NHS Providers

UK Covid-19 Inquiry public hearings: module 1, week 1 (13-16 June 2023)

The UK Covid-19 Inquiry (the Inquiry) public hearings for module 1 commenced on 13 June 2023 and will conclude on 21 July.

Module 1 is investigating government planning and preparedness and will examine the period between June 2009 (when the World Health Organisation [WHO] announced that scientific criteria for an influenza pandemic had been met) and 21 January 2020 (when the WHO issued the first situation report on what would become the Covid-19 pandemic). The Inquiry has been considering evidence on this module since on 21 July 2022 gathered through rule 9 requests under the Inquiries Rules 2006 and three preliminary hearings.

This week the Inquiry heard from core participants (CPs) including the Department for Health and Social Care (DHSC) and a number of expert witnesses including Professor Sir Michael Marmot. The Inquiry heard evidence on: a pandemic being a known possibility, the adverse impact of Brexit on resilience planning and preparedness, underinvestment in the healthcare system, and consideration of health inequalities.

Next week will see those in government prior to the pandemic give evidence, including David Cameron, George Osborne and Jeremy Hunt. They will also hear from expert witnesses Professor Sir Chris Witty and Sir Patrick Vallance.

This briefing summarises the proceedings most relevant to NHS trusts, and is the first in the series of weekly briefings on the Inquiry's public hearings. You can see our earlier briefings on the preliminary hearings on our website, as well as a set of frequently asked questions on rule 9 requests we prepared with our legal partners.

Tuesday 13 June

Witnesses

Submissions and evidence were heard from: Covid-19 Bereaved Families for Justice, Northern Ireland Covid-19 Bereaved Families for Justice, Covid-19 Bereaved Families for Justice Cymru, Scottish Covid Bereaved, British Medical Association (BMA), Trades Union Congress (TUC), Northern Ireland Department of Health, Association of Directors of Public Health (ADPH), Local Government Association (LGA) and Welsh LGA.

Chair's opening remarks

The chair opened by setting out the three questions she intends to answer within this module:

1. Was the UK properly prepared for a pandemic?
2. Was the response to it appropriate?
3. Can we learn lessons for the future?

The public hearings will examine the UK's health structures and resourcing, and to what degree health and social care suffered from underinvestment. They will also consider the impact of reforms to health structures, including the frequency that government bodies and departments were disbanded, renamed or restructured.

The chair reiterated her plans to publish reports over the course of the Inquiry after the completion of each module. Eleven modules have been announced to date, four active and seven planned for the future.

Members of bereaved families' groups held a vigil in protest outside the Inquiry this week. They are unhappy with the chair's decision to only call one member from each of the four groups to give evidence at the public hearings. The chair assured the bereaved that their voices will be heard through community events, impact films, and through the Every Story Matters listening exercise. A 17-minute impact film featuring bereaved people discussing their experiences during the pandemic and the lasting impact was broadcast and this will be a feature of future hearings.

Issues to be examined

Counsel to the Inquiry (Counsel) set out that the public hearings for module 1 will examine:

- **The UK's health structures and resourcing:** to what degree did public services, especially those of health and social care, suffer from underinvestment? How well resourced were the UK's public health structures? Reforms to health structures will be questioned, including the frequency that government bodies and departments are disbanded, renamed or restructured.
- **Health inequalities:** were they appropriately considered, and did the high levels of heart disease, diabetes, respiratory illness and obesity render the UK more vulnerable? Was there a slowdown in health improvement in the decade before the pandemic? Had health inequalities widened? Did emergency planning sufficiently take account of pre-existing health and societal inequalities,

deprivation, structural racism, and other forms of discrimination which undoubtedly exist in society? The hearings will also explore the state of the nation's public health and if emergency contingency planning considered health inequalities.

- **Emergency preparedness, resilience, and response (EPPR) structures:** were the national structures effective and practical in building the resilience of the nation? Was there strategic coordination on a local level to liaise between national and local tiers of emergency response? Was there sufficient and rigorous independent advice and did the government learn from the experience of other countries dealing with infectious diseases?

CP submissions

- The BMA and others highlighted the government's failure to implement recommendations from previous pandemic planning exercises, such as Exercise Cygnus in 2016. The ADPH and the LGA highlighted the government's insufficient understanding of the roles and responsibilities of directors of public health and local authorities at a national level, which meant they were excluded from national planning.
- There were calls for the Inquiry to explore the effect of austerity measures on public health, and for the capacity and resilience of public services to be examined, as well as the extent to which health and social inequalities were factored into pandemic planning. Calling for more transparency from government in preparedness planning, CPs referenced a culture of secrecy which reduced the opportunity for challenge and input at a local level.
- Representatives for the bereaved called on the Inquiry to examine whether the government did everything reasonably practical to prevent a foreseeable pandemic of this type or mitigate its impact if it arrived. They want the Inquiry to establish who had responsibility for civil emergency resilience, preparedness and planning at a UK level, and who was responsible for assessing the risk of a pandemic and its likely impact and how it was done. They also want the Inquiry to explore whether there was a whole system plan in place to prevent such a pandemic or mitigate its effects, and to establish if the responsibilities of central government were clear within the civil emergencies framework.

The full transcript of the day's proceedings is available here.

Wednesday 14 June

Witnesses

Submissions and evidence were heard from: Public Health Scotland, Government Office for Science (GO-Science), Department of Health and Social Care (DHSC), Welsh Government, Scottish Government, Executive Office Northern Ireland, Cabinet Office, Professor Jimmy Whitworth and Dr. Charlotte Hammer.

CP submissions

- Government representatives acknowledged that they will support the Inquiry's findings and use them influence future planning.
- DHSC called on the Inquiry not to look at decisions the department made during the pandemic through a "retro-scope", but rather in the context of the time. DHSC will not seek to claim all its actions were right or that it would necessarily have made the same decisions today. It acknowledges public discontent at numerous Covid-19 regulations, particularly those keeping family members apart from sick loved ones, and the negative effect they have had on the wellbeing of the nation. DHSC recognised the "Herculean task" it faced, describing it as the "greatest challenge ever faced by the NHS", calling the all-consuming period of the pandemic as "akin to a war". DHSC outlined a series of lessons to be learnt from the pandemic:
    - The need for a toolkit of capabilities which can adapt to deal with any public health emergencies
    - The need for a resilient health and social care system with minimal health inequalities
    - That pandemic planning must include the ability to surge and up-scale quickly
    - The need for diagnostic surge capacity
    - That future pandemic preparedness should consider and be responsive to all five routes of transmission of communicable diseases.
- The GO-Science noted that the UK had areas of national weakness in pandemic preparedness: the absence of major diagnostic industry, health inequalities, lack of excess capacity in the NHS, and scaling and operations challenges in public health structures.

Summary of expert witness evidence

Professor Jimmy Whitworth and Dr Charlotte Hammer

The Inquiry heard evidence from epidemiologists Professor Jimmy Whitworth and Dr Charlotte Hammer with a focus on the nature of pandemics and how the potential for infectious diseases has heightened. They addressed the issue of zoonotic diseases and the impact of climate and climate change on driving ecological changes. Counsel asked the witnesses about previous pandemics including SARS CoV1, MERS and swine flu, including how transmission had varied in each of these cases and as compared to Covid-19. They provided details about coronaviruses and explained that there are seven that affect humans.

On asymptotic transmission of viruses, the witnesses said that flu can be transmitted symptomatically and asymptomatically and agreed that even if the government had just focused on flu, there would be a need to prepare for both types of transmission. Asked why there had been an excessive focus on flu, the witnesses suggested it would be because it's where people had most experience and that using it as a starting point would be reasonable while further evidence was gathered.

Counsel asked about significant incidents of human-origin virus leaks, either by accident or malicious means. Witnesses explained that accidents can occur and gave examples. However, witnesses agreed that in terms of preparation and preparedness, it does not matter how a pandemic starts (zoonotic, accident or malicious act). Witnesses discussed the importance of surveillance, and how the earlier an alert is raised, the easier it is to respond. They suggested that by early 2020 the public health community knew that Covid-19 was something different and was not simply going to die out.

Expert advisory groups were discussed and it was noted that there are a number dealing with different issues. Witnesses stressed the importance of expert groups but agreed that it is important that their recommendations are coordinated and synthesised. Witnesses agreed that Public Health England (PHE) was seen as something of a beacon in the area of public health. PHE has since been disbanded and its functions split between the United Kingdom Health Security Agency (UKHSA), regional health authorities and, in part, DHSC. This means that health promotion is now separated from public health functions. The view of Professor Whitworth was that keeping these streams together was beneficial and that there are "cross-learnings to be had from having communicable, non-communicable control together" and being able to have health promotion teams working with disease control teams.

On diagnostic testing, it was acknowledged that the UK developed a diagnostic test very rapidly. However, the test was inaccessible for most people in the early stages of the outbreak and the scale of testing that was feasible was inadequate for the expanding epidemic.

The full transcript of the day's proceedings is available here.

Thursday 15 June

Witnesses

Expert evidence was heard from: Professor David Heymann CBE, Bruce Mann and Professor David Alexander.

Summary of expert witness evidence

Professor David Heymann CBE

The Inquiry heard evidence from epidemiologist Professor David Heymann CBE. On coronaviruses in animals, he explained that they are very common in the animal kingdom and transmission occurs easily between animals in the same family. He explained the origins of coronaviruses and the transfer of infection from live animals to people, with SARS and MERS discussed in detail. He was asked to explain two major theories of how Covid-19 had originated. He said one possibility was that it came from a bat into an intermediary animal and then passed to humans (possibly in a live animal market). The second theory was that it came from a laboratory leak in Wuhan. He talked about the sequence of events leading up to the global spread and the reporting of the virus by the WHO in December 2019.

The witness explained the early WHO recommendation on the use of face masks, non-symptomatic transmission, and the 'R' number. He also talked about the impact of Covid-19 on obese people and those who have diabetes. He explained that obese patients are more likely to struggle with breathing difficulties, particularly when they have a pulmonary infection. He explained that those who are obese are at greater risk of diabetes and that diabetes decreases the immune response to infections, both viral and bacterial.

On the level of preparedness in Asian countries that had had recent experience of SARS and MERS, the witness highlighted the success of contact tracing in some countries and said that when contact tracing is done locally by trusted people it works well.

He said that there wasn't sufficient evidence for the WHO to advise mask wearing at the start of the pandemic and in the early stages of Covid-19 medical masks were in short supply.

Bruce Mann and Professor David Alexander

The Inquiry heard from Bruce Mann and Professor David Alexander, experts in emergency planning and preparedness. The witnesses confirmed that the future of another novel pandemic was an inevitability and that changes needed to be made to the UK's preparedness structures. In their joint

statement to the Inquiry they stated that planning for a no-deal Brexit from 2016 onwards had the "inevitable consequence" of taking time and energy away from civil emergency planning. When asked if the government does enough within the limits of its capabilities to keep the British public safe, the witnesses expressed that in their opinion, the government does not. They said that the WHO's pre-pandemic assessment of the UK's preparedness as "world-leading" was entirely wrong.

They highlighted the issue of specificity in UK pandemic planning. Pandemic characteristics should have been identified and factored into plans and a range of scenarios should have been anticipated. Responsibilities and accountabilities need to be understood system-wide for an effective, coordinated emergency response. They noted that resilience planning on a regional level has degraded over the last ten years because of the disbandment of the Government Offices (GO) for the Regions.

There was clear advice from the Hine review into swine flu in 2010 and Exercise Cygnus in 2016 that the health and social care systems were likely to be overwhelmed in the event of a pandemic. The National Security Council (NSC) committee was also warned about the state of capacity in health and social care. The witnesses stated that recommendations were made, but planning did not follow. They recommended radical innovation and change in structuring and detailing how preparedness plans and procedures are followed through. They also recommended that to ensure accountability, there should be a single point of responsibility for pandemic preparedness planning. It was suggested that the Cabinet Office or an independent national organisation take on this role and scrutinise planning throughout the system.

The full transcript of the day's proceedings is available here.

Friday 16 June

Witnesses

Expert evidence was heard from: Professor Michael Marmot, Professor Clare Bambra and Katherine Hammond.

Summary of the expert evidence

Professor Sir Michael Marmot and Professor Clare Bambra

The Inquiry examined the expert report on health inequalities submitted by Professor Sir Michael Marmot and Professor Clare Bambra. Sir Michael told the Inquiry that most health differences are not attributable to healthcare but rather to the social determinants of health, and that the decline in life expectancy means we can no longer look forward to better health. Until 2010, life expectancy had been increasing in the UK, then the rate of improvement slowed, then stopped, and in some regions

it actually declined. Other rich countries experienced changes but only two were worse than the UK: the USA and Iceland. The improvements we have seen in health in the UK throughout the twentieth century also slowed down and the social gradient (the differences between the most and least privileged) got steeper and heath inequalities got worse.

The NHS delivers great equity in access to health according to Sir Michael, with people in the most deprived areas making greater use of services because they have poorer health. He also highlighted problems with workforce before the pandemic, including poor pay and conditions, low morale, and the high number of vacancies. He also said that the funding of the healthcare system has been inadequate since 2010.

On the impact of race, he said people in ethnic minority groups are much more likely to live in deprivation and will, as a consequence, experience poorer health and have a shorter life expectancy. There is also evidence that some health conditions are more frequent in some ethnic minority groups. On life expectancy more generally, there has been a decline in life expectancy in the bottom ten per cent in every part of the country apart from London. The decline was sharpest in the north east and north west of England.

Professor Bambra also pointed to the paucity of data on ethnic minorities and the lack of routine data collection. She said that the health community need to be better on collecting that data. Pressed as to the reasons behind the lack of data, she said that it's down to a combination of factors, including a poor response rate from some groups to the census, migration patterns, and the failure to record ethnicity at death. Sir Michael commended the work of the NHS Race and Health Observatory.

Ill heath among women has increased since the pandemic. Sir Michael does not know why but thinks it is credible to consider the impact of austerity on women as they were disproportionately affected by cuts.

Asked about social care funding, he pointed to the cuts in social care spend per person by local authority. For the least deprived 20% of local authorities (LAs), the social care spend per person went down by three per cent, and in the most deprived 20% of LAs it went down by 17% even though the greater the deprivation the greater the need. Overall local authorities spend per person dropped by 16% in the least deprived LAs compared to a drop of 32% in the most deprived. Whole system catastrophic shocks like the pandemic expose and amplify the inequalities in a society and a person's social position determines their susceptibility to those shocks.

Professor Bambra analysed pre pandemic national security risk assessments, risk registers, contingency and civil emergency planning. She said that there was no mention of risk consequences on any vulnerable groups apart from clinical risks factors and age, and nothing in terms of ethnic

minority groups or deprivation. She said this has been improved in current plans and the definition of vulnerability has now been expanded. She recommends that the different impacts on vulnerable groups should be part of pandemic planning, and pointed to the differential impact of swine flu on some ethnic groups and the much higher mortality rates in the most deprived areas. On the Hine review, she said clinical risks factors and age were the only vulnerabilities considered and she could find no evidence that health inequalities were considered in a broad range of exercises, including Exercise Cygnus. In all the exercises she reviewed, she only found one equality assessment and there was no consideration of structural racism or of the causes of health inequalities.

Katherine Hammond

The Inquiry questioned Katherine Hammond, director of the Civil Contingencies Secretariat (CCS) between 2016 and 2020 on UK civil contingency planning, preparedness and structure. She was questioned on a number of civil contingency planning documents that the CCS had released and whether they aided local structures to prepare for a pandemic. Counsel's review of the 'concept of operations' document, the CCS's primary emergency response guidance, shows that in 2019 the document still referenced government offices that had been disbanded, such as the Government Offices for the Regions. Hammond confirmed this showed that a central government document, along with other planning documents referenced by Counsel, had not been updated appropriately since its creation.

Hammond was questioned on the 2019 national security risk assessment (NSRA) and the level of risk measured for new and emerging diseases. She stated that the assessment considered an influenza pandemic to be the worst case scenario situation and that that the combination of likelihood and impact was higher for an influenza pandemic than any other type. The NSRA identified risks at a broad level and Hammond stated that the risk identified in the planning was not the one that materialised in 2020. Some of the planned-for influenza risks were applied to the Covid-19 response, such as the impact on mortality and the likelihood of high levels of workforce absence. There had been no prior consideration in any risk assessment of the need for a national lockdown, a test and trace programme, or the stockpiling of Personal Protective Equipment (PPE). Hammond also confirmed that factors considered within the risk assessment process had "no consideration of socio-economic disadvantage beyond comorbidities and prisons".

Exercise Cygnus in 2016 concluded that the UK's preparedness in terms of planning, policies and capabilities was not sufficient to cope with the extreme demands of a severe pandemic with a nationwide impact on all sectors. Hammond confirmed that the CCS recognised there was a need for a programme of work to be undertaken to implement the recommendations of this exercise. The NSC ministerial subcommittee on threats, hazards, resilience and contingencies (NSC[THRC])

commissioned a pandemic flu readiness programme, from which the pandemic flu readiness board was created. Hammond confirmed that the NSC(THRC) had been abolished in 2019 after its pandemic flu readiness programme of work had already been paused due to Operation Yellowhammer.[1] Many of the workstreams created in response to Exercise Cygnus were not completed by the time the programme was paused.

The full transcript of the day's proceedings is available here.

[1] Operation Yellowhammer was the name given for the cross-government civil contingency planning for the possibility of Brexit without a withdrawal agreement (a no-deal Brexit).