THE UK COVID-19 INQUIRY

CLOSING STATEMENT OF THE TRADES UNION CONGRESS MODULE 1

INTRODUCTION

1. This is the closing statement of the Trades Union Congress, "the TUC", in Module 1 of the UK Covid-19 Inquiry. The TUC brings together 5.5 million working people who make up its 48 member unions, from all parts of the UK, and who span a wide range of sectors profoundly affected by the Covid-19 pandemic. The sectors represented by the TUC member unions include workers in the whole range of health and social care services, construction and manufacturing, railways, aviation, education, food industries, and retail, communications workers, fire and rescue services, the civil service, and the arts.

2. As a core participant in Module 1 of the Inquiry, the TUC is working in partnership with the Wales TUC ('**WTUC**'), the Scottish TUC ('**STUC**'), and the Northern Ireland Committee of the Irish Congress of Trade Unions ('**NIC-ICTU**'). The WTUC is an integral part of the TUC but is autonomous in some policy areas. The STUC is a separate organisation to the TUC, representing over 540,000 trade union members in Scotland from 42 affiliated unions and 20 trade union councils. The NIC-ICTU is also a separate organisation and is responsible within the ICTU for all issues affecting nearly 250,000 members. ICTU has a membership of 43 unions. The TUC, STUC and NIC-ICTU frequently work in partnership, and the relationship is formalised through a body known as the Council of the Isles. The affiliated unions of each organisation are set out in the annexures to our written opening statement.

3. In Module 1, the Inquiry has received written witness statements from Kate Bell (Assistant General Secretary of the TUC), Rozanne Foyer (General Secretary of the STUC), and Gerry Murphy (Assistant General Secretary of ICTU) and has heard live oral evidence from Ms Bell and Mr Murphy.

4. Throughout the Module 1 preparations and public hearings, the TUC has sought to ensure that the Inquiry benefits from the diverse perspectives of the 5.5 million workers directly represented by the TUC, and that recommendations flowing from this module adequately reflect the experiences and suffering of the more than 15,000 people of working age who died

with Covid-19, and the hundreds of thousands of workers who contracted Covid-19 as a result of exposure in the workplace, or for whom a workplace illness has been caused or exacerbated by Covid-19.[1]

THE PANDEMIC PLAN: WOEFULLY INADEQUATE

5. Module 1, entitled 'Resilience and preparedness', was established to consider whether *"the pandemic was properly planned for and whether the UK was adequately ready for that eventuality"*.[2] Following the disclosure of over 18,000 documents to core participants, including the receipt of over 200 witness statements, and six weeks of oral evidence, two things are clear: there was no plan for the Covid-19 pandemic; and resilience and preparedness really matter.

The failure to plan for the Covid-19 pandemic

6. Planning for 'a pandemic' was, as former Chief Medical Officer, Dame Sally Davies, put it, *"monomaniacally focused on pandemic flu"*.[3] There was therefore little planning in respect of a pandemic with asymptomatic transmission, such as Covid-19. As a result, critical preparedness activities, such as addressing the lack of ability to scale testing and the rollout of tracking data, were overlooked.[4]

7. This had a knock-on impact on preparations in the devolved nations. As Richard Pengelly, former Permanent Secretary for the Department of Health in Northern Ireland, stated, the 2013 Northern Ireland Health and Social Care Influenza Pandemic Preparedness and Response Guidance (INQ000183431) was based on the UK 2011 preparedness strategy and focussed on influenza pandemic, overlooking the need for guidance on a pandemic with shorter or longer incubation periods, asymptomatic spread, mass self-isolation, and mass contact tracing.[5]

8. This failure to plan for other infectious diseases, such as coronaviruses, led to erroneous decision making in the currency of the Covid-19 pandemic, too. As Counsel to the Inquiry, Hugh Keith KC, accurately summarised in opening:

[1] See: https://www.tuc.org.uk/news/workers-memorial-day-unions-and-bereaved-families-demand-covid-inquiry-seeks-truth-about; and https://www.hse.gov.uk/statistics/coronavirus/index.htm.
[2] See: https://covid19.public-inquiry.uk/modules/resilience-and-preparedness/.
[3] Day 6 Transcript, p.33, lines 18-19.
[4] Day 6 Transcript, p.33, lines 8-19.
[5] Day 18 Transcript, p.77, lines 3-25, and p.78, lines 1-21.

> "[in March 2020] *The reality was that the United Kingdom government announced it would stop all community testing for Covid-19 and focus instead on testing people in hospitals and protecting health workers as it moved from the contain to the delay phase. So it's clear that the system had not adequately foreseen and prepared for the need for mass testing in the event of a non-influenza pandemic. For a flu pandemic, of course, you're most likely to show symptoms. You know you have a bug.*"[6]

9. Not only was the limited planning which did occur based on influenza pandemic, but it was overwhelmingly focused on managing the dead rather than protecting the living. As Director of the Cabinet Office Briefing Rooms ('COBR') Unit, Roger Hargreaves, explained, it is necessary to have in place a plan for managing bodies in the instance of high numbers of excess deaths, but this must not come at the expense of planning to prevent deaths: "*we saw this huge problem and we didn't say to the system, 'Well, how are we going to stop it?'*".[7]

10. Several witnesses have pointed out that Exercise Cygnus was founded on the premise that a pandemic influenza had already taken hold, infection levels were, hypothetically, in the millions and deaths in the hundreds of thousands.[8] The TUC does not accept that this effectively means, as some witnesses implied, that properly implementing key findings of Exercise Cygnus would not have stood us in better stead for the Covid-19 pandemic – the TUC considers that the findings of Exercise Cygnus foreshadowed many of the significant failings during the Covid-19 pandemic. However, it is illuminating in respect of the approach which the UK took to pandemic planning. There was clearly a failure to consider measures which could reduce the spread of an infection before it was widespread, such as localised stockpiles of PPE in hospitals and care homes, scalable testing facilities and digital infrastructure for recording the results of testing and contact with others. As former Secretary of State for Health and Social Care and current Chancellor, Jeremy Hunt, explained: "*So that's why, rather ghoulishly, when you read through the report of the exercise, there was lots of talk about mortuary capacity and how you would deal with so many dead bodies*".[9]

11. This is reflected in the documentary disclosure in Module 1. Numerous documents disclosed by government departments focus upon mortuary capacity, management of excess deaths and

[6] Day 1 Transcript, p.11, lines 22-25, and p.12, lines 1-7.
[7] Day 8 Transcript, p.102, lines 3-21.
[8] Jeremy Hunt: see Day 7 Transcript, p.150, lines 5-21.
[9] Day 7 Transcript, p.150, lines 22-25.

stockpiling of body bags.[10] Indeed, a full text search of Module 1 documents on Relativity for the word 'mortuary' returns 769 results.

12. The TUC would further observe that pandemic planning was similarly monomaniacally focussed on the healthcare sector. It failed to adequately consider the social care sector, which, of course, is vital to pandemic response, and failed entirely to consider the broad range of sectors which need to keep running in the midst of a pandemic crisis, such as transport, retail and manufacturing. Bruce Mann, expert witness to the Inquiry and former Director of the Civil Contingencies Secretariat, was asked during oral evidence:

> *"In your report, you identify that in relation to national crises and complex emergencies, and particularly cascading emergencies, a number of departments will have to be involved. So, for example, in relation to Covid you would have had the Department for Education in relation to schools, you've got HMT in relation to financial support, you've got the Home Office in relation to borders and enforcement, and so on and so forth. What flaws have you identified in relation to the lead government department model?"*

13. Mr Mann responded:

> *"The most obvious systemic issue is whether, for a catastrophic emergency, a lead government department can oversee preparedness for and the response on all of the issues including a wide range of issues which are outside its direct scope and responsibility."*[11]

14. Indeed, Clara Swinson, Director-General in the Department of Health and Social Care ('DHSC') & Chair of the Pandemic Influenza Preparedness Programme ('PIPP') Board, accepted under questioning that the 2011 Pandemic Influenza Strategy *"did not include any plans for mitigation measures such as lockdown, closing borders, stopping mass gatherings or controls on public transport"* and involved *"no discussion about the potential outcome of, for instance, controlling mass gatherings or closing schools"*.[12] The failure to adequately consider impacts on sectors other than the healthcare sector led to serious failings in the health and safety standards in a wide range of workplaces, which, as set out below, contributed to the unequal impact of the pandemic.

[10] See, for example: INQ000001190 at p.25; INQ000005959 at para. 8.3 INQ000007059 at pp.2-3; INQ000007068 INQ000007074; INQ000013191; INQ000013404 at p.15; INQ000019394; INQ000019395 at p.1; INQ000022690 at p.5; INQ000022695 at p.12; and INQ000022734.
[11] Day 3 Transcript, p.152, lines 10-25.
[12] Day 5 Transcript, p.164, lines 16-25, and p.165. lines 1-15

15. Overall, it is evident that the pandemic was not *"properly planned for"*.[13] The limited planning which occurred focussed on an already-widespread pandemic influenza in the sole context of the healthcare system.

The importance of planning

16. The Inquiry should robustly reject the narrative, suggested by some, that the events during the pandemic were unforeseeable and all that could really be done was to react as it unravelled. For example, Sir Christopher Wormald, Permanent Secretary of DHSC, responded to a question regarding whether the system had capability in January 2020 to respond even to a moderate pandemic, *"If you ask me now, with the benefit of hindsight of having dealt with the pandemic, there are a -- well, a large number of things that I would have wanted to have added, as it were, but that is with the benefit of hindsight."*[14] He was rightly challenged by Counsel to the Inquiry, who pointed out: *"in 2016, this departmental board was warning in the clearest terms it was more likely than not that even a moderate pandemic would overrun the system. So there is no issue of hindsight here. That was a prospective warning that the system would likely not cope."* Indeed, the Inquiry has heard evidence that the years preceding the Covid-19 pandemic included numerous prospective warnings and opportunities; from preparedness exercises such as Exercise Winter Willow, Exercise Alice, and Exercise Cygnus to epidemics of infectious disease such as the 2009 swine flu pandemic, the MERS-Cov outbreaks, and the 2013-2016 Ebola epidemic. The opportunities to foresee and to learn were numerous but so many of those opportunities were missed.

17. The evidence before the Inquiry has provided one striking example of an opportunity to foresee and learn which was not missed. The one area in which the UK was world leading during the pandemic was in the research and development, and distribution of vaccines. As the former Dame Sally Davies, explained, it was the *"only thing we had resilience in"*.[15] That resilience was not built on plucky British resolve in response to adversity as it arose; it was built on investment and the application of clinical expertise through the establishment of the Vaccine Network. As Dame Sally Davies described:

> *"following Ebola, led by Oliver Letwin, some considerable amount of money, more than £400 million Official Development Assistance was made available and we set up, I think it was £110 million, the Vaccine Network to look at what we could do – and I chaired the first meeting, then Chris Whitty took over -- to help prepare for infections that didn't have vaccines that might occur*

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[13] See: https://covid19.public-inquiry.uk/modules/resilience-and-preparedness/.
[14] Day 5 Transcript, p.90, lines 14-18.
[15] Day 6 Transcript, p.151, lines 14-25, and p.152, lines 1-8.

> *in low and middle income countries and might spill over. We funded into Oxford for a MERS vaccine, that was the basis of the successful Oxford/Cambridge/AstraZeneca vaccine that saved more lives probably across the world than the other ones."*[16]

18. The significant research and investment in relation to the development of vaccines was an instance of foresight and action; a welcome escape from short-termism. It demonstrates the tangible, life-saving impacts of properly resourced and scientifically led pandemic preparations.

Findings and recommendations

19. The Inquiry has benefitted from some frank appraisals as to the UK's pandemic planning. As has been pointed out by Pete Weatherby KC, in closing oral submissions on behalf of Covid-19 Bereaved Families for Justice, *"woefully inadequate"* and *"wholly inadequate"* are phrases used by Matt Hancock, former Secretary of State for Health and Social Care, and Bruce Mann and Professor Alexander, experts to this Inquiry, respectively, to describe the state of preparedness at the moment the Covid-19 pandemic struck.[17] The Inquiry's own assessment of the UK's pandemic plans will need to be similarly candid.

20. Evidently, there are many lessons to be learned. The UK must in future grasp opportunities to foresee challenges, learn from past experience and build meaningful resilience and preparedness into the system. In oral closing, the bereaved family groups made a range of focussed and concrete recommendations around pandemic preparedness. We consider that those suggestions carry significant force.

<u>AUSTERITY: SERVICES STRETCHED TO BREAKING POINT</u>

21. In our opening submission we expressed this to be a central theme of the evidence which rested on a simple but inescapable truth: that, no matter what planning is put in place, public services stretched to breaking point by over a decade of budget cuts will be severely impaired in their ability to cope with the shock of a national emergency such as a pandemic. What we predicted would be a *"striking feature of the evidence"*, that so many would consistently describe the disastrous consequence of austerity, has proven to be so in the oral hearings. For example:

    a. Professor Sir Michael Marmot and Professor Clare Bambra, experts to the Inquiry, gave evidence that: the funding of the health care system was inadequate post-2010;[18] pay,

[16] Day 6 Transcript, p.151, lines 21-25, and p.152, lines 1-8.
[17] Day 22 Transcript.
[18] Day 4 Transcript, p.30, lines 15-19.

conditions, vacancies and morale in the NHS were adverse immediately prior to the pandemic;[19] the fall in life expectancy for women was more pronounced and a credible explanation for that is that the burden of austerity fell to a greater extent upon women than upon men;[20] and the reduction in local authority spend was greater in areas of higher deprivation which ultimately will damage the health of the people and contribute to health inequalities.[21]

b. Sir Oliver Letwin, Former Minister for Government Policy between 2010 and 2016 and former Chancellor of the Duchy of Lancaster between 2014 and 2016, gave evidence that it is well worth investing in public health in advance as it is much cheaper to prevent things than to deal with the after-effects.[22]

c. Dame Sally Davies, former Chief Medical Officer between 2010 and 2019, gave evidence that we did not have resilience in: the public's health; the public health system - because it had been disinvested in; the NHS; social care; life sciences or manufacturing.[23]

d. Jeremy Hunt, Former Secretary of State for Health between 2012 and 2018 and current Chancellor, gave evidence that: he had been concerned in the years prior to the pandemic as to the resilience and capacity in our health care services;[24] both the NHS and social care system *"were fragile and in need or more funding"*;[25] and the fact that he was unable to secure a longer term funding settlement for the social care sector was *"one of the regrets of* [his] *time as Secretary of State for Health and Social Care"*.[26]

e. Dr Jim McMenamin, former Interim Clinical Director and Strategic Lead for the Respiratory Viral team within Health Protection Scotland and now Head of Infections Service at Public Health Scotland ('PHS'), gave evidence that PHS's opening budget and staffing levels were not sufficient for the organisation to deliver health protection in a response that was required when the pandemic hit.[27]

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[19] Day 4 Transcript, p.31, lines 5-19.
[20] Day 4 Transcript, p.37, lines 23-25, and p.38, lines 1-7.
[21] Day 4 Transcript, p.38, lines 15-25 and p.39.
[22] Day 6 Transcript, p.52, lines 15-25 and p.53, lines 1-3.
[23] Day 6 Transcript, p.151, lines 2-13.
[24] Day 7 Transcript, p.183, lines 20-21.
[25] Day 7 Transcript, p.201, lines 16-20.
[26] INQ000177796, para. 56, and Day 7 Transcript, p.187, line 25 and p.188, lines 1-10.
[27] Day 8 Transcript, p.178, lines 24-25, and p.179, lines 1-7.

f. Rosemary Gallagher MBE, Professional Lead Infection Prevention and Control at Royal College of Nursing ('RCN'), gave evidence that: the RCN was very concerned around the reduced funding for Public Health England ('PHE') and the impact that was having on local authorities and local health protection teams to support population health initiatives at the time;[28] when we went into the pandemic, there was a significant shortage of nurses (about 50,000 short) so we were immediately at risk when we needed to surge capacity;[29] funding for public health services has suffered under austerity measures and undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic.[30]

g. Dame Jenny Harries, former Deputy Chief Medical Officer between 2019 and 2021 and Chief Executive of UK Health Security Agency, gave evidence that the ring-fenced public health budget reduced over time due to austerity.[31]

h. Matt Hancock, former Secretary of State for Health and Social Care between 2018 and 2021, gave evidence that: *"you wouldn't ever send the whole of your army out into battle at once. You have spare capacity in case there's a crisis. You have what they call redundancy in the military sense. Yet every day we send our whole army of the NHS into the field and there is no redundancy. We run the NHS incredibly tight* […] *there simply isn't the resilience when a crisis comes"*.[32]

i. Jeanne Freeman, former Cabinet Secretary for Health and Sport in Scottish Government between 2018 and 2021, gave evidence that the UK government austerity policy had a direct impact on the Scottish Government budget – although the budgets for health and social care increased year on year, they did not necessarily increase sufficiently to meet additional demands.[33]

j. Dr Catherine Calderwood, former Chief Medical Officer for Scotland between 2015 and 2020, gave evidence that the NHS is working at or beyond full capacity at all times;

[28] Day 9 Transcript, p.84, line 25 and p.85, lines 1-4.
[29] Day 9 Transcript, p.88, lines 9-17.
[30] Day 9 Transcript, p.92, lines 19-25, and p.93, lines 1-11.
[31] Day 9 Transcript, p.135, lines 20-25 and p.136, lines 1-23.
[32] Day 10 Transcript, p.95, lines 23-25, and p.96, lines 1-4.
[33] Day 11 Transcript, p.144, lines 14-25 and p.145, lines 1-11.

and it is very difficult without increased capacity within the NHS to think how we could ever run exercises for future emergencies.[34]

k. Professor Jim McManus, President of the Association of Directors of Public Health, gave evidence that: cuts to local authorities have reduced the public health budget by between 26% and 33%;[35] and the work of directors of public health in terms of managing the outbreak of the Covid-19 pandemic could have been better had the cuts and impact of austerity not happened.[36]

l. Dr Denis McMahon, Permanent Secretary of the Executive Office Northern Ireland, gave evidence that: civil contingencies in NI over the relevant period were poorly resourced and the problem was no better by the time of the pandemic because of the demands of civil service cuts.[37]

m. Robin Swann, former Minister of Health in Northern Ireland between 2020 and 2022, gave evidence that: vital services had been underfunded prior to the pandemic; short-term decisions were preferred over long-term planning; and staff were left to feel unappreciated, with social care being particularly neglected.[38]

n. Dr Claas Kirchhelle, expert to the Inquiry, gave evidence that: functioning of the post-2012 local and national English public health structures was compromised by austerity politics;[39] PHE was also affected by austerity, experiencing cuts to core funding;[40] and austerity had a negative impact on public health levels and the overwhelming body of evidence collected by this inquiry speaks to that - austerity *"certainly didn't have positive impacts on pandemic preparedness"*.[41]

o. Professor Sir Stuart McBride, Chief Medical Officer for Northern Ireland since 2006, gave evidence that: he agreed with Dr Kirchhelle's observations that the provision of NI public health services had suffered due to stagnating or reduced funding and stasis;[42] and one of the most crucial aspects of the ability to respond to an emergency

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[34] Day 15 Transcript, p.19, lines 15-25, and p.20, lines 1-14.
[35] Day 15 Transcript, p.53, lines 1-7.
[36] Day 15 Transcript, p.54, lines 16-19.
[37] Day 16 Transcript, p.95, lines 2-25, and p.96, lines 1-24.
[38] Day 16 Transcript, p.175, lines 1-12.
[39] Day 17 Transcript, p.27, lines 24-25, and p.28, lines 1-13.
[40] Day 17 Transcript, p.32, lines 9-24.
[41] Day 17 Transcript, p.109, lines 10-16.
[42] Day 17 Transcript, p.178, lines 6-25, and p.179, lines 1-5.

is the resilience of the health and social care system, but the health service in 2020 was not as resilient as it even was in 2009.[43]

p. Baroness Foster, Former First Minister of Northern Ireland from 2020 to 2021, gave evidence that: reductions in public sector spending provided for in the Stormont House Agreement of 2014 could not be reversed due to the collapse of the power-sharing agreement; this all happened in the context of austerity.[44]

q. Richard Pengelly, Former Permanent Secretary for Department of Health in Northern Ireland between 2014 and 2022, gave evidence that: the view held by his top management team was that the health and social care sector resource position was a huge and material challenge – they did not have sufficient resources to meet strategic objectives;[45] and there was a mismatch between demand and capacity in the health and social care system.[46]

r. Michelle O'Neill, former Deputy First Minister of Northern Ireland between 2020 and 2022 and former Minister of Health between 2016 and 2017, gave evidence that there was a distinct lack of resource to run the health and social care system as a direct result of austerity.[47]

s. Mark Lloyd, Chief Executive of the Local Government Association, gave evidence that: local authorities' budgets have faced very significant reductions - core funding from central government for councils in England reduced by £15 billion between 2010 and 2020, a real terms reduction of 57%;[48] and in a survey conducted by the LGA and WLGA, only 18% of local authorities in England and 14% in Wales considered that they were adequately funded for a national emergency in January 2020.[49]

t. Chris Llewellyn, Chief Executive of the Welsh Local Government Association, gave evidence that austerity had a massive impact on local government finances in Wales, and as a result emergency planning services were reduced, demand for council

[43] Day 17 Transcript, p.180, lines 9-18.
[44] Day 18 Transcript, p.23, lines 15-25 and p.24 and p.25, lines 1-24.
[45] Day 18 Transcript, p.85, lines 8-25 and p.86, lines 1-6.
[46] Day 18 Transcript, p.87, lines 18-24.
[47] Day 19 Transcript, p.22, lines 12-19.
[48] Day 19 Transcript, p.127, lines 22-25 and p.128, lines 1-13.
[49] Day 19 Transcript, p.125, lines 24-25 and p.126, lines 1-5.

services increased and the impact was disproportionate in the weaker communities and parts of the economy.[50]

u. Alison Allen, Chief Executive of Public Health Agency Northern Ireland gave evidence that more resources are needed in Northern Ireland to support preparedness.[51]

v. Aidan Dawson, Chief Executive of Public Health Agency Northern Ireland, gave evidence that the impact of austerity and financial restraints, in particular on health and social care services, impacted on PHA Northern Ireland's preparedness.[52]

w. Nigel Edwards, Chief Executive of the Nuffield Trust, gave evidence that: the UK in particular has traditionally run very low margins of capacity – those countries which had higher numbers of beds and levels of staffing, more hospitals and better provided home care services have recovered significantly between than the UK;[53] demand has been increasing by 2% per year whilst the number of nurses has gone up by 0.2%;[54] social care funding comes from councils and many of them have had significant reductions in grants from local government.[55]

x. Richard Horton, Editor-in-Chief of the Lancet, gave evidence that chronic underfunding and lack of investment in the public health system left us particularly vulnerable to Covid-19.[56]

y. Kate Bell, Assistant General Secretary of the TUC, gave evidence on the impact of severe cuts on the NHS workforce - stress, reduction in resources, and the decade of pay cuts were impacting their ability to do their job;[57] and 10 years of austerity also had a damaging effect on public services in Wales.[58]

z. Gerry Murphy, Assistant General Secretary of the ICTU, gave evidence that over the ten years running up to the onset of the pandemic, health spending in Scotland was

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[50] Day 19 Transcript, p.129, lines 8-12.
[51] Day 19 Transcript, p.132, lines 2-3.
[52] Day 19 Transcript, p.182, lines 1-22.
[53] Day 20 Transcript, p.47, lines 23-25, and p.48, lines 1-14.
[54] Day 20 Transcript, p.49, lines 2-8.
[55] Day 20 Transcript, p.52, lines 17-25, and p.53, lines 1-11.
[56] Day 20 Transcript, p.75, lines 19-25, and p.76, lines 1-9.
[57] Day 21 Transcript, p.11, lines 20-25, and p.12, lines 1-11.
[58] Day 21 Transcript, p.16, lines 20-23.

6% lower per capita than in England and Wales, and was 11% lower per capita in Northern Ireland.[59]

aa. Philip Banfield, Chair of the British Medical Association's ('BMA') UK council, gave evidence that the BMA has for a number of years been highlighting the issue of capacity within the health service, to all four governments, highlighting that there would not be surge capacity if a pandemic occurred.[60]

bb. Jennifer Dixon, Chief Executive of The Health Foundation, gave evidence that: public services per person reduced by 13% in the decade prior to January 2020;[61] core NHS spending was protected relative to other public services but over that decade the NHS received slightly less than 50% than it would have expected to receive per annum compared to a long run average;[62] and social care needed more investment.[63]

22. Although unable to attend the Inquiry to give evidence in person, Rozanne Foyer, General Secretary of the STUC, explained in her witness statement that at the start of the pandemic Scotland's health and social care system, local authorities and other key public services were already struggling because the UK Government's austerity programme slashed government spending across departments and reduced the Scottish government budget year on year.[64]

23. The overwhelming trend, therefore, has been witnesses recounting the lack of capacity and resilience in UK public services and the poor state of health of the UK population due to long-term underfunding. The only real exception has been the evidence of Mr Cameron and Mr Osborne. To us, their evidence had the feeling of having come from a distant island on which NHS staff numbers were high, NHS satisfaction was high, poverty reduced, and the output of public services had the good fortune of bearing no relation to budgetary input.[65] It was not a picture we recognised nor, does it appear, one recognised by any other witness in the Inquiry.

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[59] Day 21 Transcript, p.17, lines 14-25, and p.18, lines 1-3.
[60] Day 21 Transcript, p.62, lines 13-24.
[61] Day 21 Transcript, p.88, lines 21-25, and p.89, lines 1-13.
[62] Day 21 Transcript, p.89, lines 23-25, and p.90 and p.91, lines 1-5.
[63] Day 21 Transcript, p.106, lines 8-12.
[64] INQ000180759, para. 13.
[65] See: Day 5 Transcript, p.46, lines 2-7; Day 5 Transcript, p.47, lines 6-9; Day 5 Transcript, p.48, lines 21-15, and p.49, lines 1-4; Day 5 Transcript, p.52, lines 21-25, and p.53, lines 1-2; Day 6 Transcript, lines 12-18; and Day 6 Transcript, p.111, lines 19-25, and p.112, lines 1-18.

Findings and recommendations

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

25. There has been some debate about causation of structural health disadvantages, and whether the key driver was austerity. These issues are undoubtedly complex, but it is hard to ignore that health services have been stretched, public health funding has fallen through the floor, and the welfare safety net has been diminished. In law, it is said that correlation does not equal causation, but there comes a point when the conclusion is inevitable. No other credible explanation has been offered. The best evidence and conclusion as to austerity and its relationship to structural health inequalities is that provided by Professors Marmot and Bambra.

26. Relevantly, austerity meant that public services were less resilient in their response to the pandemic as it hit. More generally, it also meant that we were less resilient as a population. In particular, those suffering from structural health disadvantages were particularly vulnerable to the impacts of a pandemic, and all the more so for the exacerbation of those health disadvantages caused by a decade of austerity.

27. The TUC considers that austerity will be a common thread running throughout the modules of this Inquiry. We look forward to the opportunity in future modules to consider how sectors such as health care, social care, and education, can be better protected by the recommendations of this Inquiry from the worst impacts of future pandemics.

HEALTHCARE: BOTTOM OF THE TABLE

The state of the healthcare system going into the pandemic

28. For a health service that has perennially faced the existential question of whether it can cope with the next winter flu, it was not surprising to hear evidence that it did not have the preparedness, resilience, and capacity for a global pandemic.

29. The lack of preparedness in the NHS was aptly described by Philip Banfield:

> *"I think we were concentrating on getting on with the everyday day job rather than the planning of what may or may not happen because* […] *our members are under such pressure every day,*

we're working constantly on the premise that, you know, our system may tip over at any moment".[66]

30. The lack of resilience and capacity in the NHS was summarised by Dame Sally Davies who described that *"by comparator data compared to similar countries, per 100,000 population we were at the bottom of the table on number of doctors, number of nurses, number of beds, number of ITUs, number of respirators,* [number of] *ventilators".*[67] Other witnesses painted a similarly damning picture of the state of the health care system going into the pandemic. Some of that evidence is referred to at paragraph 20 above.[68]

31. It is recognised that Jeremy Hunt agreed in June 2018 an increase in NHS funding of £20.5 billion by way of the 'NHS Long Term Plan'. However, that increase was only set to start in the 2019/20 financial year and was intended to take full effect by the 2023/24 financial year.[69] Many of the solutions required in the health care sector involve long-term planning, research, and investment. Jeremy Hunt himself highlighted that plans to train more doctors face a significant lag before the benefits are reaped, due to the time it takes for a doctor to qualify.[70] Furthermore, the proposed increase in spend was an annual real-terms rise of 3.4% per year, which remains below the average increases of 3.7% a year since the NHS was founded and the 4% increase experts suggest is required to meet rising demand whilst maintaining standards of care.[71] Although it was an improvement upon the average real terms increase of 1% per year from 2009/10 to 2018/19,[72] the NHS Long Term Plan was simply too little, too late. It was not capable of resolving the challenges in healthcare before the pandemic hit.

The state of the healthcare system post-pandemic

32. Resilience in the face of a pandemic includes not only the ability to treat the urgent cases in the peak of the pandemic, but also the ability to continue to provide healthcare to the population during the currency of the crisis, and to be able to return within a reasonable timeframe to something resembling an effective health service.

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[66] Day 21 Transcript, p.83, lines 16-21.
[67] Day 6 Transcript, p.151, lines 7-11.
[68] See, in particular, the evidence listed in respect of: Professors Marmot and Bambra, Dame Sally Davies, Jeremy Hunt, Rosemary Gallagher, Matt Hancock, Dr Catherine Calderwood, Professor Sir Stuart McBride, Richard Pengelly, and Nigel Edwards.
[69] See: https://www.jeremyhunt.org/nhs-long-term-plan.
[70] Day 7 Transcript, p.186, lines 17-25.
[71] See: https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained.
[72] See: https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained.

33. Given the gaps in planning, and the lack of surge capacity, it is a real credit to the commitment, skill, and determination of those in our health service that we did not run out of intensive care beds. The real price has been longer term; in respect of the impact more generally on the ability of the NHS to meet needs for health care. Quite shockingly, recent data from the BMA shows that, as of May 2023, the number of people on an NHS waiting list for hospital treatment had risen to 7.47 million.[73] As Kate Bell, Assistant General Secretary of the TUC, described in her oral evidence, that number can be compared with the 4.2 million patients on waiting lists at the beginning of the pandemic.[74] Median waiting times have almost doubled from 7.2 weeks before the pandemic, to 14.1 weeks as of this year.[75] That is a huge long-term cost to patients of the lack of resilience and capacity in the NHS. It is also, of course, an unfair demand on the workforce who, burnt out from the demands of battling a pandemic in an under-resourced system, now face the pressures of managing and responding to enormous and growing waiting lists. As Ms Bell highlighted, in a survey by the TUC of 1000 NHS staff, 69% of workers said that reductions in staffing and resources were putting patient care at risk.[76] The sharp rise in waiting lists faced by the NHS now is therefore also a matter of patient safety. Similarly, vacancies are worse now than they were before the pandemic, reaching a 5-year high in December 2022.[77] Staff sickness absences have increased significantly since the pandemic, with these statistics being attributed to increases in work-related stress.[78]

Findings and recommendations

34. For the reasons set out above, we say that the findings of the Inquiry in this module should deal frankly not only with the lack of capacity in the healthcare sector as it came into the pandemic – but also the state of affairs facing it now, as they reflect the grave lack of preparedness, capacity and resilience in the system as at January 2020.

35. The findings and evidence as to the pre-pandemic state of healthcare in the UK will no doubt inform the work of Module 3 of the Inquiry.

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[73] See: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis.
[74] Day 21 Transcript, p.15, lines 4-12.
[75] See: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis.
[76] Day 21 Transcript, p.16, lines 5-15.
[77] INQ000190680.
[78] See: https://www.nuffieldtrust.org.uk/news-item/nhs-in-england-grappling-with-difficult-new-normal-as-staff-sickness-soars-post-pandemic.

SOCIAL CARE: THE NEGLECTED SECTOR

36. In the TUC's opening statement to this module we suggested that, in social care, the problem has been not one of repeated restructuring and reorganisation, as seen in the NHS, but one of neglect: there has been no attempt to structure at all. We observed that the overall workforce is larger than that in the NHS, yet, there is no equivalent to NHS England. A body tasked with oversight of the social care sector could seek to provide some strategy and direction to the sector.

37. We identified the following factors as causative to the crisis in social care: successive reductions in central government funding to local authorities, simultaneously combined with increased demand; an unsustainable business model; low pay resulting in staffing shortages and insecurity of work for those within the sector; lack of strategic planning or capability to foresee challenges; absence of a centralised data system; fragmented and ill-equipped physical infrastructure; and lack of centralised oversight.

38. We pointed out that the TUC has repeatedly called for a national Social Care Forum, to "*bring together government, unions, employers, commissioners and providers to coordinate the delivery and development of services, including the negotiation of a workforce strategy*".[79]

39. All those observations have been underlined by the evidence.

The crisis in social care

40. Part of the difficulty stems from reductions in funding. A decade of funding reductions prior to the pandemic saw councils lose 60p out of every pound of funding, which necessarily has had an impact on social care funding.[80]

41. Professor Sir Michael Marmot explained in his oral evidence that not only did the grant to local government reduce, but the way in which that reduction in spending impacting spend on social care was not consistent across local authorities. He explained that in the least deprived 20% of local authorities, social care spending per person went down by 3%, whereas

[79] At para. 41. See: https://www.tuc.org.uk/research-analysis/reports/fixing-social-care.
[80] Day 1 Transcript, p.166, lines 19-25.

in the most deprived 20% of local authorities, social care spending per person went down by 17%.[81]

42. Meeting minutes of the DHSC Departmental Board in 2016 demonstrate that the DHSC was aware that successive reductions in local authority budgets were likely to have a negative impact upon the adult social care sector, but did not appear to have any planned measures to oversee and intervene in this regard:

> *"Members agreed that social care was a concern. There was a risk that some local authorities may attempt to sequestrate money from the care budget for other purposes. The Department was able to safeguard continuing service provision as it had the statutory power to request inspection by the Care Quality Commission. This power had never been exercised, and it was not known if there would be the political appetite for it in any event"*.[82]

43. On being asked about funding and the difficult picture facing the social care sector, Mr Osborne pointed out that the cuts in local authority funding were *"not* [...] *secret"* but were *"publicly announced as part of a programme of trying to reduce government expenditure"*.[83] No doubt they were, but an openness as to cuts in funding does not make the challenges faced by the social care sector any less difficult.

44. There are huge challenges facing the social care workforce. Nigel Edward's evidence summarises the untenable position in respect of the social care workforce prior to Covid-19 striking in 2020:

> *"Workforce challenges in the social care sector were well-known before Covid-19 yet little had been done to address them. There had been no dedicated, long-term social care workforce strategy since 2009. In our work with the Health Foundation and King's Fund (NE/19), we sought to highlight concerns over high vacancies, high turnover, low pay and poor conditions. In the year before Covid-19 hit (2018/19), care worker turnover rates were around 40% and there were in the region of 115,00 vacancies. Around one quarter of staff were on zero hours contracts"*.[84]

45. As the Inquiry has heard, the use of zero-hours contracts has a knock-on effect on work security: data from 2017 shows that median pay for a zero-hours contract worker was around a third less per hour than for an average employee.[85]

46. Kate Bell noted in oral evidence that she has been a member of the government's Low Pay Commission since 2017 and every year that commission has heard evidence *"both from*

[81] Day 4 Transcript, p.38, lines 15-21.
[82] INQ000057271, p.9, para. 32.
[83] Day 7 Transcript, p.107, lines 14-17.
[84] INQ000148416, p.11, para. 44.
[85] INQ000177807, para. 59.

employers within the social care sector and from workers themselves that the sector is in crisis, that terms and conditions are particularly poor".[86] Gerry Murphy explained that in Northern Ireland in 2020, 55% of workers employed in the health and social care sector were earning less than the real living wage.[87]

47. Workforce issues in nursing have also worsened the staffing crisis in the social care sector, as Rosemary Gallagher highlighted: *"the RCN has raised concerns over a number of years around a reduction in the community nursing workforce and the implications for that, not just in terms of community care but the knock-on effect of care in hospitals"*.[88]

48. Fragmentation, while evidently an issue in the healthcare sector, is writ large in the social care sector. DHSC has described that social care is managed across 152 local authorities and is made up of *"around 25,800 registered social care establishments"*.[89] Nigel Edwards explained in his witness statement that fragmentation in the social care sector is as a result of *"the large number of providers* [...] *not all of which provide regulated services, and the fact that services are commissioned by local authorities, the NHS and private individuals"*.[90] The witness statement of Cathie Williams, Chief Executive of the Director of Adult Social Services, describes how reductions in the central government grant to local authorities increased fragmentation in a sector which was already highly privatised:

> *"These surveys underline that over the course of the past decade, councils made cumulative savings of £7.7bn in a climate of austerity, which has contributed to the number of people able to access state-funded long-term support decreasing year on year since 2015/16. This resulted in a level of fragility and challenge to resilience, not previously experienced"*.[91]

49. In relation to Scotland, Ms Foyer explained: *"The structural complexity and use of private profit-seeking providers in social care undermines the stability of the sector and did not provide a resilient basis for the sector when the pandemic arrived"*.[92]

50. The Inquiry has received evidence that the NHS has a *"much clearer set of standards defined than the social care sector"*.[93] Nigel Edwards has explained in his evidence to the Inquiry that:

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[86] Day 21 Transcript, p.26, lines 10-16.
[87] Day 21 Transcript, p.18, lines 19-22.
[88] Day 9 Transcript, p.102, lines 1-5.
[89] Day 2 Transcript, p.19, lines 9-19.
[90] INQ000148416, p.5, para. 18.
[91] INQ000080743, p.5.
[92] INQ000180759, para. 20.
[93] Day 20 Transcript, p.44, lines 10-11.

"Complex structures and a lack of clarity over where responsibility lay for social care had an impact on how well prepared the government was to respond to Covid-19. The NHS has NHS England to coordinate centrally but social care has no equivalent".[94]

51. Lack of centralised oversight appears also to have contributed to the failure to bring about any significant reform in the social care sector in the decades prior to the Covid-19 pandemic. George Osborne, in his oral evidence to the Inquiry, stated that *"the UK social care and health system is experiencing exactly the same kinds of pressures as the pressures being experienced in most western democracies at this moment"*.[95] However, as Nigel Edward's evidence demonstrates, the response by England to those rising pressures has not been the same as in other comparable countries, as it has *"failed to bring about any substantial reform to the funding or design of the social care system over the preceding two decades despite urgent calls for reform dating back to 1999"*.[96]

52. There were also significant challenges in terms of the availability of data on the sector. The Inquiry has heard that going into the pandemic, there was no central government understanding as to how many people were receiving or needed adult social care, nor how many registered homes were providing care.[97] This is a glaring omission given the complexity of the sector.

An absence of pandemic planning

53. A scarcity of detailed planning appears unsurprising when viewed in light of the complete lack of visibility and centralised oversight in an undoubtedly fragmented sector.

54. Bruce Mann described the UK Influenza Pandemic Preparedness Strategy from 2011 as *"very slim on the social care aspect"*.[98] Indeed, from the DHSC's own 'Operational Response Centre Lessons Learned Reviews' it is clear that there was confusion within the department regarding responsibility for social care pandemic planning – it states: *"some commented that emergency planning had assumed care providers would be responsible for their own response, and a centralised government role had not been anticipated"*.[99] It further states that *"some respondents stated that the pandemic highlighted glaring omissions in strategic direction of integration and preparedness meaning*

[94] INQ000148416, p.5, para. 18.
[95] Day 6 Transcript, p.94, lines 3-6.
[96] INQ000148416, p.9, para 36.
[97] See, for example, the evidence of Matt Hancock (Day 10 Transcript, p.75, lines 11-22) and the evidence of Andrew Goodhall (Day 14 Transcript, p.34, lines 2-4).
[98] Day 3 Transcript, p.199, lines 1-5.
[99] INQ000087227, p.6, para. 6.4.

that the social care system was not able to respond to a major health emergency".[100] This passage was put to Clara Swinson during oral evidence; she accepted that there were difficulties in the strategic direction of integration and preparedness within the system.[101]

55. In her witness statement, Rosemary Gallagher MBE described a failure to properly incorporate the community and care home sectors into pandemic plans:

> *"Previous resilience planning, both nationally and locally, had not adequately incorporated the community and care home sectors. From my perspective, there had not been a whole system approach to planning. This was evident at the start of the pandemic, during efforts to rapidly scale up acute capacity, when some community staff were being redeployed into the acute sector without sufficient thought being given to the services that needed to continue in the community. For example, the RCN heard reports that community nursing staff were being asked to go and work in hospitals when community services needed to be augmented at the same time to ensure essential services, such as child protection and end of life care, could continue".*[102]

56. The Inquiry has of course received significant evidence from witnesses, including Sir Christopher Wormald and Andrew Goodhall, Permanent Secretary to Welsh Government, that key recommendations in respect of social care following Exercise Cygnus were not implemented before the pandemic. Sir Christopher confirmed that there were no significant changes to the resilience of the social care system between the Exercise Cygnus report in 2016 and the pandemic striking in 2020 and that the system "*remained fragmented*".[103]

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

Findings and recommendations

58. The Inquiry should move forward from Module 1 with some stark findings as to preparedness and capacity in social care, covering what we consider to be the five core issues:

    a. extreme fragmentation of the sector;
    b. underfunding and neglect of the sector;
    c. workforce issues, including in relation to vacancies, terms and conditions, and working conditions;

[100] INQ000087227, p.6, para. 6.4.
[101] Day 5 Transcript, p.184, lines 17-21.
[102] INQ000177809, para. 48.
[103] Day 5 Transcript, p.94, lines 11-25 and p.95, lines 1-5.

d. failure in centralised and strategic oversight; and

e. a stark lack of pandemic planning.

59. The Inquiry cannot seek to recommend the solutions to those problems in this module, but it should be moving towards Module 6 with a sense of conviction that fundamental change is needed.

HEALTH INEQUALITIES

Foreseeability

60. As a starting point, it was foreseeable that a pandemic would have a disproportionately adverse impact upon lines of socioeconomic disadvantage, and along the intersection of such disadvantage with precarious work, ethnicity, disability, age, gender, caring responsibilities, and poor health. As explained by Professors Marmot and Bambra, the historic and global experience of a range of 'whole system shocks', whether it be a financial crisis, extreme weather events, or, indeed, pandemic flu, is that such shocks expose and amplify pre-existing health inequalities.[104] The examples are numerous, but perhaps among the most striking, given its timing, is that in the 2009 swine flu pandemic the mortality rate in the most deprived 20% of England's neighbourhoods was over three-times higher than in the least deprived 20%.[105] It is evident that the uneven impact is not unique to Covid-19.

61. It is a clear and well understood point; Mr Cameron was willing to be candid about it: "*it was well known, and I knew, that when you have health pandemics of any sort you get differential effects on different parts of the population*".[106]

Lack of planning

62. It is also evident that these matters were not considered in the UK's pandemic planning. The evidence is that such consideration relating to unequal impacts of a pandemic as there was, was limited to clinical vulnerabilities.

63. That was acknowledged by both Sir Christopher Wormald in evidence given on behalf of DHSC, and by Katherine Hammond in evidence given on behalf of the Cabinet Office.

[104] INQ000195843, para. 150.
[105] INQ000195843, para. 174.
[106] Day 5 Transcript, p.54, lines 8-10.

64. Sir Christopher accepted under questioning that DHSC never commissioned advice on the implication of health inequalities on pandemic planning impacts and mitigation strategies, and that there was no thinking on this topic within the Department, or as part of any single exercise between 2007 and 2018.[107] It is clear from the evidence of Ms Hammond that risk assessment was limited to clinical vulnerabilities such as diabetes and heart disease, and a piece of work in relation to the prison population.[108]

65. Professor Bambra confirmed in oral evidence that health inequalities were not examined in any of the exercises she analysed: Winter Willow, Taliesin, Valverde, Alice, Silver Swan, Broad Street, Cerberus, Pica and Exercise Cygnus.[109] Although local surges were mentioned in Exercise Cygnus, there was no discussion of the potential role of area-level deprivation or other community characteristics, such as the ethnic composition of the population, in leading to such surges.[110] Professor Bambra further explained that in the entire body of work on pandemic preparedness which she and Professor Marmot reviewed, there was only one equality impact assessment from 2011 and no evidence of the "*routine assessments*" which Sir Christopher Wormald claimed had taken place.[111]

66. Melanie Field, Chief Strategy and Policy Officer of the Equality and Human Rights Commission ('EHRC') stated in evidence that she was not aware of, and could not find any evidence on the EHRC systems of, any contact by any UK government seeking assistance of the EHRC in relation to pandemic planning and preparations.[112] She confirmed that she was surprised by this, given that a key part of the EHRC's role is to support duty holders under equality legislation.[113]

Impact

67. The evidence is that the UK entered the pandemic with increasing health inequalities and with health among the poorest people in our society in a state of decline, as it has been since 2010. One of the starkest features of that health inequality is the vast difference in life expectancy between the most and least deprived areas. As the expert report by Professors Marmot and Bambra describes: "*the health picture, then, coming into the pandemic was stalling life expectancy,*

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[107] Day 5 Transcript, p.149, lines 15-25, and pp.150-151.
[108] Day 4 Transcript, p.189, lines 7-25 and p.190 and p.191, lines 1-7.
[109] Day 4 Transcript, p.51, lines 8-25, and p.52, lines 1-2.
[110] Day 4 Transcript, p.51, lines 14-25, and p.52, lines 1-2.
[111] Day 4 Transcript, p.52, lines 3-25, and p.53, lines 1-4.
[112] Day 20 Transcript, p.25, line 8-15.
[113] Day 20 Transcript, p.25, lines 18-24, and p.27, lines 1-9.

increased regional and deprivation-based health inequalities, and worsening health for the poorest in society".[114]

68. One of the key determinants of health is work. Being in good employment is protective of health, and, as Professors Marmot and Bambra describe, good work is *"free of the core features of precariousness, such as lack of stability and high risk of job loss, lack of safety measures* […] *and the absence of minimal standards of employment protection"*.[115] Further, *"insecure and poor-quality employment is also associated with increased risks of poor physical and mental health"*.[116]

69. Whilst addressing the place for insecure work in the employment market, and its regulation, may be beyond the scope of this Inquiry, the Inquiry must consider its relevance to the unequal impacts of a pandemic, and how a pandemic plan may mitigate those impacts. (In that regard, we respectfully disagree with the Chair's intervention during oral closing to the effect that such matters are beyond the scope of the Inquiry).

70. Unemployment is relatively low, but as described by Professor Marmot in the *'10 Years On'* report, there have been some *"profound shifts in many aspects of the labour market and employment practices"*.[117] One challenge is rates of pay, with more people in poverty now being in work than out of work. Insecure work has increased. In 2010 Professor Marmot had suggested that *"getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option"*, but he reflects in the 10 Years On report that *"this seems to a large extent to be what has happened"*.[118] One aspect of that is zero-hours contracts; the 10 Years On report described that in 2010 there were 168,000 working on zero-hours contracts, but as of Autumn 2018 there were nearly 900,000.[119] Minority ethnic workers are far more likely to be on zero-hours contracts, than white workers.[120] By occupational group, those with the highest proportion of workers on zero-hours contracts are the elementary occupations and the caring, leisure and other service occupations.[121] Those occupational groups, as the House of Commons Women and Equalities Committee, in the *'Unequal impact? Coronavirus and BAME people'* report, has

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[114] INQ000195843, para. 46.
[115] INQ000195843, para. 21.3.
[116] INQ000195843, para. 21.3.
[117] INQ000108755_0059 (document pagination p.58).
[118] INQ000108755_0062 (document pagination p.61).
[119] INQ000108755_0066 (document pagination p.65).
[120] INQ000108755_0067 (document pagination p.66).
[121] See: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/emp17peopleinemploymentonzerohourscontracts.

recognised, have a higher than average proportion of black and minority ethnic workers.[122] They are, of course, precisely the occupations that saw the highest death rates from Covid-19.

71. During the Covid-19 pandemic, there was a continued need for us to travel and to eat. As Kate Bell stated during oral evidence, *"workers beyond the health sector were likely to face an impact, recognising that healthcare workers need to travel to work, need to use community services* [and there are] *interrelationships between those workers"*.[123] There was a need, more broadly, to keep the economy going. The burden and risk of continuing to attend work falls not on the professional occupations, but on those professions who need to attend work in person and in doing so expose themselves to risk. Those professions of course include health and social care, but also a range of other sectors across, particularly, the elementary and service occupations, including transport, food processing, communications, construction, and others. That burden falls on a cohort of working people, a great many of whom are in low paid and insecure work, and who suffer from structural health disadvantages.

72. Furthermore, not only are those on zero-hours contracts more likely to be working in sectors where contact with the public is unavoidable, they are also more likely to face difficulties when they become unwell or need to self-isolate or shield. As Ms Bell described in oral evidence, *"our evidence shows that those on zero hours contracts, again a quarter of the social care workforce on zero hours contracts, are much less likely to have access to decent sick pay. So around a third of those on zero hours contracts don't earn enough to qualify for sick pay when they fall sick"*.[124]

73. Finally, the ongoing suffering caused by Long Covid has also had a disproportionate impact. Self-reported Long Covid has shown to be more common in women, people living in more deprived areas, those working in social care and those with another activity-limiting health condition or disability.[125] New research led by the Universities of Southampton and Oxford has found that the risk of Long Covid is strongly associated with area-level deprivation.[126] Lead Researcher, Nazrul Islam, stated: *"Our findings are consistent with pre-pandemic research on other health conditions, suggesting that workers with lower socioeconomic status have poorer health*

[122] See: https://committees.parliament.uk/publications/3965/documents/39887/default, at para. 55.
[123] Day 21 Transcript, p.37, lines 1-7.
[124] Day 21 Transcript, p.28, lines 14-19.
[125] See: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections.
[126] See: https://journals.sagepub.com/doi/10.1177/01410768231168377.

outcomes and higher premature mortality than those with higher socioeconomic position but a similar occupation".[127]

Findings and recommendations

74. We consider that the findings of this Inquiry ought to be that disparate impacts upon vulnerable and/or marginalised groups were foreseeable but were not considered in pandemic planning. The evidence shows this had a devasting impact; deaths and other suffering (both directly because of the virus and indirectly because of measures to control the virus) were concentrated amongst the most disadvantaged groups in society; the impacts can be seen along the intersection of such disadvantage with precarious work, ethnicity, disability, age, gender, caring responsibilities, and poor health.

75. Bruce Mann and Professor David Alexander express the view that risk assessment and emergency planning should identify vulnerabilities, then consider the consequences for people.[128] They explain that doing so would provide a focus in risk assessment and emergency planning for the populations most vulnerable to, and most disproportionately affected by, the consequences of emergencies because of their income, geographical location, or other characteristics.[129] A more important and difficult question then arises – how should planning for a future pandemic address these matters?

76. A number of witnesses and core participants have put forward recommendations in respect of mitigating the uneven impacts of a pandemic. Of course, in a sense we welcome all ideas, but we do say that many, particularly when focused on how pandemic planning may address inequalities, have tended to be rather nebulous in nature, and it is not at all clear how they would lead to concrete and meaningful action. Some have been, to take an observation made by the Chair during the public hearings, noble but beyond the scope of this Inquiry.

77. We consider that this Inquiry should aim to provide clear and detailed recommendations as to what should be in, as DHSC put it in opening, "*the toolkit of capabilities which can adapt to deal with*" the many different possible characteristics of a future pandemic.[130]

78. Part of what we have learnt in his module is that unless we become a healthier, fairer, and more equal society, then a future pandemic will again see a disproportionate impact on

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[127] See: https://www.southampton.ac.uk/news/2023/05/long-covid.page.
[128] INQ000203349, para. 417.
[129] INQ000203349, para. 417.
[130] Day 2 Transcript, p.21, lines 17-20.

disadvantaged groups. It is important that the Inquiry makes the appropriate findings as to pre-existing structural inequalities and their relevance to uneven impact. It may also be that the answers, to a point, lay beyond this Inquiry. It comes, ultimately, to questions such as the value we as a nation wish to put on matters such as fair work, access to core services, and public health. The Inquiry itself cannot answer those questions, but it must make crystal clear findings as to the consequences of not doing so.

79. There are however some critical, concrete recommendations which it would be entirely appropriate for this Inquiry to make in respect of pandemic planning. Our key points may be summarised relatively shortly:

    a. Pandemic planning needs to consider health and safety measures across a range of workplaces.
    b. It needs to be supported by an effective and funded health and safety regulator.
    c. It should be achieved through an approach of social partnership with employers and workers, via representative unions.
    d. Doing those things listed at sub-paragraphs (a) to (c) above will preserve lives of those at work and will ameliorate some of the uneven impact of future pandemics.

Pandemic planning across a range of workplaces

80. Pandemic planning must include sufficient policies, guidance, legislation, and schemes to enable the protection of these groups. Given what we know about the causes and driving factors behind the unequal impact of the pandemic, and given the regulated nature of the workplace, there is a critical opportunity to protect the most vulnerable in society through workplace planning.

81. It must include PPE that is fit for a non-influenza pandemic and is capable of being distributed to, if not required to be stockpiled in, health and social care settings. In the context of social care, delivered across many thousands of locations, it is difficult to see how a plan could work effectively other than by stockpiling locally, if not within each care home. It must also include planning for PPE across a range of sectors. What will the provision and guidance be, in advance of the next pandemic, for PPE in a processing plant, in a supermarket, or on a bus? Will that be government stockpiles, or will it be for employers to be able to cater for that in meeting their health and safety obligations? If the latter, are those health and safety obligations adequately clear and well understood? These questions remain unanswered, but they are important.

82. The relevance of PPE across a range of settings, in mitigating not only the impact of a pandemic, but also the uneven impact of a pandemic, was made by Professors Marmot and Bambra. They said in their report:

> *"Employers in other key industries (such as the food supply chain, personal care, transport or education – where there are disproportionality more workers from minority and low paid groups) could then have taken such concerns into account in their workforce planning during the pandemic. For example, employers could have taken additional measures to protect these occupational groups such as making PPE available and mandatory in more exposed professions and for more vulnerable groups"*.[131]

Whilst Professors Marmot and Bambra focused on employers, government and regulators clearly also have a role to play in ensuring safe and effective PPE is available.

83. It is of course beyond the scope of this Inquiry to end zero-hours contracts and create meaningful and accessible statutory sick pay. However, this Inquiry must address the need for pandemic planning to include preparations for self-isolation payment schemes which ensure that those who do not receive adequate sick pay will be able to stay at home when they are unwell, and do not need to choose between not self-isolating and exposing themselves and others to increased risk, or self-isolating and not having the money to live and eat. The same applies to workers who may need to 'shield' at home, either because they themselves are disabled or otherwise vulnerable, or because they have a family member who is vulnerable, and who work in sectors where remote attendance is not possible. Pandemic plans must provide for schemes which ensure shielding citizens receive adequate pay.

Health and safety regulation

84. Of course, those sorts of measures will mean little in practice without an effective health and safety regulator, with sufficient resources and powers of inspection. We fear becoming a broken record on this point, but it is important, and we still cannot see that it is being addressed. To place an emphasis on health and safety and health and safety regulation may not be a glamorous answer but, ultimately, it is important. As Mr Murphy explained in his witness statement: *"health and safety at work must be seen as a central part of the state's preparedness in the event of a pandemic"*.[132]

85. The health and safety sector prior to the pandemic had faced over 20 years of successive cuts to its workforce and budget. In October 2010, the TUC issued a report observing that the

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[131] INQ000195843, para. 186.
[132] INQ000177806, para. 29.

Health and Safety Executive ('HSE') had lost 25% of its employees over the 15 years prior, which had led to a significant fall in the number of inspections and prosecutions.[133] Over the following four years of austerity, continued cuts resulted in a further 40% cut to state funding of the HSE.[134] By the 2019/20 financial year, NHS has seen a funding cut of 54% since 2009/10; the number of inspections had fallen by 70% and the number of prosecutions by 91%.[135] The picture in terms of local authority health and safety inspections was very similar: over the period from 2010 to 2017, the number of local authority inspectors decreased by 46% and the number of enforcement notices fell by 64%.[136]

86. As Kate Bell set out in her witness statement, the severe cuts to the UK HSE and its Northern Ireland counterpart, particularly following 2010, were accompanied by a dangerous narrative that dismissed workplace health and safety as unhelpful red tape that did nothing but frustrate businesses and the economy.[137] This led to decisions by government to reduce the number of inspections taking place, including halting proactive inspections in a wide range of industries.[138]

87. But that is a reckless approach, and the inevitable consequences have come to pass. As Professor Philip Banfield stated in oral evidence: "*there is a legal duty on behalf of the employer to the employee to make reasonable attempts to protect that employee, and we feel very strongly that the information that was available prior to the pandemic wasn't heeded*".[139] Mr Banfield's evidence on the importance of health and safety monitoring was summarised thus:

> "*if health and safety workplace law and guidance were properly to be implemented and enforced, there would be a greater attention to detail and therefore, by implication, it would be less likely that that sort of risk assessment process would be overlooked and less likely that flaws in, for example, the use of respirators and the systems for their use would be allowed to go unchallenged*".[140]

88. To a worker sitting on a processing plant, who may already be suffering the disadvantages of low pay in insecure work and suffering the associated poorer health outcomes, an effective health and safety regulator may be the difference between working in an environment with or without adequate measures such as social distancing and PPE.

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[133] INQ000145942, p.2.
[134] INQ000103570.
[135] INQ000177807, para. 82.
[136] INQ000177807, para. 91.
[137] INQ000177807, para. 81.
[138] INQ000177807, para. 81.
[139] Day 21 Transcript, p.71, lines 17-20.
[140] Day 21 Transcript, p.72, lines 9-16.

Social partnership

89. Whereas the approach to social partnership in Wales and Scotland is developing, in England and Northern Ireland there is very little attempt by central government to engage constructively with employers and unions. Mr Murphy explained in his witness statement: *"the side-lining of the trade union movement in terms of proper social engagement has had disastrous consequences for workplace health and safety, for the health and social care system and for society at large"*.[141] When Exercise Cygnus occurred, for example, as far as we are aware, no unions were contacted to advise on the exercise or participate. We are also not aware of any evidence, before this Inquiry or otherwise, that member unions of the TUC, WTUC, STUC or ICTU have been consulted in relation to pandemic planning at any stage. As a result, pandemic preparations did not benefit from the on-the-ground information and perspective which could have informed critical decision making.

90. Delivering a plan which achieves measures across a range of workplaces also requires an approach of partnership in consultation with the relevant industries, including both employers and unions. Mr Murphy stated in oral evidence: *"a formal social dialogue mechanism to facilitate co-operation and joint working* […] *between government and the trade unions is essential"*.[142] Ultimately, if preparedness is needed across a range of workplaces, then there needs to be engagement of front-line workers across the necessary range of sectors. The answer must lie in the responsible action of employers, supported by government. That inevitably necessitates a collaborative approach. As Ms Bell stated:

> *"we could have brought the voice of our workforce, who of course hold considerable expertise across the areas which are covered by that civil contingency planning. So of course we represent workers in the key sectors which are involved"*.[143]

91. Furthermore, union engagement should work in tandem with health and safety inspection. As Mr Murphy explained in oral evidence:

> *"the fact indeed that the Health and Safety Executive, even though it's allowed under statute to have three trade union representatives on its board, had none, meant that it was devoid of any vital evidence and intelligence which may have been possible for a workplace representative to provide to it"*.[144]

[141] INQ000177806, para. 57.
[142] Day 21 Transcript, p.40, line 25, and p.41, lines 1-3.
[143] Day 21 Transcript, p.36, lines 16-20.
[144] Day 21 Transcript, p.31, lines 14-19.

92. Mr Murphy provided evidence to the Inquiry that formal engagement fora in respect of civil contingencies planning have worked in the devolved nations and in counterparts across Europe.[145] The TUC, WTUC, STUC and ICTU are of course in the position to provide a representative and mediating function between Government and unions; they can facilitate engagement fora and they can identify the relevant unions able to input expertise on any particular aspect of pandemic planning. As Ms Bell aptly summarised, *"the key points are regular meetings, a spirit of openness and collaboration, and a clear process for how government and unions themselves will act on those findings"*. [146]

CONCLUSION

93. We have been grateful for the opportunity to contribute to Module 1. We stated in our written opening that it would be *"an invaluable and unique opportunity not only to learn the lessons of the great tragedy that was the Covid-19 pandemic, but also to shed light on, and to improve, some of the decision-making processes of the governments in our four nations"*.[147] Having heard the breadth and detail of the evidence in this module, that observation stands. However, there are some areas where we consider that evidence was lacking. We say, respectfully, that we have not in this module seen the necessary consideration of preparedness in sectors beyond health and social care. But we say that with the hope and expectation that the issue is going to be the subject of detailed evidence in future modules.

94. We again commend the Inquiry for its endeavour in bringing an investigation of such scale and complexity to the close of its public hearings in its first module in a short timescale.

95. We are grateful to the Chair for her indication that she will finalise and publish the Module 1 interim report as soon as possible and aims to do so by early summer 2024. We look forward to the findings and recommendations contained therein.

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2 August 2023

[145] Day 21 Transcript, p.41, lines 3-21.
[146] Day 21 Transcript, p.39, lines 20-24.
[147] At para. 55.