UK Covid-19 Inquiry public hearings: module 1, week 5 (10-13 July 2023)

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

This week the Inquiry heard from Michael Gove, Northern Ireland ministers, Nigel Edwards (chief executive of the Nuffield Trust), Mark Lloyd (chief executive of the Local Government Association), and Richard Horton (editor in chief of the Lancet).

Next week the Inquiry will hear evidence from members of the four national bereaved families groups and from key public figures including professor Philip Banfield, chair of the British Medical Association's UK council, Dr Jennifer Dixon, chief executive of Health Foundation and Kate Bell, assistant general secretary of the Trades Union Council.

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

Monday 10 July

Witnesses

Dr Claas Kirchhelle and Professor Sir Michael McBride.

Summary of witnesses' evidence

Dr Claas Kirchhelle

Dr Kirchhelle is a tenured assistant professor of the history of medicine at University College Dublin. His evidence to the Inquiry was given as an expert in the history of public health.

[1] 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 Inquiry Rules 2006 and three preliminary hearings.

Dr Kirchhelle gave the Inquiry a history of diagnostic and public health laboratories in the UK. He detailed the different public health roles and organisations in the UK from the 19th century to the 21st century.

Dr Kirchhelle was taken through the "somewhat erratic" government support for the Health Protection Agency (HPA) from 2003 to 2012/13. He said it was a classic example of "yo-yo funding" for public health in and outside of crises. Once the immediate perception of a crisis has passed, funding tends to go down. Dr Kirchhelle thought the huge fluctuations in funding would certainly have made it difficult to plan for resilience capability building.

On the creation of Public Health England (PHE), Dr Kirchhelle said that his historical investigation has shown that senior microbiologists and HPA officials had consistent concerns about PHE's position as an executive body within the Department of Health and Social Care (DHSC). There were concerns about PHE's ability to speak openly to power. Local health authorities polled by Ipsos MORI after its establishment said that they felt PHE could do more to lobby DHSC on public health protection.

Concerns around surge capacity were voiced in multiple preparedness exercises, particularly the ability to surge beyond the initial hit of one or two high consequence infectious disease (HCID) cases. He said it is a perpetual challenge with every emerging pathogen when you move from the core elite capability of processing and public health handling towards a broader health systems response.

On the history of non-medical interventions, he said that these have been a core part of pandemic planning since the 1990s. He said what was new with the Covid-19 pandemic was the scale of lockdowns and societal closure that was considered. He didn't think that interventions of that scale were considered in initial influenza pandemic planning. Not enough emphasis was placed upon behavioural science in pandemic planning, with insufficient regard to cultural and structurally determined aspects of behaviour. He said it would have been good to use ethnographic and sociological studies of mixed responses within the UK population to plan these types of interventions.

Dr Kirchhelle said that at the scientific level there is no evidence of group think. He agreed with Dame Jenny Harries' evidence that influenza was the most realistic disease to plan for due to the robust data showing influenza occurs regularly. Dr Kirchhelle said moving forward it may be useful to prepare more generically for airborne pathogens but he "[does not] subscribe historically to the argument that group think delayed preparedness".

Professor Sir Michael McBride

Sir Michael has been the chief medical officer (CMO) for Northern Ireland since September 2006.

Sir Michael detailed the role of the Public Health Agency (PHA) in Northern Ireland. In response to outbreaks of infectious diseases, the UK Health Security Agency (UKHSA) would establish an incident management team at a UK level and then the PHA would manage the response at a Northern Ireland level while liaising with the UKHSA.

Sir Michael said that Northern Ireland worked closely together with the UK in terms of developing guidance and shared documents across the UK and devolved governments. The Northern Ireland Health and Social Care influenza pandemic preparedness and response guidance 2013 was based on the UK influenza pandemic preparedness strategy 2011.

Sir Michael participated in Exercise Cygnus and provided input to the lessons learned report produced at a UK level. Northern Ireland also developed its own lessons learned report which identified 10 key areas to be progressed. Of those, six were completed by the onset of the onset of the Covid-19 pandemic, with factors such the approach to the UK influenza pandemic preparedness strategy 2011 and the demands of Operation Yellowhammer[2] affecting completion of the others.

Sir Michael said that in terms of scale, Northern Ireland benefits from being integrated into the UK pandemic preparedness systems. Northern Ireland has a very small group of departments and could not replicate the expertise or scale of work that takes place within the UK.

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

Tuesday 11 July

Witnesses

Rt Hon Baroness Arlene Foster and Richard Pengelly.

Summary of witnesses' evidence

Rt Hon Baroness Arlene Foster

Baroness Foster was first minister of Northern Ireland from 2016 to 2017 and from 2020 to 2021.

Baroness Foster said that the UK government in Westminster has sovereignty over Northern Ireland but Northern Ireland Office (NIO) ministers do not intervene in a direct rule manner. The NIO rarely takes decisions that affect Northern Ireland but there have been occasions where it has intervened,

[2] 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).

such as on the budget for Northern Ireland. If there is a deficiency in the Northern Ireland administration, then those in Westminster with responsibility for Northern Ireland have a responsibility to step in. She said that if there was a difficulty with resourcing around resilience and planning for emergencies, there was a duty on the Westminster government to take appropriate action.

Due to the unique mandatory coalition which takes place in Northern Ireland, there are five political parties in government. Departments and ministries may be held by someone from a different political party than the first or deputy first minister. Unless departmental matters are brought to the attention of the Executive, the first and deputy first minister are not necessarily aware of them. Baroness Foster was not made aware of the outcome of Exercise Cygnus and a Northern Ireland report on Exercise Cygnus had not been produced by the time the power-sharing agreement collapsed in January 2017.

Richard Pengelly

Richard Pengelly was permanent secretary at the Department of Health Northern Ireland (DH) between 2014 and 2022.

Pengelly said that the Northern Ireland Health and Social Care influenza pandemic preparedness and response guidance 2013 "was very much piggybacking" the UK influenza pandemic preparedness strategy 2011, so any drawbacks to the UK strategy would have naturally flowed through into the Northern Ireland strategy.

Pengelly is not aware of anybody in DH or the CMO engaging with the NIO about any possible gaps in resilience or preparedness. As resilience and preparedness fall under the civil contingency remit of the Executive, he would expect that if gaps had been identified, a conversation between the NIO and the Executive, rather than the DH, would have been needed.

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

Wednesday 12 July

Witnesses

Michelle O'Neill, Member of the Legislative Assembly (MLA) of Northern Ireland, Mark Lloyd, Chris Llewellyn, Alison Allen and Aidan Dawson

Summary of witnesses' evidence

Michelle O'Neill MLA

Michelle O'Neill was minister of health from 2016 to 2017 and deputy first minister of Northern Ireland between 2020 and 2022.

O'Neill said that she delegated attendance at Exercise Cygnus to her CMO, Professor Sir Michael McBride. O'Neill said that she was aware of the UK influenza pandemic preparedness strategy 2011 during her time in office, but was not quite sure of how it integrated into the local Northern Ireland scenario.

The Northern Ireland Health and Social Care influenza pandemic preparedness and response guidance 2013 makes no reference to the fact Northern Ireland has a land border with another country, the Republic of Ireland. O'Neill said that a recurring position, advanced by many professors during the Covid-19 pandemic, was the need for an all island of Ireland approach to protection from disease, as already exists in many agricultural and animal disease planning documents. She said it should follow logically that there should be the same approach to public health. O'Neill said that she would recommend a British and Irish government collaboration on a two-island approach to human diseases. Issues such as travel arrangements could be planned in advance of an emergency.

O'Neill said that in her experience there wasn't an easy flow of communication at ministerial level with London.

Mark Lloyd, Chris Llewellyn and Alison Allen

Mark Lloyd is the chief executive of the Local Government Association (LGA), Chris Llewellyn is chief executive of the Welsh Local Government Association (WLGA), and Alison Allen is chief executive of the Northern Ireland Local Government Association (NILGA). They submitted joint evidence to the Inquiry.

The witnesses said that their organisations work together on a number of local government issues with the UK government. Meetings of the UK's four local government organisations occur at least once a year. The witnesses said that there is learning that needs to be taken into how the Civil Contingencies Act 2004 (the Act) is constructed and delivered. Local governments need to be properly trusted as part of the civil response mechanism and the Act could be used to increase engagement with local leaders. Local councils are expected to lead responses in their community, yet during the Covid-19 pandemic they were learning about new issues and responses from afternoon press briefings.

Local resilience forums are planning entities not legal entities and the responsibility for emergency responses sits with category 1 and 2 responders. There is at times an issue with the flow of information to partner organisations at a local level. Llewellyn said that there are also issues with

communication between devolved administrations and the UK government. He said there needs to be a protocol for how information is shared and to whom.

Lloyd confirmed that the LGA did not become aware of Exercise Alice[3], the 2016 tabletop exercise to prepare the UK for an outbreak of Middle East respiratory syndrome (MERS), until autumn 2022. He said that the local government family wasn't aware of the report or its conclusions and learnt about it through the work of the Inquiry.

Lloyd said that while teams were making preparations for a no-deal European Union (EU) exit, they were also focussing on other areas. He said that on the plus side, preparation a no-deal brought together partners to work on the challenges. On the negative side, the focus on this work meant that some routine activity, including work on pandemic flu, was deferred.

Aidan Dawson

The Inquiry heard evidence from Aidan Dawson, chief executive of PHA Northern Ireland.

Dawson said that prior to the pandemic, Northern Ireland did not have capacity to do modelling of disease progression. In hindsight, he thought that there should have been a consultant epidemiologist employed by the PHA and that it should have had its own modelling capabilities. He agreed with remarks made by Michelle O'Neill MLA that there were staffing problems and an insufficient training budget across emergency prevention, preparedness and response capability. He said that they also faced issues because they had a small team who couldn't focus on emergency planning when they were preparing for Brexit.

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

Thursday 13 July

Witnesses

Marcus Bell, Melanie Field, Nigel Edwards, Dr Richard Horton and the Rt Hon Michael Gove MP.

Summary of witnesses' evidence

Marcus Bell

[3] The Exercise Alice Public Health England (PHE) report was obtained by Moosa Qureshi, an NHS doctor, in October 2021 through a freedom of information request. The redacted report is currently available on Mr Qureshi's website https://cygnusreports.org/wp-content/uploads/2021/10/Report-Exercise-Alice-Middle-East-Respiratory-Syndrome-15-Feb-2016.pdf

Marcus Bell joined the Cabinet Office in 2016 when he became director of the Race Disparity Unit (RDU) and the Disability Unit (DU). From September of 2020 he became director of the Equality Hub (EH).

In 2020 the EH brought together the RDU, DU and the Government Equalities Office (GEO) which had existed since 2007. The EH's focus is on disability policy, ethnic disparities, gender equality, LGBT rights and the overall framework of equality legislation for the UK. Alongside the EH there is the Social Mobility Commission, an independent arm's-length body. Its focus is on improving social mobility and its secretariat is part of the EH.

The units were brought together in 2020 because the then minister for equalities, Rt Hon Liz Truss MP, thought it would be more efficient. Bell explained that every single policy issue has an equality dimension to it and for the most part the EH looks to individual government departments to manage their own equality issues. The EH provides guidance from time to time to departments and focuses at any one time on a limited number of issues that are a particular priority for ministers.

On pandemic preparedness, he said the RDU and DU had no involvement in pre-pandemic preparedness within government and his understanding from GEO colleagues is that they did not have any involvement either. Asked specifically about updates to the UK influenza pandemic preparedness strategy 2011, he confirmed their advice was not sought. On the equality assessment that was prepared on the strategy, Bell agreed with the analysis of professors Marmot and Bambra, that it was fairly limited in terms of identifying the multiple issues faced by different social groups, and that there is little provided on what action should be taken to mitigate any differential impacts. He stressed that it is the responsibility of lead departments to prepare equality impact assessments and to reach out to the EH to seek guidance and assistance as needed.

Bell summarised three key recommendations produced by EH in December 2021 in terms of future approaches to pandemics. Firstly, it is essential to have effective tailored communications with different groups within the general public. Secondly, building and maintaining trust with all groups is vital. Finally, having high quality data is critically important, particularly about mortality and other impacts, so that the government can act swiftly as issues emerge. He was unable to say what progress had been made in relation to these recommendations.

Melanie Field

Melanie Field has been chief strategy and policy officer of the Equality and Human Rights Commission (EHRC) since 2015 and has worked at the EHRC since 2014.

The EHRC is a non-departmental public body established by the Equality Act 2006 and set up in 2007. It replaced predecessor equality commissions, the Commission for Racial Equality, the Equal Opportunities Commission and the Disability Rights Commission. It has responsibility for protecting and promoting equality and human rights, including enforcing the Equality Act 2010. It is funded by the GEO. Its statutory remit covers England, Scotland and Wales. In relation to Scotland, its human rights remit extends only to matters reserved to the UK Parliament; the Scottish Human Rights Commission has responsibility for devolved matters.

Field confirmed that none of the governments of the three nations had contacted the EHRC for assistance with pandemic planning and emergency preparedness. She went on to explain that the public sector equality duty (PSED) under section 149 of the Equality Act 2010 is the legislative driver for public bodies to consider equality issues when performing their functions. She also emphasised that the PSED cannot be delegated. Wherever you are in the system, you need to comply with it, as it relates to the functions that you are performing as a public body. The EHRC could have engaged with the governments in terms of providing support about how to comply with that duty.

Field agreed that there needs to be investment in high quality linked data. She said that there isn't consistency of approach to data collection or comprehensive data collection around people's protected characteristics in the health and care sector.

Early in the pandemic there was an inability to evidence indications of disproportionate deaths among certain ethnic minority communities because of the inability to link data on ethnicity to death certification. The EHRC would always advocate for collecting comprehensive data that is disaggregated, so that the different situations of different population groups can be analysed. That is important both for predicting what might happen but also for monitoring, in real time, what is happening and then being able to respond to it.

On the impact assessment produced for the UK influenza pandemic preparedness strategy 2011, Field said that there is no note of any engagement with any groups representing ethnic minorities or any reference to existing information about health inequalities. Those systems and mechanisms need to be in place. You also need to have relationships and understanding of those communities before trying to respond to an emergency so that you have those relationships to draw on.

Field said that the human rights framework should absolutely be guiding both the planning and the response to any emergency.

Nigel Edwards

Nigel Edwards has been chief executive of the Nuffield Trust since 2014.

Edwards gave evidence on the extent to which the NHS and social care structures were capable, and envisaged to be capable, of responding to the severe demands of the pandemic.

Edwards said that in the years leading up to the Covid-19 pandemic the Nuffield Trust did not look at the area of pandemic planning or preparedness specifically as they did not have the internal expertise. Other sources suggested that the UK's general level of preparedness was satisfactory. He said that one of the main areas of focus over the years has been NHS' ability to deal with winter, in the context of its overall resilience and capability.

After 2020, the Nuffield Trust undertook two pieces of work looking at lessons which could be learned from the pandemic in the context of infection prevention and building design. One piece funded by DHSC's New Hospital Programme looked at what should be learnt from the way hospitals are designed and operated to make them more resilient in the future. The second piece was funded internally and looked at the response of small hospitals. The sample of hospitals that the Nuffield Trust spoke to had plans in place for dealing with influenza, but not for a long-term sustained pandemic. In a number of cases, the size of the pipework to supply oxygen and the machinery used to condense oxygen was inadequate to deal with the scale of the required oxygen flow to treat Covid-19. Major engineering and structural changes had to be made to accommodate the demand. Edwards concluded that planning documents were not adequate, which partly reflects the nature of the treatment regime that was required.

Edwards said that the NHS typically has a much clearer set of defined standards compared to the social care sector. Exercise Alice only covered health and while Exercise Cygnus did look at social care, Nuffield Trust researchers were not able to find a great deal of evidence that lessons learned from the exercise were incorporated into social care. The general lower level of required standards in social care continued after that exercise. Edwards said that in the social care sector there is no comparable mechanism to identify the number of people receiving care as there is in the NHS. He said that information on who is employed and providing care in the sector is also poor.

On resilience, Edwards said that the UK health system has traditionally run with very low margins of spare capacity. This means that having a plan for dealing with a sudden surge or emergency is very important. The scope of the plan however is limited as the level of spare capacity in the system is relatively low. The Nuffield Trust's international research suggests that the ability to recover from a shock is closely related to the overall level of capacity and pre-existing resilience in the system.

The NHS has a very low number of beds per capita compared with other high-income countries. It tends to run them at a much higher rate of occupancy which means that its ability to absorb shocks or increases in demand is much lower. And although the number of beds has remained static, the population has both grown and aged over this period. So, while demand has been going up by 2% a year, the number of beds has remained static, and the number of nurses has gone up by 0.2% over this period, which means that the hospital system is highly constrained.

Edwards said the workforce had been growing in the five years preceding the pandemic, but so too had the number of vacancies. There were also more people working on temporary contracts which affects the ability of the NHS to provide services that respond to growing demand. In community services, there is a less clear view of what the capacity of the system is, but there has not been a growth in community services to compensate for the growth in the ageing population and its high level of need.

Edwards said the capital budget in the NHS has been reduced. The implication is money that should have been spent on equipment, repairs or maintenance was shifted to keeping everyday operations going. The backlog maintenance bill of the NHS had grown substantially in the period leading up to the Covid-19 pandemic. Funding for the social care sector comes from councils and many of them had a significant reduction in the grants they received from central government. The spending in 2019 in real terms was at 2010/11 levels, but the demand for social care had significantly increased over that same period.

In his written evidence, Edwards identified that while the terms of the UK's exit from the EU were being negotiated, the exit began to have an impact on the resilience of health and social care systems. From 2016 there was a substantial drop in the migrant workforce coming from the EU, which negatively impacted the available social care workforce. When the Covid-19 pandemic hit, there was a shortfall in the social care workforce.

Edwards said that in the Nuffield Trust's research they did not find evidence of planning for the needs of people with non-clinical vulnerabilities in plans for health emergencies.

Dr Richard Horton

Dr Horton is the editor-in-chief of The Lancet medical journal. He is an honorary professor at the London School of Hygiene and Tropical Medicine, at University College London and at the University of Oslo.

On the Global Health Security Index (GHSI), Dr Horton said that it is an excellent document setting out the technical capacities of a public health system in the face of a pandemic, but it omits the human

dimension. That is how our political and health leaders frame the threat, how we assess the threat and how we respond. The GHSI also fails to take into account the way people respond in the face of a crisis.

Dr Horton said that until 2002, the medical community thought that coronaviruses were a relatively benign category of virus and were astonished when the severe acute respiratory syndrome (SARS) CoV-1 emerged. He referenced a 2004 global report commissioned by the US Institute of Medicine which documents the medical community reaction to the 2002 SARS outbreak and warns of the need to better understand this category of virus and to develop diagnostics, treatments and vaccines. He said that despite the clear warnings, this type of threat was not elevated in our National Risk Register. He said there was a general group think in the western medical and public health community that focused on influenza as the threat. In China and the Asia-Pacific region there was a different perception. He said colleagues in China were very aware that coronaviruses were a major threat. Dr Horton said the UK was complacent due to overconfidence in the NHS' ability to cope with a pandemic and a mistrust in evidence coming from China.

Dr Horton said that simulation exercises are crucial for identifying possible weaknesses in pandemic planning. Exercise Cygnus clearly documented areas of weakness around surge capacity, triage management, social care and regional and local planning. He said it seems that the UK did not take note of those vulnerabilities or act on them.

Dr Horton said that a pandemic preparedness and response plan needs to view a pandemic as a syndemic.[4] He said that in pandemic prevention we should be giving greater attention to those who are living with chronic disease and in deprived communities. He said the UK was particularly vulnerable because while we do have an excellent national health system which is able to treat people who present with particular diseases, we do not have an effective public health system that is able to focus on health promotion and disease prevention. Chronic underfunding of public health left us particularly vulnerable to Covid-19.

On education of UK healthcare workers, Dr Horton said that threats to UK health and health security are going to come from outside the UK, therefore our doctors, nurses and health workers need to be aware of the threats and be ready to respond to those threats. An educational revolution could relocate the UK in a global community. It needs the UK to have a far more expansive view of what constitutes national health and a national health service.

[4] A set of linked health problems involving two or more afflictions, interacting synergistically, and contributing to excess burden of disease in a population. Syndemics occur when health-related problems cluster by person, place, or time.

Rt Hon Michael Gove MP

Michael Gove has been secretary of state for the Department for Levelling Up, Housing and Communities (DLUHC) and minister for intergovernmental relations since October 2022. He previously held the same position between 15 September 2021 and 6 July 2022. He was chancellor of the Duchy of Lancaster from July 2019 to September 2021, and minister for the Cabinet Office from February 2020 to September 2021.

Gove spoke about the Exit Operations cabinet subcommittee (XO), which he chaired. He explained that this had been set up after Boris Johnson became prime minister as there was widespread feeling that there had been insufficient focus and urgency in the preparations for an EU exit, and specifically for a no-deal exit. He agreed that the XO had strong backing from No 10 and that it is hard to prioritise work in government, especially where it is cross cutting, unless there is a consistent push from the centre.

Gove did not agree that preparations for a no-deal EU exit had a detrimental impact on pandemic planning. No activity has been identified that would have enabled the government to manage the Covid-19 pandemic significantly better.

Gove agreed with evidence given by Sir Oliver Letwin, that ministers working within resilience need to have appropriate training. He said the lead government department system has its flaws but there are some situations in which that is the best approach to deal with a particular situation. Although DHSC had a good secretary of state and an excellent team, it could not coordinate the scale of activity across government needed during the pandemic. He agreed that government groups and bodies working on resilience should all sit within the same department and this could be done via a machinery of government change.

Gove agreed that because the LGA only recently heard about Exercise Alice that central government is acting in secrecy. He said that the DLUHC is a good friend of local government but not every government has been as open, trusting and collaborative with local government as it should be. However, he said that the Resilience Framework that Rt Hon Oliver Dowden MP published means that information will be shared more effectively to ensure that the whole resilience community is involved.

He did not agree that staff having to concentrate on preparation for a no-deal EU exit had a detrimental impact on adult social care. However, he said the way in which the discharge of patients from NHS beds into adult social care was an object of "regret and concern".

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