People's Covid Inquiry February-June 2021

Expert witness statement

Professor Gabriel Scally

Session 1 24 February 2021

COVID-19: HOW PREPARED WAS THE NHS?

STATEMENT

I (name) Gabriel Scally

Job title/ role/ President Epidemiology and Public Health Section Royal Society of Medicine, Visiting Professor of Public Health, University of Bristol, member of Independent SAGE

will say as follows:

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 24 February.

2. I am able to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.

3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement

I was born in Belfast and studied medicine at Queen's University. Subsequently, I trained, first in general practice and then in public health medicine.

I was Director of Public Health for the east of Northern Ireland until 1993 when I moved to England to be a Regional Director of Public Health (RDPH). I worked in the NHS and the civil service as an RDPH until 2012. For most of this period, I was RDPH for the South West region of England.

I assisted with the Inquiry into Hyponatraemia-related deaths in Northern Ireland and recently carried out the inquiry into the CervicalCheck failures in the Republic of Ireland.

I am currently a Visiting Professor of Public Health at the University of Bristol and President of the Epidemiology and Public Health Section of the Royal Society of Medicine. I am a member of Independent SAGE, the group set up to contribute open and independent scientific advice on the UK's coronavirus crisis.

4. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

As a Regional Director of Public Health, I had considerable responsibilities for emergency planning and preparing this within the NHS and the Government Office for the Southwest region. During my time in the post, I dealt with several national emergencies, including foot and mouth disease, the fuel tanker drivers' strike, and pandemic influenza.

5. How are you able to assist the Inquiry – what is your expertise/ knowledge/ specialism?
My extensive professional background in public health has enabled me to analyse and understand how the UK has responded to the pandemic from its outset. In particular, I have been studying and researching COVID-19 response in the UK as a whole. I have also taken a significant interest in the pandemic response in Northern Ireland and the Republic of Ireland.

6. What in your view were the original vision and principles underpinning the NHS?
I believe that the commendable principles were outlined very clearly in 1946. In his speech in the House of Commons on April 30th 1946, moving the second reading of the NHS Bill, the minister stated that the first reason an NHS was needed was that money should not be allowed to stand in the way of obtaining an efficient health service. He noted the critical principle that; a person "ought not to be financially deterred from seeking medical assistance at the earliest possible stage". His second reason was that the national health insurance scheme did not cater to the self-employed, and if employment was lost, so was the insurance. The minister also gave supporting reasons in respect of physical and mental disability, which he believed were poorly provided for. The same principles motivated the simultaneous inauguration of the Northern Ireland Health and Social Services.

It was not until 1974 (1973 in Northern Ireland) that public health services and many community health services were merged with the hospital service. These included control of infectious diseases

Please briefly outline your testimony below or attach/reference an article which will provide the panel with relevant information.

Countries that successfully contain COVID-19 and reduce it to tiny numbers of cases have been able to protect their economies from substantial damage and provide their citizens with a near-normal life experience. On the other hand, failure to suppress COVID-19 successfully has forced countries to rely upon periodic imposition of severe social and economic restriction to limit the loss of life and prevent their health services from being overwhelmed.

The UK government's performance in protecting its citizens from the deadliest pandemic in more than a century has been lamentable. The UK's early response was examined in a published article in May 2020.[1]

[1] Scally G, et al. The UK's public health response to covid-19 BMJ 2020;369:m1932

With well over 100,000 deaths from COVID-19, all potentially avoidable, and the worst economic performance of any country in the G20 group of nations, there is little to praise.[2] It is impossible to critique the UK's strategy because there has never been an explicit strategy for responding to the pandemic.

Suppose there is a strategy, even an implicit rather than an explicit one. In that case, it is to suppress the virus's level when necessary to stop the number of severe cases requiring hospitalisation becoming greater than the NHS capacity available. The government initially appeared to have adopted a strategy to accumulate immunity amongst the population by permitting widespread infection. This approach was devoid of merit and contrary to basic public health principles of dealing with a dangerous infectious organism. The second approach that appeared to be adopted was aimed at suppressing, to a certain extent, the level of COVID-19 infection, with what seemed to be a primary purpose of preventing the collapse of hospital services under an overwhelming burden of acutely ill patients.

The primary mechanism of curbing infections that the government has adopted is enacting severe social and economic restrictions. The WHO guidance on the use of lockdowns is unambiguous. Lockdown should be a last resort, and instead, priority should go to established public health inventions that have a proven record of suppressing infectious disease outbreaks. These include basic individually based hygiene measures such as hand washing, the wearing of face coverings, interpersonal distancing, reduced social or employment generated physical contact and restricting travel. Appropriate organised public health interventions include a well-resourced Find, Test, Trace, Isolate and Support system aimed at dramatically cutting transmission. An important measure is the prevention of importation of new disease cases and the ability to constrain movement within the country's geographical boundaries.

The mechanisms for protecting the population from large-scale severe infectious disease or environmental hazards had been consistently downgraded since 2010. The abolition of Government Offices for the Regions was an early act of the coalition government. It removed a tier of regional coordination that had proven effective in severe national emergencies in the 1990s and 2000s. The loss of the emergency planning role, in particular, created a significant deficit.

I resigned from my post as a senior civil servant with the Department of Health in early 2012. In November of that year, I gave oral evidence to the House of Commons Communities and Local Government Committee. In that evidence I warned of the very distinct possibility that the new structures would not work in the event of a serious national emergency. I also stated that "I do not

[2] https://www.oecd.org/newsroom/g20-gdp-growth-third-quarter-2020-oecd.htm#:~:text=2020%20%2D%20Gross%20domestic%20product%20(GDP,the%20final%20quarter%20of%202019.

want to be sitting and talking about this in the aftermath of something that goes wrong".[3] I enclose an extract of the committee's report, which contains my evidence (Questions 104 and 111).

The abolition of regional working changed the organisational capacity for dealing with major emergencies in England dramatically. A two-tier system was adopted with no structured process for cooperation between local resilience fora in place of a straightforward three-tier approach of national, regional and local resilience mechanisms. In a March 2012 revision to the government guide *Emergency Preparedness,* it was left entirely to the local fora to decide whether and how to cooperate.[4] (Attached) This point represents the end of reliable and structured emergency planning for England.

The lack of senior public health medicine capacity in the four health departments of the United Kingdom is, in my view, a major contributory factor to the poor performance of the country in keeping the population safe from COVID-19. Until recently, it was the practice, since the 19th century, that a public health physician occupied the post of Chief Medical Officer (CMO). It is a signal of the decline in the public health functioning of the departments of health that at the beginning of the pandemic, three of the four posts were occupied by clinicians rather than those with training and qualifications in public health medicine. I pointed out in a British Medical Journal paper in 2013 that: "The state of global health is such as to indicate clearly that we are in desperate need of passionate public health heroes at the heart of national governments around the world".[5]

The abolition of Public Health England amid this pandemic also gives me substantial cause for concern. It risks magnifying the damage already done to the public health system over the past decade.[6]

I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Gabriel Scally **23 February 2021**

---

[3] House of Commons. Communities and Local Government Committee. The role of local authorities in health issues. Eighth Report of Session 2012–13. 27 March 2013.

[4] Chapter 16 Collaboration and Co-operation between Local Resilience Forums in England: Revision to Emergency Preparedness. Cabinet Office. March 2012.

[5] Scally, G., 2013. Chief medical officers: the need for public health at the heart of government. BMJ, *346*.

[6] Scally, G., 2020. The demise of Public Health England. BMJ 2020;370:m3263

SIGNED **DATE**

Please return to Inquiry@keepournhspublic.com

Thank you
Olivia O'Sullivan
Secretary to the panel
The People's Covid Inquiry

Inquiry@keepournhspublic.com