AAMER ANWAR & CO
SOLICITORS & NOTARIES

MODULE 1 CLOSING WRITTEN STATEMENT

RECOMMENDATIONS

SCOTTISH COVID BEREAVED

As the 1946 Constitution of the World Health Organization states "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Having received disclosure over the past months and listened to the evidence over the past 6 weeks, Scottish Covid Bereaved considers that the UK and Scottish Governments have failed in their obligations to protect the health of the those within it, by failing to prepare for what they knew was an inevitable pandemic.

The Office of the UN High Commissioner for Human Rights and the World Health Organisation have identified key aspects of that right to health which includes; The right to prevention, treatment and control of disease; access to essential medication; all services, goods, and facilities must be available in sufficient quantity, accessible, acceptable and of good quality. States cannot justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources. The Special Rapporteur on the right to the highest standard of health has stated the health system has to have several components, two of which are:

1. An adequate system for the collection of data, said data being separated on certain grounds such a sex, age, ethnicity etc. and 2. And a national capacity to produce enough well-trained health workers who enjoy good terms & conditions of employment.

Against these markers, the UK Government has failed to protect the right to health in its preparation for the covid pandemic. The focus was placed on an influenza pandemic, public health underfunded, people were denied access to essential medication, necessary goods and facilities – such as PPE – were not available in sufficient quantity and quality. There was no adequate system of data collection and data disaggregation. The NHS had a decade of austerity leading to chronic underfunding. Brexit had reduced the numbers of healthcare workers such that there was a shortage of well-trained health workers., putting a stress on the workers who remained. Very few people employed by the NHS in Scotland and in the UK consider that they enjoy good terms and conditions of employment. Specific planning and preparations to ameliorate the effect of a pandemic for discriminated and marginalised groups - who often already share a disproportionate amount of health problems - were non-existent. On the 19th July the BMA set out in some detail the stark reality for the NHS and those working in it. The Scottish Covid Bereaved recognises, agrees and adopts the submissions that bleak picture set out the state of the NHS, for those working in it and in particular too for discriminated groups.

It is submitted that the Chair should make it clear in her recommendations that there was a failure to protect the health of those in the UK and Scotland.

IDENTIFYING THE CAUSE OF THOSE FAILURES

In order to make recommendations which are likely to have a significant effect when the next pandemic arrives it is submitted that in the first instance the cause of the failures should be identified, and recommendations should address how to tackle these.

The SCB acknowledge from the outset that there is a limit to what recommendations can be made by any Inquiry, and the Chair's recommendations must be tailored accordingly. The SCB also considers that it would be wrong to try and make recommendations to deal with issues at a granular level. It is submitted that what is required is to assess, in broad terms what went wrong with pandemic planning and preparedness and to try and address those issues.

Prior to looking at these issues individually, it is submitted that the Chair should address the context in which the pandemic took place – specifically that austerity had left the National Health Service in a position where it had insufficient resilience to cope with a pandemic and

that planning for a no deal EU exit meant that crucial work which ought to have been done in relation to pandemic planning was not carried out. Austerity had also affected Public Health and the public care home system in the same way. A combination of austerity and Brexit also affected the number of skilled healthcare workers available to work in the NHS and in care homes. It is submitted that the Chair should make it clear that it is critical to the success of any pandemic resilience plan in the future that body who deals with caring duties including social care, our NHS (both in Scotland and elsewhere) requires to be properly funded and to have sufficient staff with good working conditions to make it resilient to future strain. The SCB noted the submissions on behalf of the BMA on the 19th July and would adopt the views expressed therein in relation to the state of the NHS and the lack of resilience therein both financially and in respect of the people that work in it. Without a healthy NHS there is no healthy UK population, and it does not matter what other resilience planning is built if the cornerstone of the NHS is not in itself resilient enough to withstand another pandemic. It is submitted the Chair should also address the effect of planning for a no deal EU exit at the expense of pandemic planning and make it clear that whatever the other emergencies that arise, priority should be given to planning for a pandemic, given its level of risk.

Against this background, there were a number of themes which emerged in the evidence of the witnesses and the expert reports.

FAILURE TO ORGANISE

When looked at in retrospect, the lack of centralised co-ordination in relation to planning and preparing for a pandemic was quite extraordinary. This, combined with a misplaced self-congratulatory view that the UK was somehow a world leader in pandemic preparedness, left the UK in a state of chaos in March 2020. Policies such as furlough and other financial plans were being made up "on the hoof", co-ordination within the 4 nations was patchy, 2011 pandemic preparedness plans had not been implemented, nor for the most part had the recommendations of Exercise Cygnus. Throughout the hearing in module 1 it became apparent that there was no overall co-ordination to implement such plans that were in place. Whilst there had been pandemic exercises there had been no "joined up thinking" of what a pandemic would look like in practice at all levels of society. There was no one "in charge". Different groups appeared broadly to be doing the same jobs, names of committees changed whilst broadly speaking the work remained the same. Acronyms abounded. Whilst in retrospect it has

become clear that local targeted pandemic responses were essential to success in keeping people safe, it was also apparent that there still requires to be centralised overall control and oversight of such arrangements. The pandemic response system at UK level has to be streamlined.

In the foregoing circumstances the Scottish Covid Bereaved submits that a role should be created within UK Government to be the Risk and Resilience Minister. That role ought to be held by a Senior member of government – in order to command the attention of the PM when necessary. It is submitted that whoever holds this role should chair a permanent Pandemic Resilience Committee – a blueprint for a such a system can be taken from the Standing Committee on Pandemic Preparedness as is in place in Scotland. Such a body should be the central point for consideration of academic and scientific information and advice in relation to pandemic preparedness and the execution of pandemic planning in the event of a global health incident, and have communication and input with NERVTAG and SAGE and the proposed new independent body set up (below) . Such a committee should liaise with similar bodies all four nations so that the next planning and execution will be a co-ordinated event. The CMOs of each of the 4 Nations ought to be members of the committee, as well as the UK Minister for Health and the ministers for health in the Devolved Administrations. Also, Directors of Public Health ought to be part of this Committee. There ought to be representatives from Local Authority and Voluntary Groups, as well as representation from groups known to suffer discrimination. Given the importance of this body to all those within the UK its scope, duties and responsibilities ought to be set out in statute, as well as the make-up of its members. This body should incorporate any work done by meetings/exercises/reports of whole system group into its discussions. This body should also have within its remit a review of the level 1 and 2 responders to assess the current levels and whether or not changes should be made to the current classifications.

FAILURE TO CONSIDER PANDEMIC PLANNING AND RESILIENCE IN A WHOLE SYSTEM WAY

The Inquiry evidence showed that pandemic planning did not properly consider all the bodies that are involved in that process. In Scotland a philosophy was adopted that resilience was everybody's business. This was in sharp contrast to the UK, where it required legal action to

seek to obtain the report on Exercise Cygnus. If it is true that the reasoning was such that it was withheld so as not to frighten the public, Politicians ought not to treat its voting public like children. Had the report been made public there was at least a possibility that the light of publicity could have ensured that there was public appetite to ensure that the recommendations were carried out and not in part shelved for no deal exit from the EU. Public Health, which came to the fore in the pandemic, was left out of vital planning work. This was an almost incomprehensible error - given it is the branch of medicine dealing with public health, including hygiene, epidemiology, and disease prevention. Further, it became clear that those dealing with the realities of a pandemic on the ground at local level were woefully ill-informed and had not been asked for input into the pandemic response. There had been no planning with groups discriminated against, even though it is commonly accepted that those who are discriminated against have worse health outcomes than those not so.

It is submitted that following the Scottish example again, UK bodies should collaborate as part of their remit in civil emergency planning to create a "whole system" response for the UK. The ethos of such a system is collaboration and co-operation. Politics ought not to feature in such work and everyone should work to a common aim of improving the system in place. Rather than, as was proposed, seeking to remove powers from Scotland in relation to pandemic planning, Scotland should instead take an active part in preparation and decision-making in the event of a pandemic. Lines of communication as between public bodies in the event of a civil emergency should be set out clearly in one policy guide, also setting out the hierarchy of power in such circumstances. Devolved administrations should have their say and be included in all whole system planning. It should be made clear that if a pandemic event occurred devolved administrations should have a seat at the discussion table, including SAGE. The whole system response should include working in a collaborative way with academia, community planning, health and social care , Local Government, Scottish and UK Government, NHS, private and the voluntary sector. The work done in collaboration with these groups should be incorporated into pandemic planning work. As part of the whole system response bodies should be specifically tasked with addressing the issue of how to improve health outcomes for discriminated groups. In order to promote the best collaborative approach the outcome of any UK Govt pandemic planning should be made public, in order that a whole system response can be tested and reviewed against such findings.

Using a whole system approach, Public Health should have a vital part to play in the process of pandemic planning which was inexplicably absent from previous planning. As the pandemic arose it became clear that public health messages, for example on hygiene to wash hands or later in relation to vaccination became vital tools in curbing the spread of the virus. It is very important that public health messages to the public are worked on as part of any pandemic planning. Unfortunately, misinformation and conspiracy theories abound and the public must be properly informed by bodies which they can have trust in that they are being given the best advice. Winning "hearts and minds" with public health messages is an important part of future pandemic planning and this can only be done by a focus on Public Health bodies as part of the whole system plan.

It should be noted that the SCB are in no way self-congratulatory about the work done in Scotland : Whilst we in Scotland had planned for a whole system response, it was clear that in the event the hopes fell short when implemented – the staggering evidence of Jean Freeman, Scottish Health Minister, manning a telephone line to assist with finding PPE at the start of the pandemic, does not inspire confidence that the whole system response was properly working. Whilst whole system planning is by its very nature a constant work in progress much more has to be done to realise the ideals of having such a response.

FAILURE OF EXPERTS

It appears by way of "groupthink" or a lack of appetite to challenge to the orthodoxy we prepared for the wrong pandemic : whilst experts say it was most likely that an influenza pandemic would have been the next one, we focused on that to the exclusion of other pandemic risks. This had effects both in the way we planned in exercises and in the implementation of those plans, leaving us short on essential items such as PPE. Further, and again inexplicably, it does not appear that work was done finding out how other countries who had dealt with pandemic threats such as MERS and SARS were not considered. In Scotland as the pandemic was emerging, it was only due to personal connection of a 3rd party that they were able to facilitate a call between our CMO in Scotland and the CMO in Singapore to have a chat about the emerging pandemic.

The setting up of an independent scientific academic body, tasked with addressing all the pandemic risks as per the National Risk Register would assist in properly preparing for

the next pandemic. Challenge to the orthodoxy ought to be promoted in such a forum. To encourage heterodoxy, Chatham House rules could be implemented if necessary to ensure reports from such a body would not identify the individuals with differing scientific views. Further such a group ought to be tasked with considering comparative approaches worldwide to pandemic planning and containment. In this way we can obtain valuable practical advice from those who may have more experience than us. The work of such a group could be considered by NERVTAG and a representative from the new body should be invited to sit on NERVTAG. This body would be tasked with looking at threats worldwide and considering the efficacy of the responses to them. Collaboration with CMOs from other countries could be encouraged by such a group.

FAILURE TO HAVE A WHOLE SYSTEM APPROACH TO COLLECT DATA

There was a failure to have a system in place to allow health data to be comprehensively collected and disaggregated in the UK to allow information to be drawn from it which would help in pandemic planning (for example to see where the greatest resources were needed) and implementation of such plans.

It is suggested that there is a body set up specifically to collect and analyse health data. As part of the whole system response to pandemic planning it should collate data from all public bodies and private care facilities to do so. At present Scotland has an Information Services Division of the NHS that works in partnership with other bodies such as GPs, Community Health groups, Local Authorities but it is submitted a broader health data body, as part of a whole system approach in the UK would be a valuable tool to assist in pandemic preparations. Such a body would be able to provide valuable, reliable data to, for example the Pandemic Resilience Committee (as proposed above) in order for it to take decisions UK wide. One of the important benefits of a specific UK health data body is that specific work can be done to highlight discriminated groups with health inequalities and plan for that.

CONCLUSION

|In order for us to be as prepared as we can be for the next pandemic we must ensure that we have "joined-up thinking" not "groupthink". We must fortify the existing supports we have by

ensuring our NHS and Care Service is resilient. We must adopt a whole system plan which means that pandemic planning is everyone's business in the UK. We must make sure that in doing so focus is brought to bear on existing health inequalities and how those discriminated against. We must also focus on the academic and scientific expertise which will assist us plan, as well as ensuring that we collect and analyse health data to allow that planning assistance to reach the places that it needs to. We must promote the work of Public Health. We must streamline our systems, banish acronyms and constantly changing committee names, we must have a UK Minister of Risk and Resilience and a standing Committee on Pandemic Resilience Committee . We must ensure that our work is collaborative and co-operative as it was in the early days of the pandemic when, borne of necessity, obstacles were overcome and creative solutions to problems were found. It is in this spirit we need to continue if we are to provide the necessary protection from the next pandemic.

The SCB a note however that almost all, if not all, politicians who gave evidence said that things could have or should have been done differently and that lessons must be learned. The work of this Inquiry will put those good intentions to the test. These policy makers are not limited in the same way as an Inquiry is in terms of recommendations and can seek to implement political changes in a way which the Inquiry cannot. The SCB hope that those in Government and the Opposition, both in the UK and in Scotland listen to the submissions from all core participants, and of course the final recommendations of the Chair and implement the changes required.

The Scottish Covid Bereaved is grateful for the work done by the Chair, Counsel to the Inquiry, both Senior and Junior, and all the staff of the Inquiry who have worked hard in Module 1 and successfully elicited important evidence on which this module's recommendations will rest. We are similarly grateful to the other Core Participants who have flagged up important issues from diverse perspectives. Finally, the Scottish Covid Bereaved are grateful to its own members, whose hard work and unfailing spirit have led us to the completion of Module 1.

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