

20 **MS STUDD:** It is on.

21 **LADY HALLETT:** Is it?

22 **MS STUDD:** Can you hear me now?

23 **LADY HALLETT:** Try again.

24 **MS STUDD:** Can you hear me?

25 **LADY HALLETT:** Yes.

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1 could manifest. For example, in the 2002 National
2 Security Risk Assessment, pandemic risk now reflects
3 a broader range of infectious disease.

4 The Cabinet Office recognises the uncertainty which
5 is inherent in risk assessment and preparedness, and
6 endorses the value of building flexibility, innovative
7 thinking and diverse perspectives into its planning
8 system. A future pandemic could be very different, so
9 we must be able to adapt to novel risks and challenges.

10 This is how, for example, we define the National
11 Resilience Planning Assumptions in the National Security
12 Risk Assessment to help emergency planners understand
13 and prepare for the common consequences of risk.

14 The Cabinet Office has also increased the
15 opportunities for expert input into the risk assessment
16 process, especially from external experts.

17 We would also draw the Inquiry's attention to the
18 planned publication of the latest National Risk Register
19 this summer, which is the government's most transparent
20 approach to date for publicly sharing information about
21 risk, and ensures that we continue to be open to
22 external challenge and input.

23 The second evidential theme concerns communities and
24 putting equality considerations at the heart of the
25 Resilience Framework.

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1 **MS STUDD:** The Cabinet Office welcomes the opportunity to
2 make an oral closing statement, and we continue to
3 support the important work of this Inquiry. We have
4 listened with care to the evidence of all the witnesses
5 who have appeared before you over the last six weeks.
6 In this oral statement, we will review some of the key
7 evidential themes which you have been considering.

8 The first is understanding risk. In terms of risk
9 methodology, evidence has rightly covered the National
10 Risk Assessment and the National Security Risk
11 Assessment process, and in particular the way in which
12 pandemic influenza and emerging infectious disease were
13 considered in those documents.

14 The inclusion of pandemic influenza as one of the
15 most significant risks on the risk matrix reflected
16 an objective and widely held assessment of the risk that
17 it posed, and as you have heard in evidence it continues
18 to pose to this country.

19 Rightly, the experience of the pandemic has prompted
20 change, which we've already put into effect. The
21 Cabinet Office has made the most significant reforms to
22 the National Security Risk Assessment since its
23 foundation in the early 2000s. Where appropriate, the
24 National Security Risk Assessment now considers multiple
25 scenarios to reflect the different ways in which risks

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1 The Cabinet Office has noted the interest of the
2 Inquiry in the issue of the pandemic's disproportionate
3 impact on particular groups. The Resilience Framework
4 sets out our ambition to transform resilience and adopt
5 a whole-society approach, with communities, members of
6 the public and businesses engaged in making decisions
7 about managing risk. It makes a specific commitment to
8 better identify and support at-risk groups and seeks
9 voluntary and community sectors' integration into the
10 work, with stronger local resilience fora working with
11 us to help prevent, prepare for, respond to and recover
12 from risks that the UK faces.

13 The United Kingdom Resilience Forum process
14 stimulates additional opportunities for input from
15 national, regional and local government, private and
16 voluntary sectors, and other interested parties. It is
17 right that we invite external challenge and obtain
18 different perspectives on what resilience means to all
19 parts of the population.

20 Data is key to understanding how different groups
21 are affected in a disaster and the causes of any
22 disparity. The Cabinet Office is reforming the way it
23 utilises data and analytics, to prepare for and respond
24 to crises through the National Situation Centre. We are
25 developing a measurement of socio-economic resilience,

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1 including evaluating how risk impacts across communities
2 and vulnerable groups to guide and inform
3 decision-making on risk and resilience. These plans are
4 in development and much work remains to be done.

5 The third evidential theme is responsibility and
6 accountability. The Inquiry has asked many questions
7 about the perceived complexity of the government's
8 structures for resilience and emergency management. The
9 Deputy Prime Minister and Chancellor of the Duchy of
10 Lancaster holds overall responsibility for national
11 resilience and chairs the national security committee
12 resilience subcommittee. This is a new ministerial
13 forum to take decisions on resilience and preparedness.

14 The Cabinet Office's intention in the Resilience
15 Framework is to ensure that roles are simplified and
16 clarified as much as possible. This is a wide-ranging
17 and complex subject area, with many organisations
18 involved, representing the full span of the public,
19 private and voluntary sectors.

20 However, notwithstanding that, the Cabinet Office's
21 reflection on the evidence heard by the Inquiry is that
22 the structures are well embedded and generally well
23 understood by those who are working within them. The
24 Cabinet Office will obviously consider carefully any
25 conclusions or recommendations from the Inquiry on the

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1 that the lead government department model needs to be
2 strengthened, with the Cabinet Office providing greater
3 clarity in relation to the responsibility for risks,
4 including those which are more complex and cut across
5 departmental boundaries.

6 The Cabinet Office's Resilience Directorate will
7 proactively seek to ensure that cross-cutting work is
8 carried out and tested with lessons from recent national
9 exercises.

10 In addition, the Inquiry has heard evidence of the
11 various steps the Cabinet Office took to assist local
12 resilience forums in gaining assurance, including the
13 promulgation of resilience standards in 2018 and 2019.
14 The Resilience Framework sets out further steps that the
15 Cabinet Office and Department for Levelling Up, Housing
16 and Communities are taking by way of investing into and
17 strengthening the local resilience fora. Similar
18 standards and assurance will be extended to the public
19 health sector.

20 In addition, the United Kingdom Government continues
21 to work closely with the devolved administrations to
22 promote effective emergency planning whilst respecting
23 the devolved settlements.

24 Resilience planning has to be rooted in the real
25 world and focused on where the greatest risk lies.

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1 structures around resilience.

2 Under the lead government department model,
3 the Inquiry has heard it was the lead government
4 department which took the lead in preparing for any
5 risk. The role of the Cabinet Office at the centre of
6 government was to provide support, co-ordinate and
7 direct resources as appropriate. The Inquiry has
8 explored the appropriateness of that model. Some
9 witnesses consider that preparedness under this model
10 did not anticipate the cross-cutting nature of
11 a response to the pandemic, including the need for
12 non-pharmaceutical measures such as national lockdown,
13 furlough, prolonged school closures, or the preparation
14 of the population for measures such as mask wearing.

15 However, the Inquiry has also heard the approaches
16 to pandemic planning did reflect the scientific
17 consensus at the time and took account of the
18 contemporaneous international guidance and practice.

19 The Cabinet Office remains of the view that the lead
20 government department model is an appropriate way of
21 allocating principal responsibility. The relevant
22 departments have the expertise for what is inevitably
23 a diverse portfolio of risks. It is the lead department
24 that has the relationships and the levers to be best
25 equipped to lead the response. But it is recognised

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1 Spending on preparedness comes at a cost and has to be
2 balanced with spending on other important areas.
3 Flexibility is essential to resilience.

4 The Inquiry has spent considerable time considering
5 evidence about the impact on pandemic preparedness of
6 planning for the no-deal exit from the EU,
7 Operation Yellowhammer. A number of witnesses
8 considered that significant parts of
9 Operation Yellowhammer work were of assistance during
10 the Covid-19 pandemic and ensured that we were
11 match fit.

12 Operation Yellowhammer was a very substantial
13 investment in the United Kingdom resilience capabilities
14 and the government's understanding of the resilience of
15 our society and of our economy. This included
16 stocktakes of supply chains, including medical supply
17 chains, readiness for problems at the borders, the
18 setting up of departmental operational centres, and
19 daily ministerial meetings on preparedness. Extra staff
20 were recruited and trained in crisis management who were
21 then redeployed to support our response to the emerging
22 Covid-19 pandemic when the threat of no-deal had passed.
23 All of this was invaluable.

24 The Cabinet Office has reflected on how the
25 department maintains focus on longer term resilience

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1 while also responding to crises and near term events.

2 The Inquiry has heard that several changes have been
3 made, including the separation of roles into the
4 Resilience Directorate and the COBR unit. Political and
5 public interest in resilience will be a central driver
6 of improved future outcome. Starting this autumn, there
7 will be an annual statement of civil contingencies risk
8 and the UK's performance on resilience made to
9 Parliament. There will also be an annual survey of
10 public perceptions of risk, resilience and preparedness.
11 With this momentum, resilience issues will remain at the
12 top of the agenda, and the system will remain
13 accountable to Parliament and to the public.

14 These reforms are significant. They provide this
15 country's resilience with new leadership, focus and
16 direction, and go well beyond the Cabinet Office's
17 traditional role. They will require the government and
18 others to consider the risks we face as a society, how
19 to prepare for them, and how to respond to them, taking
20 into account the very powerful evidence of the bereaved
21 that we heard yesterday. As we must never forget, at
22 the heart of all this there is a human cost.

23 The government looks forward to the Inquiry's
24 observations and recommendations and will continue to
25 support it in its vital work.

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1 Secondly, there are around 135 statements of
2 witnesses who have not given oral evidence but whose
3 statements we consider it will be necessary -- to some
4 extent, rather -- to refer to in your report.

5 So may I have permission for those two bodies of
6 material to be published?

7 **LADY HALLETT:** You may.

8 **MR KEITH:** My Lady, that does indeed conclude Module 1.

9 Of course you will be resuming the evidential hearings
10 in Module 2 on Tuesday, 3 October.

11 **LADY HALLETT:** Not so fast, Mr Keith, I think Mr Weatherby
12 wants to say something.

13 **MR WEATHERBY:** Yes, I'm sorry, very briefly. I wasn't aware
14 that Mr Keith was going to mention the documents. Could
15 we have a little time, with our closing submissions, to
16 perhaps add to that list? That would assist --

17 **LADY HALLETT:** Yes, of course. Send any thoughts through,
18 Mr Weatherby, of course.

19 **MR WEATHERBY:** Thank you very much.

20 **MR KEITH:** That's it.

21 **LADY HALLETT:** Well, thank you all very much indeed. We've
22 now completed the hearings for Module 1, resilience and
23 preparedness for the pandemic, in just over a year from
24 the day of our official start. Given the amount of
25 material that's had to be gathered and then analysed,

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1 **LADY HALLETT:** Thank you very much indeed, Ms Studd.

2 **Closing remarks**

3 **LADY HALLETT:** Mr Keith, I think that completes the closing
4 submissions.

5 **MR KEITH:** It does indeed.

6 My Lady, may I just raise the important issue of the
7 publication of material that is relevant to
8 the Inquiry's work in Module 1.

9 As you know, a number of documents have been adduced
10 in evidence, either because they've been brought up on
11 the screen during the hearing or because you've already
12 given permission for them to be published, but you will
13 inevitably be drawing upon a wider body of material for
14 the purposes of your report writing.

15 So may I therefore seek your permission to publish,
16 firstly, around 560 documents which the Inquiry team has
17 identified as being necessary for the Inquiry to publish
18 in connection with your forthcoming work on the report
19 writing in Module 1?

20 The list of those documents -- and they comprise
21 things such as policy papers, presentations, minutes of
22 meetings, reviews, reports into exercises, reports on
23 exercises, emails, risk registers and reports from
24 NGOs -- will be provided to the core participants,
25 of course.

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1 I think that's a huge achievement, and I owe a great
2 debt of gratitude to a lot of people -- many of whom are
3 in this room today, but many who are elsewhere -- and
4 without your significant work, we couldn't have got this
5 far this quickly. I think it is a great credit to
6 everybody involved, material providers, the lawyers, the
7 paralegals, the secretariats for all different
8 organisations, that we have got this far.

9 I'd also like to praise the members of the public
10 who have attended, I think one of whom has been here
11 virtually, if not every day -- I think every day. So
12 especially the bereaved, obviously, they have acted with
13 great dignity in the hearing room. I know that feelings
14 are running very high at times and I would like to
15 thank you for your composure and your dignity in
16 appreciating the formality of the proceedings in the
17 hearing room. So thank you all very much.

18 The next stage for the Inquiry team is to start
19 drafting -- I think drafting has probably already
20 started in some respects -- and finalising the report
21 for Module 1. As I have made clear many times, I intend
22 to finalise it and publish it as soon as possible.

23 There's obviously a very great deal of material to
24 consider, and so I will ensure that it's published --
25 the hope is that it will be published by early summer

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1 next year. If we could do it any quicker, obviously we
 2 will, but given the amount we have to go through, we
 3 will have to see.

4 Anyway, that is my hope and my plan, because -- as
 5 I think it was Ms Marsh-Rees said yesterday -- the
 6 sooner I can get any recommendations, if I make any,
 7 public, then the sooner they may be implemented and the
 8 sooner they may have an effect.

9 So thank you all very much, for those who have
 10 followed online, for those who have been here, and for
 11 the participants and the lawyers involved. Thank you.

12 **(12.43 pm)**
 13 **(The hearing adjourned until Tuesday, 3 October 2023)**

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