

MISCONDUCT IN PUBLIC OFFICE

Why did so many thousands
die unnecessarily?

Report of the People's
Covid Inquiry

December 2021

PEOPLE'S
COVID
INQUIRY



Learn lessons, save lives.

THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place fortnightly from 24 February-16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

1 December 2021

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MICHAEL MANSFIELD QC

Chair of the Inquiry Panel



What was the point of it all?

The phenomenon of the 'pandemic' is hardly novel. There is a long history of the planet being plagued; they are regular occurrences beginning with the first recorded in 430 BC through to the notorious Black Death (1350), bubonic plague during the life of Shakespeare in the mid-16th century, the Great Plague (1665), Cholera (1817), a sequence of severe influenza outbreaks – Russian (1889); Spanish (1918); Asian (1957); Swine (H1N1-2009) – and most recently and highly relevant, Severe Acute Respiratory Syndrome (SARS – 2003) and MERS (2012, spread from camels).

Anyone in government responsible for health and safety must have been aware of the risk of a pandemic recurrence. This responsibility is well-recognised by the tenets of international and domestic law. Internationally it is embraced by a number

of different instruments – the Universal Declaration on Human Rights (1948 Article 25); the Charter of the UN (Article 1 1945); the Constitutional provisions of the World Health Organisation (WHO) and the World Health Assembly (1946/1948 – creatures of the UN and engaging over 190 states), both committed to countering cross-border health threats and giving rise to the International Health Regulations (IHR 2005).

Of especial interest is the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). Articles 12 (1) and (2) read:

'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest standard of physical and mental health.'

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right SHALL include those necessary for ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.'

The United Kingdom ratified this treaty in 1976.

Domestic law reflects these obligations via the Human Rights Act 1996 (HRA) s6, by which the government must act in a manner compatible with the European Convention Articles (ECHR), for example Art 2, the Right to Life. Even more specific is the National Health Service Act 2006 s2A which imposes a duty to protect public health from diseases and other dangers to public health, and indicates appropriate steps which may be taken. Public Health England (PHE) was the executive arm of the Department of Health and Social Care (DHSC) dealing with this along with the Minister who bore ultimate responsibility,

Secretary of State for Health, Matt Hancock. Both PHE and Mr. Hancock have gone. PHE was replaced by the UK Health Security Agency in the summer of 2020. According to the government website this agency will be responsible for planning preventing and responding to external health threats and providing intellectual, scientific, and operational leadership at national, local, and global levels. It will ensure the nation can respond quickly and at greater scale to deal with pandemics and future threats.

So what has been going on up to now? Or is this an admission of failure?

Besides the general historical context described above, there were far more specific warnings which were either ignored, or put on the back burner. In 2006, the Government Office for Science predicted a global pandemic within the next 30 years due to a virus mutating from a wild animal to humans (zoonotic disease). Ten years later, in 2016, there were two exercises, the full details of which have not been made public until recently – Cygnus and Alice.

The details of Cygnus were eventually leaked after threats of legal action. The Health Minister at the time in the House of Lords, Lord Bethell, in June 2020 asserted that Cygnus-style simulations should remain secret ‘so that the unthinkable can be thought’. More machinations from a government which had lost the trust and confidence of the people.

They did not want the public to know that three years earlier the Cygnus report came to this conclusion:

‘The UK’s preparedness and response in terms of plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic

that will have a nationwide impact across all sectors.’

What the Health Secretary Mr. Hancock failed to reveal was that on top of Cygnus, in the same year there had been a number of exercises modelling different scenarios. Ten in all: some were for Ebola, some for flu – but one was for coronavirus, deriving its basis from a MERS outbreak caused by this virus. This too was kept secret. PHE and the Department of Health and Social Care were both centrally involved.

The Government should, therefore, have been well prepared for the eventuality that presented itself at the end of 2019. The NHS and social care infrastructure should not have been neglected and run down; effective in-date Personal Protective Equipment should have been readily stored and accessible; track and trace provision should have been anticipated as vital to basic public health measures; extra NHS hospital space carefully planned; an adequate NHS trained staffing complement at the ready; quarantine conditions and support sorted; strict border controls and isolation facilities programmed in advance. None of this is hindsight, as we make clear. This People’s Covid Inquiry report is unequivocal – dismal failure in the face of manifestly obvious risks.

Even if distracted by Brexit – or Shakespeare – the Government went on to miss, overlook, or ignore the more immediate warning signs, which, if acknowledged, could have made a real difference to outcomes. On 31 December 2019 China alerted the WHO about a cluster of what was thought to be pneumonia cases in Wuhan.

Of itself this was not perhaps overly concerning. However, events escalated in a way that was not entirely unexpected – especially given the exercises undertaken.

On the 10 January 2020 the World Health Organisation issued a technical guidance package on how to detect, test and manage a potential respiratory pathogen (SARS and MERS). On 12 January 2020 China shared the genetic sequence for SARS-CoV-2. On the 23 January Wuhan and other cities were in lockdown. By 30 January 2020 the WHO declared a global emergency and the following day, 31 January, the first two cases were confirmed in the United Kingdom.

Yet it is not until the end of March that Mr. Johnson gets his act together. The Government was caught seriously on the back foot and remained that way for the rest of 2020, as detailed in the evidence. There has been no accountability in any form, and it cannot be offset by the vaccine distributed by the NHS throughout 2021.

There was no consistent, comprehensive and coordinated plan of public health strategy. What leapt off the press conference page was the dilatory initial response; the absence of any effective track and trace system; the sheer waste of taxpayers' money ploughed into the pockets of private cronies; the contradictory messaging; the abject failure to provide PPE; the albatross of Nightingale hospitals; the lack of trained staff; the failure to utilise NHS primary care facilities; the misrepresentations about care home ringed protection; the parlous state of the NHS in the first place. Above all is the utter distrust of the public and the disrespect for the frontline workers, who, once the claps and saucepan fanfares had abated, were offered a 1%, below-inflation, pay rise for their life-endangered troubles.

The UK remains near the top of the death and infection rate table. Mr. Johnson says (15 November 2021) he cannot rule out

more of the same on-the-hoof policy for winter 2021. Yet again he was advised months ago to implement a controlled raft of well-recognised public health suppression measures that accommodate the ongoing threat without resorting to the spectacle of see-saw lockdowns and disruption.

This Inquiry performed a much-needed and urgent public service when the nation was hit by a catastrophic pandemic coincident with an unprecedented period of democratic deficiency. It afforded an opportunity for the beleaguered citizen to be heard; for the victims to be addressed; for the frontline workers to be recognised; and for independent experts to be respected. When it mattered most and when lives could have been saved, the various postures adopted by government could not sustain scrutiny. This was especially so when initially the Government thought the best thing would be to ignore the virus because overreaction could do more harm than good.

The Prime Minister initially rejected the idea of an independent public judicial inquiry into the COVID-19 pandemic. Pressed by the bereaved and others, he eventually conceded in the summer of 2020 that there would be one – but not until later. Months went by and nothing more was said until earlier this year when the bereaved repeated their request. Again rebuffed, the time was not right, and it would interfere with government work. Once a bevy of notables lent their weight to the glaring and urgent need, Mr. Johnson relented and announced that there would be one 'launched' in the Spring of 2022. More silence thereafter. Despite continued requests – no definition of 'launch', no date, no judge, no terms of reference, no infrastructure. Nothing. Nor is there now, as we head towards

publication of our report having conducted a four-month People's Inquiry in the Spring of 2021.

It was plain to Keep Our NHS Public (KONP), the organisers of the People's Covid Inquiry, that Government words were bloated hot air, hoping to delay and obfuscate. Within this narrative lies a theme of behaviour amounting to gross negligence by the Government, whether examined singularly or collectively. There were lives lost and lives devastated, which was foreseeable and preventable. From lack of preparation and coherent policy, unconscionable delay, through to preferred and wasteful procurement, to ministers themselves breaking the rules, the misconduct is earth-shattering.

The public deserves the truth, recognition, and admissions.

For behaviour to be categorised in criminal law as misconduct in public office, it must be serious enough to amount to an abuse of the public's trust in the office holder and

'must amount to an affront to the standing of the public office held. The threshold is a high one requiring conduct so far below acceptable standards as to amount to an abuse of the public's trust in the office holder.' (A-G Ref No3 2003 (Attorney General))

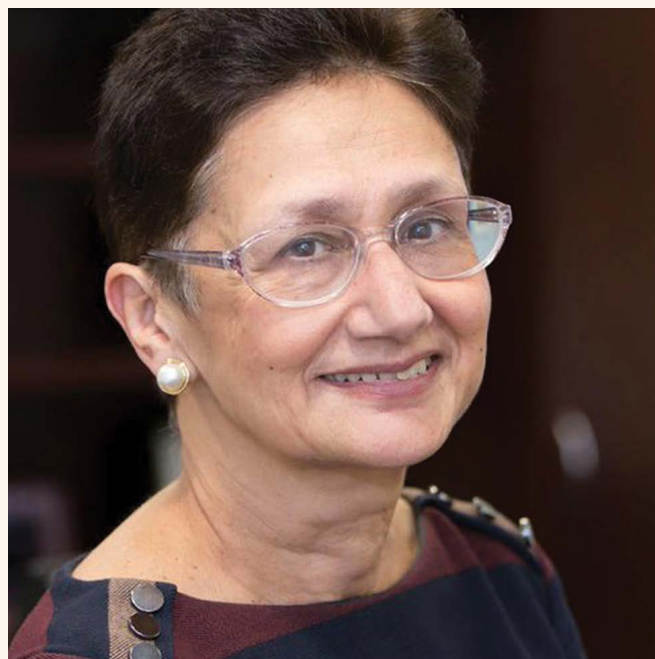
The test for a jury has been said to be whether the conduct is worthy of condemnation and punishment:

'Does it harm the public interest?' (LCJ in Chapman 2015)

16 November 2021

PROFESSOR NEENA MODI

**MB ChB MD FRCP FRCPCH
FFPM FMedSci**



The NHS was not well prepared for the pandemic. The UK COVID-19 death toll need not have been so high. The straitened circumstances of the NHS were an important contributor to what transpired.

The NHS entered the pandemic weakened by over a decade of austerity. Hospital capacity was among the lowest in Europe, staffing vacancies numbered 100,000, infrastructure had been allowed to decline, services were characterised by a poorly integrated patchwork of providers, including a growing number of for-profit providers, and staff morale had declined through years of underfunding, not having their voices heard, and the loss of colleagues as a consequence of Brexit. That the NHS was able to carry on during the pandemic was due to the commitment of front-line workers. Their sense of pride in delivering a vital UK service was restored by the recognition of the country.

This sense of pride has been under-recognised, and its worth under-estimated. NHS staff want, expect, and need decent salaries, but what sustains them is not the prospect of ever greater personal gain, but the knowledge that they provide a first-rate service, free at the point of need, available to all.

The acclaimed aspect of the UK pandemic response, the COVID-19 vaccine roll-out, was also largely due to the over and above commitment of NHS staff. However, instead of the pandemic being a wake-up call to invest in the NHS as a public service of vital importance to the UK population, and to strengthen the strong sense of united purpose and pride among the NHS workforce that is one of its greatest assets, the Government continued to favour and follow a policy of undermining the NHS by outsourcing to private providers.

The Government was well aware of the fragile state of UK health services. This led to the slogan 'protect the NHS'. Yet, instead of investing in NHS infrastructure that would be of value during and beyond the pandemic, for example by enabling general practitioners to provide telephone triage and on-line consultations with their patients, The Government side-lined primary care, by outsourcing to private providers of NHS 111 services. The lack of training of NHS 111 staff and reliance on untested algorithms contributed to the high numbers of deaths.

The UK COVID-19 death toll was also made worse by years of disinterest in, or deliberate neglect of the wider determinants of health. These inter-related factors encompass housing, education, child development, financial security, and work and environmental conditions, and act to increase or decrease an individual's risk of poor health. The failure to recognise and address health determinants has led to a

decline in the health of the UK population, a widening of health inequalities, and the consequent increased burden of COVID-19 mortality and morbidity falling upon the most disadvantaged sections of society.

The spread of the pandemic, and the death toll was also worsened by a poor public health response – the consequence of over a decade of reduced funding, loss of expertise, dissipation of services, and multiple reorganisations. However, the Government chose not to invest in strengthened public health systems, nor to redress past errors, or act on previous pandemic preparedness recommendations, including those of Exercise Cygnus in 2016, and chose not to restore a service that was once an international gold standard. Instead, the Government chose to outsource crucial test and trace operations, wasting £37bn on a failed system that exacerbated the spread of COVID-19, and increased the UK death toll, disbanded Public Health England and embarked, mid-pandemic, on yet another restructuring of public health provision.

Future resilience to health emergencies, no less the ability to cope with normal NHS requirements, requires a change in focus, direction, and strategy. The focus must be integrated investment in primary care, acute, community, mental health, public health, and social care services. The direction must be restoration of exemplary-quality, predominantly publicly provided and publicly delivered services. The strategy requires policies that address the wider determinants of health, and recognition that NHS workers want, deserve and need fair, stable, pay and conditions, but are driven to deliver their best by pride in the compassionate, equitable, public-sector service they provide.

10 November 2021

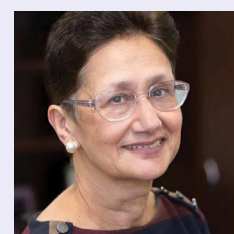
Michael Mansfield, chair of the panel

Michael Mansfield is an internationally renowned human rights lawyer. He has represented individuals, families, and groups in some of the most controversial legal cases the UK has seen: the Stephen Lawrence inquiry; the Bloody Sunday Inquiry; the Hillsborough disaster; Jean Charles de Menezes; the Marchioness inquiry and 'Shoot-to-kill' in N Ireland. He has chaired international people's tribunals on the Middle East; the Lewisham People's Commission on Lewisham Hospital and the North West London NHS Hospital Inquiry (Lewisham, Charing Cross and Ealing hospitals all saved from closure). He is currently heavily involved in the Grenfell Inquiry.



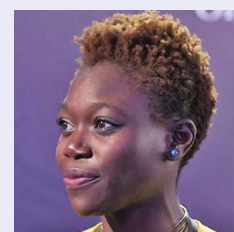
Professor Neena Modi, panel member

Neena Modi is Professor of Neonatal Medicine, Imperial College London and President of the British Medical Association. A leading researcher and fellow and member of council of the UK Academy of Medical Sciences, Neena has worked to improve children's health throughout her career. She is the immediate past-president of the UK Medical Women's Federation, and past-president of the UK Royal College of Paediatrics and Child Health.



Dr Tolullah Oni, panel member

Tolullah Oni is an Urban Epidemiologist & Public Health physician at the Medical Research Council Epidemiology Unit, University of Cambridge and Fellow of Wolfson College, Cambridge and the African Academy of Sciences. Tolullah was born in Lagos, studied in London and worked in South Africa for over 10 years. Her research, focused on ways to improve health in cities, has been profiled in The Lancet journal. She sits on the editorial board of The Lancet Planetary Health, Cities and Health, and PLOS Global Public health journals, serves as commissioner on the Global Commission for Post-Pandemic Policy and is a member of Independent SAGE.



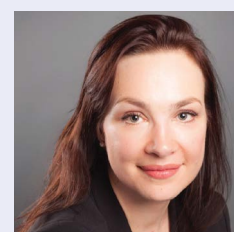
Dr Jacky Davis, panel member

Dr Jacky Davis is an NHS consultant radiologist at Whittington Hospital in North London. Jacky is a founder member of Keep Our NHS Public. She co-authored the books *NHS SOS: How the NHS Was Betrayed and How We Can Save It*, and *NHS For Sale*. Jacky is also a member of BMA Council.



Lorna Hackett, Counsel to the Inquiry

Lorna Hackett is a barrister and co-founder of Hackett & Dabbs LLP. She specialises in human rights and public law. She is committed to protecting the most vulnerable within society and has a strong track record in judicial review proceedings. She trains other barristers in advocacy and is a renowned public speaker on social justice and prisoners' rights.



ASCL	Association of School and College Leaders
BAME	Black, Asian and Minority Ethnic
BMA	British Medical Association
CAMHS	Child and Adolescent Mental Health Services
CCAS	COVID-19 Clinical Assessment Service; part of NHS 111
CHPI	Centre for Health in the Public Interest
Coronavirus	A family of viruses that cause illness in humans and animals; seven different types have been found in people, including the one causing COVID-19
COVID-19	The illness caused by being infected with SARS-CoV-2 virus
CQC	Care Quality Commission
DfE	Department for Education
DHSC	Department of Health and Social Care
DPH	Director of Public Health
DNACPR	Do Not Attempt Cardio-pulmonary Resuscitation agreement
DNAR	Do Not Attempt Resuscitation agreement
DPAC	Disabled People Against Cuts
DPIA	Data Protection Impact Assessment
DWP	Department of Work and Pensions
ECHR	European Convention on Human Rights
FFP2	Filtering Facepiece 2 PPE mask that filters at least 94% of airborne particles
FFP3	Filtering Facepiece 3 PPE masks that filters at least 99% of airborne particles
FRSM	Fluid resistant surgical masks; ineffective in filtering airborne particles
FTTIS	Find, Test, Trace, Isolate, Support
FOI	Freedom of Information
GDP	Gross domestic product (monetary measure of the market value of all the final goods and services produced in a specific time period)
HCW	Health Care Worker

HDU	High Dependency Unit
HSE	Health and Safety Executive
HMRC	Her Majesty's Revenue and Customs
ICNARC	Intensive Care National Audit and Research Centre
indie_SAGE	Independent Scientific Advisory Group for Emergencies
JBC	Joint Biosecurity Centre
ITU	Intensive Therapy Unit
Long covid	Not recovering for several weeks or months following the start of symptoms that were suggestive of covid, whether you were tested or not
MERS	Middle East Respiratory Syndrome
MRSA	Methicillin-resistant Staphylococcus aureus
NAO	National Audit Office
NEU	National Education Union
NHSE	NHS England
NHS 111	Single non-emergency number for medical advice in the United Kingdom
NICE	National Institute for Health and Care Excellence
NIHP	National Institute for Health Protection
NPC	National Pensioners Convention; the principal organisation representing pensioners in the UK
NPI	Non Pharmacological Intervention
OECD	Organization for Economic Cooperation and Development
ONS	Office for National Statistics
PCI	People's Covid Inquiry
PHE	Public Health England
PPE	Personal Protective Equipment (masks, gloves, gowns, eye protection)
PTSD	Post Traumatic Stress Disorder
RCPsych	Royal College of Psychiatrists

R number	The number of people each case infected on average: an R number > 1 means exponential growth of cases
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
SAGE	Scientific Advisory Group for Emergencies
SARS-CoV	Severe Acute Respiratory Syndrome coronavirus
SARS-CoV-2	Severe Acute Respiratory Syndrome coronavirus 2 (the cause of COVID-19)
SMR	Standardised Mortality Ratio; quantity of increase or decrease in mortality of a particular group with respect to the general population
SPI-B	Scientific Pandemic Insights Group on Behaviours
SSP	Statutory Sick Pay
TUC	Trades Union Congress
WBG	Women's Budget Group
WHO	World Health Organisation
UKHCA	UK Home Care Association
UKHSA	UK Health Security Agency
YouGov	International internet-based market research and data analytics firm based in UK

Pandemic strategies terminology

Exclusion	Maximum action to exclude disease e.g. some Pacific island territories
Elimination	Maximum action to exclude disease and eliminate community transmission for a defined period of time e.g. mainland China, Taiwan, New Zealand
Suppression	Action increased in stepwise and targeted manner to lower case numbers and outbreaks e.g. most of Europe and North America
Mitigation	Action taken to 'flatten the peak' to avoid overwhelming health services and protect the vulnerable, but not to stop community transmission e.g. Sweden (initially)
Eradication	Global eradication of a disease (smallpox is a rare example)

2020

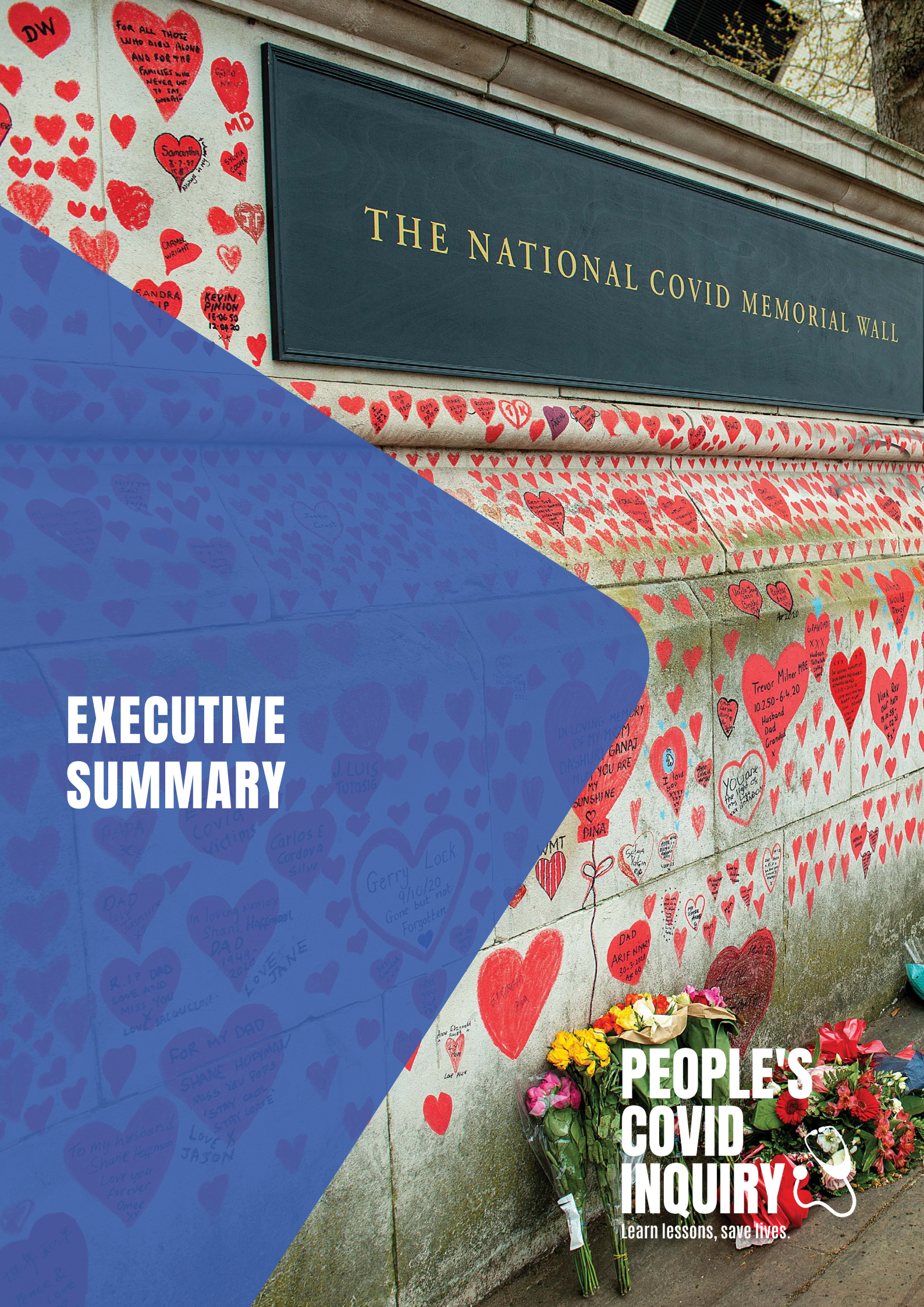
January 23	China lockdown of Wuhan, Hubei and other cities 2 months for UK government and Public Health England to prepare
January 24	Articles in The Lancet confirm evidence of dangerous new coronavirus in China
January 30	World Health Organisation declared global emergency
January 31	First UK case identified
February 28	First UK community transmission identified
March 10-13	Over 60k people per day allowed to mix at Jockey Club's Cheltenham Festival
March 11	World Health Organisation declared pandemic
March 11	50k allowed to attend Liverpool v Atletico Madrid football match at Anfield
March 12	initially rigorous testing and contact tracing abandoned
March 23	Imperial College London pandemic modelling suggested 200k deaths possible, prompting announcement of first UK lockdown
March 25	Coronavirus Act 2020 Royal Assent
March 25	Parliament suspended
March 26	First UK lockdown legally in force for three weeks (renewed 16 April)
April 21	Parliament reconvenes
June 23	First UK lockdown ends
July 4	First local lockdown – Leicester
September 2	Boris Johnson reiterates refusal to meet Bereaved Families for Justice
November 5	Second national lockdown in England announced
November 26	National Audit Office report: Investigation into government procurement during the COVID-19 pandemic
December 2	Second lockdown ends despite rising cases, notably in Kent
December 11	National Audit Office report: The government's approach to test and trace in England – interim report

December 26	Extension of Tier 4 restrictions across the country (from London and South East England announced 21.12.20)
December 21	Alpha variant of SARS-CoV-2 – B.1.1.7 (now VOC-20DEC-01) – identified as main factor in Kent, Southeast England and London (the ‘Kent’ variant’)
2021	
January 3	Prime Minister Johnson announces all primary children to return to school
January 6	Third England lockdown (reversing schools decisions) Milestone: ONS notes 150,000 covid-related deaths Report that £37bn spent on ‘test and trace’ has had no discernible impact on the pandemic
February 24	First session of the People’s Covid Inquiry (9 sessions to 16 June 2021)
March 8 & 29	Lifting third lockdown Step 1: schools, outdoor sports, social gatherings
March 10	Public Accounts Committee report: COVID-19: Test, track and trace (part 1) – no evidence Test and Trace investment had made any impact on virus spread
April 12	Lifting third lockdown Step 2: indoor leisure, outdoor attractions, hairdressers, outdoor hospitality, local holidays
April 15	Elective surgery waiting list reaches 4.7 million Bereaved Families for Justice Wall of Remembrance
May 17	Lifting third lockdown Step 3: social contact rules lifted, international travel
June 16	Ninth and final session of the People’s Covid Inquiry
June 21	Lifting third lockdown Step 4: nightclubs, theatre, weddings
July 7	People’s Covid Inquiry Preliminary Findings and Press conference
September 28	Boris Johnson finally meets Bereaved Families for Justice for the first time
October 12	Coronavirus: lessons learned to date. Report of the Joint Health & Social Care Committee and the Science & Technology Committee, House of Commons

- October 27** Public Accounts Committee report: Test and Trace update – ‘outcomes muddled ... a number of its professed aims ... overstated or not achieved.’
- October 31** Average daily UK deaths (within 28 days of Covid) rises from 111 to 169
- December 1** **People’s Covid Inquiry Report published**
- December 25** Deadline Boris Johnson set himself for announcing the chair of the public inquiry into the handling of the coronavirus pandemic

See also:

<https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf>



THE NATIONAL COVID MEMORIAL WALL

EXECUTIVE SUMMARY

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

INTRODUCTION

'The first responsibility of any Government is to protect its citizens.'
(Matt Hancock, ex-Secretary of State for Health & Social Care, August 2020)

'We truly did everything we could, and continue to do everything we can to minimise loss of life and suffering.'
(Prime Minister Boris Johnson January 2021)

'How many more people need to die, how many more lives need to be lost to this virus before we start to learn lessons and prevent further deaths, further tragedies? We have a tragedy on a national scale, unprecedented in our times, and still the Government is dragging their feet.' (Jean Adamson, Covid-19 Bereaved Families for Justice)

By June 2020 the UK already had the worst per capita death toll from COVID-19 in Europe, despite being the sixth richest nation in the world. By January 2021, the Office of National Statistics noted that the UK had reached the milestone of 150,000 COVID-19 related deaths and throughout February and March 2021 Britain had the worst global per capita death toll. It is, therefore, undeniable that, among the richest nations in the world, Britain's overall response has been among the worst in terms of avoidable deaths.

In the face of these appalling figures, many had hoped that the Westminster Government would heed calls from organisations such as the COVID-19 Justice for Bereaved Families for a public inquiry. It did not. Faced with the Government's refusal to set one up, the national campaign organisation Keep Our NHS Public felt that a public inquiry could

not wait until the pandemic was over and launched its own.

The People's Covid Inquiry began in January 2021. The Inquiry set out to investigate the shocking scale of this tragic loss of life with the aim of learning lessons as quickly as possible in order to save lives and to better protect the population.

The Government was informed of the inquiry on 23 February 2021 and invited to take part. No response was received.

The first session of the People's Covid Inquiry began on 24 February and convened in live sessions fortnightly until 16 June 2021. The Government was sent further invitations to engage with the Inquiry on 29 March and 18 May 2021. No response has been received to date.

The Inquiry took evidence over nine sessions from over 40 witnesses including international and UK experts, frontline workers, bereaved families, trade union leaders, and representatives of disabled people's and pensioners' organisations. The evidence heard was sometimes shocking, sometimes moving and always informative. The main findings are summarised below.

THE DECADE PRIOR TO THE PANDEMIC

The Inquiry heard that following the change of Government in 2010, the new Government's ambition was to 'roll back the state'. Public spending fell from 42% to 35% of GDP between 2010 and 2019, and the Government's 'austerity' and deficit reduction policies resulted in a slowing down of the social progress made in the previous decade. This was particularly the case for lower income groups. As a result, health inequalities increased, and health

gains slowed down or even stopped – ‘we lost a decade with regard to health equity’ (Professor Michael Marmot; report para 1.2.1- 1.2.8).

Since health equity* is a good marker for the state of a society, this meant that the UK was vulnerable when the pandemic struck, and this was reflected in the structural inequalities which emerged (report para 8.17; 8.22; 8.27).

‘There was a very, very high differential mortality gradient where the most disadvantaged groups have clearly been most vulnerable both to contracting Covid and to getting seriously ill and dying from it... I think there’s a clear relationship between those two - between what happened in the run up to 2020 and what happened during the pandemic itself.’ (Professor Jonathan Portes)

SPECIFIC FAILURES OF PANDEMIC PREPARATION

In 2006 the Government Office for Science predicted a global pandemic within the next 30 years, due to a virus mutating from a wild animal to humans. Despite this the Government did not act on the recommendations of Cygnus, their own pandemic preparedness exercise conducted in 2016, which showed that preparations were inadequate (report section 1.4). In the past there had been a number of planning exercises for emergencies such as pandemics but all such contingency planning was ‘stripped

out’ after 2010 with ‘local agencies left to make their own arrangements’.

At the same time public health services had been decimated after the Lansley ‘reforms’ of 2010 (para 1.4.2 – 1.4.5).

Evidence from previous pandemics such as SARS and MERS was also ignored, in particular that FFP3 masks would be needed for healthcare workers in the event of a pandemic, rather than basic surgical masks (report sections 5.1; 5.2; 5.3; 5.4).

THE STATE OF THE NHS PRIOR TO THE PANDEMIC

Numerous witnesses referred to the crisis already affecting the NHS prior to the pandemic (see report section 1.2). After a decade of investment in the NHS (2000 – 2010), the following decade saw the policies of ‘austerity’ and marketisation drag the service down. As a result, targets were routinely missed, waiting lists rose, and by 2019 the NHS was short of 100,000 staff, leading to a heavier work load. The number of hospital beds fell drastically with the result that at the start of the pandemic the UK had ‘one of the lowest beds-to-patient population ratios in Europe’. At the same time social care was also in crisis.

Particular reference was made to the dire state of learning disability and mental health services, including child and adolescent mental health services (CAMHS) (report section 1.3; para 4.26.6-4.24.9). There were already long-term problems involving staff shortages and lack of beds and other resources, but ‘things had definitely gone downhill’ in the decade prior to the pandemic. For example ‘very often there had been no beds available for children at significant risk’. Thus these services were already

* Inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources. Marmot uses the term inequities to describe those systematic inequalities between social groups that are judged to be avoidable by reasonable means and are not avoided, hence unfair.

in crisis and could not meet the 'surge of mental health referrals' during the pandemic.

Reference was also made to the Government's 'just in time' business model for procurement which delegated much of the procurement process to a 'complex web of external companies...The Government had allowed the private sector to take over' (report para 7.3.3). This meant that the system was too slow to respond when the pandemic arrived:

'The last decade has seen funding stripped from public health, local Government and the NHS, leading to increasing levels of ill health. The end result has placed an impossible burden on the NHS.' (Dr John Lister; report section 1.5)

'We weren't prepared. We didn't have the PPE, we didn't have the protocols, we didn't have the rapid response systems, we didn't have the infrastructure. I think that the NHS ...has been starved of funds for the last 12 years.' (Dr Chidi Ejimofe; report section 5.11)

THE STATE OF PUBLIC HEALTH PRIOR TO THE PANDEMIC

Public health doctors and others noted that one of the reasons that the country was unprepared for a pandemic was because public health structures were 'decimated' after the Lansley reforms in 2010, when a new structure, Public Health England, was introduced. There was a 'plethora of evidence' that public health had been in decline in the subsequent decade, with a 'significant shift away from public health, unprecedented in the last 100 – 150 years'. During this time many of the organisations and structures responsible for planning services relevant

to a pandemic were weakened or abolished:

'Public health in general became a lesser interest of the Government. If the system had been operating well and run by public health people....we would have coped much better. We have Governments that have no real interest in the health of the population.' (Professor Gabriel Scally; para 1.42 – 1.47)

THE STATE OF OTHER PUBLIC SERVICES INCLUDING SOCIAL CARE AND EDUCATION PRIOR TO THE PANDEMIC

The inquiry heard that other public services besides the NHS were also in crisis before the pandemic – 'the system was already at breaking point'. Social care was estimated to have 110,000 vacancies at the start of the pandemic and in particular care homes had been struggling for some time due to underfunding and staff shortages. The National Pensioners' Convention begged the Government for years to reform and properly fund social care but the 'arrogant or incompetent' Government had never replied to any of their letters (report section 2.8; 4.9).

At the same time school funding was cut 'dramatically' and the schools with the poorest children suffered the largest cuts. As Professor Marmot was prompted to ask when considering the social determinants of health: 'What genius decided the best way to use public money would be to reduce spending per pupil on education?' (section 1.2). Class sizes had to increase, with no compensatory increase in space, which meant social distancing was more difficult than in other countries during the pandemic (section 4.25).

NORMAL RESPONSES TO A PANDEMIC

Public health doctors and others were unanimous in their views on what constituted normal public health strategies in response to a pandemic (sections 2.1; 2.3; 3.2). Since it is not possible to eradicate the virus, the best strategy is to attempt to eliminate it through well-established public health measures. WHO advice about this was very basic – to find the virus, isolate those who have it, trace and test their contacts and to act fast. Lockdown may be used until a find test, trace, isolate and support (FTTIS) system is in place, and closing the borders would be part of that lockdown process. Other countries such as New Zealand, Australia and Greece did this early on, with returning citizens subject to strict quarantine.

Many Governments responded in this way after Chinese scientists published an article in *The Lancet* (23.1.20) with information about the virus, including the infectivity rate and death rate. The inquiry heard from a professor of public health in Otago (report section 2.4) that New Zealand started out with a strategy of mitigation, but quickly moved to elimination after seeing the success of many Asian countries. They instituted a lockdown when there were only 100 cases (and no deaths) in the country, and achieved elimination of the virus after 7 weeks. Since then they had enjoyed ‘zero covid’ (defined as 28 days without covid in the community against a background of high level testing) for most of the previous year. Those countries which refused to tolerate virus circulating in the community had much lower mortality rates than the UK and less economic contraction.

Experts felt that repeated lockdowns represented a failure to implement basic public health measures (section 2.1).

THE GOVERNMENT’S RESPONSE TO THE PANDEMIC

Many witnesses commented that one of the Government’s major mistakes was not acting quickly enough. They were not ‘engaged’ and they appeared to have no understanding of the risks the country faced. There was particular criticism of the Prime Minister, Boris Johnson, especially what was perceived as his cavalier attitude, boasting about shaking hands with Covid patients, and the fact that he didn’t attend the first 5 COBRA meetings. His attention seemed to be ‘elsewhere’:

‘The Government wasn’t on top of this in January/February. The Prime Minister wasn’t talking about it. And he’s a very strong leader of his party, and therefore the Government. And if he wasn’t engaged, I suspected the Government wasn’t engaged. Or it had a different agenda.’ (Stephen Cowan, leader of Hammersmith and Fulham Council; section 8.3)

‘My family had to sit and watch my Dad die for two weeks, and then you see the leader of the country stand up and make jokes about the fact that people are being robbed of their breath. He also called on (health care workers) to risk their lives and then decided not to provide the support they needed.’ (Lobby Akinola, Covid-19 Bereaved Families for Justice; para 2.17; 4.52)

As a result they failed to establish a functioning FTTIS or to close the borders as other countries had done. They knew in February 2020 that there was a likely 80% infection rate and a 1% mortality for Covid and by the start of March 202 it was clear that cases were doubling every 3-4 days, but the UK only locked down on the 23 March 2020. One witness felt that if we

had gone into lockdown two weeks earlier then the spread of the virus would have been ‘massively less’ and far fewer lives lost (para 4.1.1). Meanwhile, large sporting events continued and several witnesses concluded that the Government originally intended to go for a ‘take it on the chin’ strategy of herd immunity, despite the predicted death toll if they did (sections 2.1; 3.3; 8.1). By April and May 2020 hospitals were being overwhelmed, which would have been much less likely with an earlier lockdown.

The Government was also criticised for ‘exceptionalism’, rejecting public health measures that other countries were taking to get on top of the virus as ‘only appropriate for low and middle-income countries’ and not following WHO advice, which was deemed to be only for ‘developing countries’ (para 8.2.13-15).

The Government acted from the beginning as though large scale deaths were inevitable, with Johnson warning in March 2020 (before the lockdown was announced) that many more families were ‘going to lose loved ones before their time’. However, other countries including densely populated ones, managed to avoid the high death rate seen in the UK.

Witnesses criticised the Government’s apparent willingness to trade off the nation’s health against the nation’s economy. They felt that it was better to take whatever measures were necessary to address the health crisis, even at the cost of economic output in the short term, because the alternative of not dealing effectively with it would lead to greater and longer term economic losses (section 8.1).

‘The trade-off between the economy and public health is a false one. The smaller the mortality from Covid the smaller

the hit to the economy ...’ (Professor Sir Michael Marmot, section 1.2)

One witness felt that the Government’s response amounted to ‘negligent manslaughter’, in fact not even negligent in that the Government was fully informed of the risk to public health, of suffering and mass deaths, but went ahead anyway.

Finally there was concern that the Government had decided to ‘put all its eggs in one vaccine basket’, in other words to trust to vaccines alone to get the country out of the pandemic, rather than continuing with basic public health measures alongside a vaccination programme.

FAILURE TO SET UP A FUNCTIONING FIND, TEST, TRACE, ISOLATE AND SUPPORT (FTTIS) SYSTEM

‘We have a growing confidence that we will have a test track and trace system that will be world beating and it will be in place by 1 June 2020.’ (Boris Johnson to Parliament 20.5.20)

‘From the beginning we have never had a proper FTTIS.’ (Professor Sir David King)

A number of witnesses highlighted the importance of FTTIS and the consequences of its ‘abysmal failure’ (sections 2.3; 7.5). A successful FTTIS depends on early implementation, rapid identification of cases, rapid contact tracing and supporting people to isolate. This is a basic public health response to a pandemic but the Government had already abandoned widespread testing by March 2020, due to a lack of capacity.

For a long period there was no functioning FTTIS, the Government having failed 4 times to launch one. ‘For some reason’ the

Government persistently ignored 44 public health laboratories and finally employed private sector firms to set up a parallel system of testing sites. Companies were brought in who had 'no experience of how to run these services' (section 7.5):

'We at iSAGE were simply amazed. In the middle of the biggest pandemic in over 100 years we set up private companies with no healthcare experience to run [the FTTIS] from scratch. I believe that was a disastrous decision.' (Professor Sir David King)

There were many problems with this 'bizarre and ineffective model'. The system was centralised and not integrated with primary care (section 2.3, 2.4). Patients were told to travel hundreds of miles for their tests and results didn't get to GPs. It resulted in 'unimaginable costs' and yet witnesses said that it had never worked effectively:

'Several multiples of funding of what primary care gets in a year have gone to Test and Trace which doesn't seem to have helped at all.'

Witnesses including GPs felt that primary care, together with public health partners, could have taken on FTTIS if properly resourced. GPs are trusted by their communities and thus understand how to reach them and what messaging to use, especially with immigrant and lower socio-economic groups. They would also have had a better understanding of who to test when capacity was low.

Lack of testing early on meant frontline staff had to isolate unnecessarily, leading to acute staffing shortages in the NHS and in care homes.

Finally there was repeated criticism of the failure to support those who did have to

isolate, especially financially. This meant that often the chain of infection wasn't broken when workers had to choose between isolating or food on the table for their families (section 8.2).

Witnesses contrasted the failure of the outsourced FTTIS system with the success of the vaccination programme, which had been run by the NHS.

LACK OF RESOURCES

'The issue with PPE was so appalling, they (ITU) were receiving second-hand PPE, some of which had blood on it.' (Michael Rosen, author)

The lack of essential resources was a recurrent theme throughout the inquiry. Stocks of personal protective equipment (PPE) were already 'massively run down' before the pandemic, and the Government did not take advantage of a short grace period to obtain more before the pandemic arrived in the UK. On the contrary it shipped quantities of PPE to China in February 2020 (section 7.8):

'We thought – this is major, and waited for something to happen in the UK. We saw only absolute inaction.' (Dr Michelle Dawson)

The consequence was 'an abject failure' to protect front line workers, including those in care homes, who were forced to see Covid patients without any protection. Staff were photographed wearing bin bags and other makeshift items, and this played 'a significant role in hospital acquired infection' at the beginning, both for staff and patients. (Bereaved Families for Justice for instance reported that their members estimated that 40% of their loved ones had contracted Covid in hospital). Many staff had to find their own PPE, and

described donations coming from local businesses. The Government eventually punished hospitals which were forced to source and pay for PPE outside the NHS supply chain by refusing to reimburse them for it, which put the hospitals out-of-pocket to the tune of ‘tens of millions of pounds’ per hospital (para 7.8.12).

Hospices and care homes have different supply routes and got no response from a promised ‘hotline’. One witness described being faced with having to send their ‘profoundly vulnerable dying patients’ back home (section 4.19):

‘We were talking to local businesses, veterinary practices, anyone we could think of because we couldn’t get them from Government. It was a complete dereliction of duty.’ (Dr Rachel Clarke)

Advice about PPE changed 40 times in 6 months and there was a strong suspicion that the Government ‘rationalised the rationing’ i.e. tailored the advice to avoid admitting to the shortages (section 5.4). There was criticism of the Government’s failure to distribute PPE more widely in the second wave, instead of which billions of pounds’ worth of PPE were ‘sitting in thousands of containers in Felixstowe docks’:

‘I can’t describe how desperate it was. Porters, who are usually on zero hours contracts, were still having to move infected bodies, with no body bag, no mask and no gown. Every single day, there was an NHS worker in tears in the changing room. We saw colleagues dying. And we were terrified we would be the next one. And you just have to keep going, keep working.’ (Dr Michelle Dawson; section 7.8)

COVID CLINICAL ASSESSMENT SERVICE (NHS 111)

Several witnesses talked of failures involving NHS 111’s Covid triage service (sections 2.7; 4.4; 7.4). The Government made a decision that all Covid calls would go through NHS 111, thus bypassing ‘one of the best primary care systems in the world’. Patients were told ‘very strongly’ to ring NHS 111 and not to trouble their GPs.

The Covid response service was outsourced at the beginning of the pandemic. There was very limited training for staff, with a steep learning curve and ‘inflexible scripted questions’ which didn’t take account of the very varied symptoms of Covid. It was not always understood that patients could be dangerously short of oxygen without being breathless. Particular mention was made of inappropriate questions about whether callers’ lips were blue (as an indicator of hypoxia), which was misleading and inappropriate for Black people.

Many who needed hospital treatment were told to ‘stay at home and take paracetamol’ with the result that some patients died at home without ever having seen a doctor:

‘I have a horrible feeling that if some patients had been passed on to their GPs we might have saved some lives. People died at home because they didn’t get the medical attention they needed quickly enough.’ (Dr Helen Salisbury)

LACK OF COHERENT GUIDANCE AND POOR MESSAGING

Witnesses felt that guidance from central Government was often lacking. When it did finally materialise, it was incoherent and ‘not fit for purpose’. For instance, local Government ‘found themselves in the front line’ and had to take matters into their own hands in the absence of guidance from the centre, while on London Underground the unions eventually took charge of protecting workers when Government guidance was not forthcoming (sections 5.8; 5.11):

‘We were having to create our own guidance, we weren’t getting anything nationally.’ (Dr Chidi Ejimofa)

‘Eat out to help out’ (Para 2.4.3) was mentioned as a policy that had made no sense to frontline workers (and had probably been responsible for a sixth of new Covid case clusters in the summer of 2020).

Government messaging was also heavily criticised as being ‘woeful’ (section 4.7). It was often unclear, confusing, contradictory or just plain wrong. For instance, 96% of people had understood the message to ‘stay at home’ but only 30% thought they understood ‘stay alert’, because ‘what on earth does that mean?’. Witnesses also instanced the huge spike of avoidable deaths in January after opening up for Christmas, and because of the message ‘Stay home, protect the NHS’. Many did stay at home, either because they didn’t want to burden the NHS or because they were afraid of going into A&E departments. This resulted in excess deaths, either from acute illnesses such as heart attack and stroke, or late presentation of serious illnesses such as cancer. Experts warned

the Government about this but the Government ignored the warning.

Witnesses felt that messaging for minority ethnic groups had been ‘poor to non-existent’. Minority ethnic patients have specific needs, in particular due to poor experiences in accessing health care and poorer health outcomes and communication with them throughout the pandemic had been ‘wholly unacceptable’.

Finally, there was a feeling that the Government had tried to blame businesses, care homes, employers and individuals for Government failings (section 4.7):

‘Now their narrative of “responsibility” is effectively saying “We wash our hands of this, it’s over to you. And if things go wrong, it’s your fault.”’ (Professor Steven Reicher)

FAILURE TO CONSULT OR TAKE ADVICE

Witnesses felt the Government had shown a blatant mistrust of professionals and experts (section 8.1). A wide range of individuals and organisations including public health experts, teachers’ unions and local Government complained that the Government had never consulted them nor heeded their advice either before or during the pandemic. Prior to the pandemic the National Pensioners Convention (section 2.8) wrote repeatedly to the Government about reforming and funding social care but never heard back while health unions had drawn attention to problems with the NHS to no avail.

During the pandemic itself the Government did not consult staff involved in mental health care nor those responsible for at risk patients in the community about their special needs. At no stage did the

Government talk to or take advice from the teaching unions – ‘we were completely blanked by the Prime Minister’. One witness believed that if the Government had listened there would have been less disruption of education and fewer deaths.

Finally, the Government, having put their faith in technology rather than basic public health measures, did not consult the experts in those technologies.

FAILURE TO TRUST

Witnesses felt that the Government’s failure to consult and take advice was grounded in distrust of professionals and experts. For instance, they didn’t trust GPs, the NHS and public health to run FTTIS. They particularly regretted the Government’s failure to trust the public during the pandemic. Instead, the Government had viewed the public as ‘a problem’ with a poor grasp on reality and unable to deal with the crisis. In fact, research and evidence show that people tend to come together and support each other in a crisis, and that mutual support is critical to any public response (section 4.7). As a result of this distrust the Government never tried to mobilise the public, communities, or the 750,000 volunteers to take more control of the situation once the pandemic struck, but rather just told them what to do.

The Government also made a serious mistake in accepting advice early on ‘from non-behavioural scientists’ that the British public could not cope with a lock down, and delayed locking down, resulting in tens of thousands of avoidable deaths (section 4.7):

(The Government’s) paternalist psychology, that people are weak and frail and can’t do things for themselves,

their positioning of their best asset, the public, as a problem, is one of the fundamental failures of this whole pandemic.’ (Professor Steven Reicher)

FAILURE TO BE HONEST

Several witnesses mentioned the fact that the Government suppressed or manipulated data in their dealings with the public. There was also concern about a ‘data grab’ in which it was felt that the Government hadn’t been transparent with the public (see below).

PRIVATE SECTOR PRIORITISED OVER NHS

We have already described the Government’s ‘disastrous decision’ to bypass the NHS and use the private sector to run the FTTIS system (section 7.5). This has thus far cost the tax payer £37 billion without, according to the Public Accounts Committee, making a measurable difference to the pandemic despite its ‘unimaginable’ costs. But this is not the only instance of the Government turning to the private sector either because it had run down the NHS to the point where it couldn’t respond to the pandemic adequately or because they preferred to use the private sector even when the NHS could have stepped up.

Austerity and marketisation had already weakened the NHS over the previous decade, so that it went into the pandemic with too few beds and staff and a crumbling infrastructure (section 1.5). As a result the Government had to arrange for extra hospital beds to deal with the anticipated demand, and took out a contract with 26 private health companies to block book the entire capacity of their hospitals (section 7.2).

The inquiry heard that there was ‘a real problem of transparency’ about how much the Government paid for the contract and how much of the capacity had actually been used. The think tank CHPI estimated that on average there was one Covid patient per day in the private beds, while the contract was thought to be costing the tax payer between £170 million and £400 million a month. While being very poor value for money the contract allowed the private hospitals to survive the effects of the pandemic so that they were now in a good position to deal with the backlog of non-Covid work, both via the NHS and via private demand:

‘What we’ve seen is a subsidy going into the private hospital sector to help it survive the initial effects of the pandemic, and now, potentially, to help it thrive as a result of the increased demand for health care.’ (Professor David McCoy)

To this end the Government will continue to set aside money to pay for NHS patients to be seen in the private sector to the tune of £2.5 billion a year for the next four years, double the amount spent in 2018 and 2019. Witnesses said this money should be going to boost the capacity of the NHS rather than the private sector.

The Government also built 7 Nightingale hospitals to deal with Covid patients, at a cost of over £530 million, at least £50 million of which went to private companies (para 2.8.6; 5.11.11). They didn’t discuss them with NHS staff, who could have pointed out that there was no one to staff them. As a result they only treated a handful of patients between them.

A Labour MP described how the Government had launched the Leamington ‘Lighthouse Project’ to build a ‘megablab’ in his constituency (the latest of 9-10

such megalabs contracted to private and private public partnerships parallel to the NHS; section 7.6). He questioned why the Government had chosen to set up a brand-new laboratory instead of expanding local NHS pathology services, and expressed concerns about the quality standards of the facility. There had been a total lack of transparency around the project, and the contract was awarded without going out to tender:

‘There have been too many failures and too much taxpayers’ money squandered by this Government for us to allow ministers to avoid accountability in the way they are at the moment.’ (Matt Western, Labour MP)

CORRUPT CONTRACT PROCESSES

Witnesses also expressed dismay about the lack of transparency around the awarding of contracts during the pandemic. As with the Lighthouse Project described above, some were awarded without being put out to tender and to people who had little or no relevant experience. A witness who set up a charity to obtain PPE described how the Government failed to take up contracts she had managed to negotiate for millions of items of PPE, with the result that at a time of acute shortage the items were sold to other countries (section 7.8):

‘We spoke directly to the Cabinet Office, we sent them the correct paperwork. And I followed it up a week later, and nothing had happened. Those masks could not be held and so they were sold to Germany, because they were fit for purpose... I wasn’t a VIP, I didn’t have access to the VIP lane. And it wasn’t followed up.’ (Dr Michelle Dawson)

Over 70 companies contacted the BMA to say they could supply high quality PPE but had received no response from the Government (section 7.8). The BMA forwarded these offers to the Department of Health but had no reply. Money spent on the procurement of PPE was clearly ‘hugely wasteful and occasionally corrupt’:

‘They opened up high priority lanes that led to fast-track contracts. It wasn’t what you knew but who you knew in Government...contracts were handed out to firms that had no history of making PPE or medical grade equipment. There is a clear history of lack of transparency, waste and cronyism surrounding the Government’s contracting process throughout the pandemic.’ (Dr David Wrigley)

THE COVID-19 DATA STORE

The inquiry heard about ‘an unprecedented collection of NHS data’, collated nationally and held in a single place, called the COVID-19 data store (section 7.10)*. This had been set up in March 2020 through contracts with US tech giants like Google and Amazon. The Government had released no details, but it was believed that all GP records would go into the store unless patients opted out. Unfortunately, most patients know nothing about it as there has been very little publicity and no consultation:

‘The data protection laws require your explicit consent to what happens with your data. The obligation is on the Secretary of State and NHS digital to seek your consent and to notify you about this proposal. Currently their notification is simply a web page, and

a link to how you can opt out.’ (Rosa Curling)

NHS data is extremely valuable to the commercial sector, who know that the NHS, with its highly centralised system, and its unique mass of health data, provides extraordinary opportunities from which to profit.

There was significant concern about how secure people’s confidential health data would be with these tech giants, who would be able to access it and whether the public could prevent their data from being used for private profit. (Since the Inquiry, NHSE Digital have been forced to postpone from 1st July to 1st September and then postpone again without a date; para 7.10.9).

THE EFFECTS OF THE PANDEMIC ON PARTICULAR GROUPS

The Inquiry heard from a wide range of individuals and organisations representing groups who had suffered particularly badly during the pandemic (section 5.5).

Witnesses testified to the fact that there was ‘an abject failure’ to protect NHS workers (section 5.1). The principal determinant of dying from the disease was catching it, and therefore depended on exposure to the virus. Unforgivably there was a failure to provide adequate PPE to those exposed with the result that front line NHS workers had a seven-fold increase in their risk of getting (and thus dying from) COVID-19 (over 850 died between March and December 2020). Guidance around PPE had changed frequently.

The NHS started the pandemic 100,000 staff short. This, combined with a lack of testing in the early days, meant that

* <https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/covid-19-response/nhs-covid-19-data-store/>

staffing was at times ‘the worst I’ve ever seen it’, with instances of one nurse to 21 patients. As the pandemic progressed some of the work force who had ‘been in the trenches’ for months, and seen colleagues severely ill and dying from Covid, would no longer accept the dangerous working conditions.

Others suffered burnout, moral injury and post-traumatic stress disorder (sections 5.1, 5.12). Burn out involved emotional exhaustion and arose from working long hours in stressful conditions. Moral injury gave rise to feelings of distress and guilt as a result of being asked to do a job to a standard that was not acceptable:

‘I feel hugely let down by the Government, cannon fodder absolutely nails it.’ (quoted by Sumner, para 5.12.1)

‘You care about your job, you want to do it well, you don’t go into nursing to potentially harm people, but that’s how it feels sometimes. You’re put into situations where you can’t do a decent job, and it isn’t safe.’ (Kirsty Brewerton)

One witness felt that staff would give up the ‘insulting’ 1% pay rise offer if they could only get the resources to do their jobs properly:

‘We worked for peanuts with our flimsy PPE, crossing our fingers, we can beat it, the Government sicken me with their lack of empathy. 30% pay rise for them and a clap for us. What a mug I was for being a nurse.’ (NHS nurse)

Despite the widespread burnout and moral injury there was little or no attempt to offer routine risk assessments or support for mental health or other problems, and when risk assessments were instituted after a ‘groundswell’ of protests they were

criticised as tick box exercises (section 5.12):

‘When we asked our participants during the interviews, how they were doing, many of them said, “God, that’s the first time somebody’s asked me that”, and really broke down, were really, really emotional.’ (Dr Elaine Kinsella)

Many frontline NHS staff are poorly paid, women and/or minority ethnic workers on minimum pay and conditions, and don’t have the luxury of working from home and many felt they couldn’t afford to self-isolate (section 3.8; 6.0; 6.7). There was also particular concern about minority ethnic NHS staff who were dying at much higher rates. It was already known before the pandemic that they were more at risk of discrimination, bullying, and harassment and therefore knew that if they raised concerns once the pandemic began, they were the least likely to be heard or acted upon:

‘It’s hard and dangerous work. And for people to do that hard and dangerous work every day, they need to know that it’s worth it and that it means something. But they are starting to feel hopeless, they are starting to feel that they have lost the point, they’ve lost the drive to keep working.’ (Dr Rachel Sumner)

FRONT LINE WORKERS LET DOWN

The pandemic exposed who the real ‘essential workers’ are in a crisis – teachers, transport workers, care home staff, hospital porters, supermarket shelf stackers (section 5.8). As with the NHS, many are poorly paid, living in deprivation, some on zero hours contracts and unable to work from home. Not only were they exposed to Covid on the front line, often with inadequate or no PPE, but many fell

into other risk categories such as poverty, co-morbidity, obesity, ethnicity, and living in crowded accommodation (sections 6.1 – 6.5).

If asked to self-isolate they were faced with having to live on £95/week and many felt they couldn't afford to stay at home (section 4.8). One private contractor was refusing to pay even minimum wages to any worker testing positive. The Government was severely criticised by many witnesses for not giving financial support to poorly paid workers who needed to self-isolate (section 8.2):

'The biggest obvious policy error has been the failure to raise sick pay or to put in place an effective system of sick pay that incentivises people ... to take time off work to self-isolate. That has been a real false economy, which has undoubtedly inhibited the effectiveness of Test and Trace, and therefore probably led to more people getting sick than needed to be, prolonging the pandemic unnecessarily.' (Professor Jonathan Portes)

Often employers shirked responsibility for making work places safe, and it was up to trade unions to establish Covid safe environments and to look at risk assessment especially for minority ethnic workers (sections 5.8. 5.9). For example bus drivers working for private companies had to take their own safety measures such as erecting plastic screens and closing access via the front doors of buses. One employer, Aviva, sent out a notice saying these measures had not been agreed and threatening disciplinary action if they continued

'Bus drivers told me they were just totally abandoned. The lack of any safety measures to protect the drivers was quite astonishing ...the horrific death toll

of London bus drivers was tragic.' (Unjum Mirza)

Workers on London Underground (section 5.8), largely in public hands, still had to fight for fundamental protections such as masks and hand gel, and to get their cabs cleaned properly. Finally they had to threaten that they would not take the trains out if they weren't supported in these basic public health measures. Once again there was little or no attempt to do any risk assessments

The consequences have been shocking: in London alone, within a month of lockdown, 21 transport workers had died from COVID-19.* Sadiq Khan said 88 transport workers, including 51 bus drivers had died from COVID-19 (May 2021**).

There were concerns about confusing guidelines for the reporting of covid contracted through occupational exposure and a fear that not only were the numbers of health workers with Covid underreported but a vital opportunity to investigate such cases had been missed (section 5.7). Even so HSE received about 25,000 such reports, the vast majority of which hadn't been investigated:

'The employer has an obligation to take steps to protect their workers. People who take this burden (of Covid exposure) by virtue of their work on behalf of society, deserve that level of protection as a precondition and the right levels of personal protection, as well as the vaccine, as a fundamental right.' (Professor Raymond Agius)

* <https://www.standard.co.uk/news/london/transport-london-21-coronavirus-deaths-mayor-sadiq-khan-a4413431.html>

** <https://www.london.gov.uk/questions/2021/1345>

CHILDREN AND YOUNG PEOPLE

The inquiry heard that the UK had had the longest periods of closure or near closure of education (section 4.2.4). As noted above the Government failed to consult the profession and ignored its recommendations for dealing with the crisis:

'Our schools were largely closed for much the longest period, and I think that is a record of failure by this Government.'
(Kevin Courtney)

School funding was cut 'dramatically' after 2015, and the schools with the poorest children had suffered the largest cuts. As a result, class sizes increased to where they were 40 years ago, without any compensatory increase in space. Thus, social distancing was much harder than in other countries, and schools suffered more disruption. There was inadequate ventilation in most schools, with no moves to improve the situation and there was a shortage of PPE for teachers, who felt vulnerable.

Other problems had interrupted children's education, including the failure to deliver laptops and broadband, and the determination of exam grades by 'mutant algorithms', which had been 'a farce' and very stressful for pupils. Children from poor homes had been particularly badly affected by the pandemic as they typically had little space and few resources at home, and their parents were less likely to work from home:

'Teachers see the differential impact that social class and inequality has had. It's a fundamental issue that has to be addressed. There are massively discriminatory impacts of the school closures, the school disruption. The Government has to work with us to put

those things right, not only as a result of Covid, but also the inequality that existed pre-Covid, that was shown up during Covid.' (Kevin Courtney)

The pandemic exacerbated many mental health problems in children and adolescents, and following the first lock down there was a surge of mental health referrals. These commonly involved eating disorders, depression and self-harm, problems which thrive on isolation. Many children were also very stressed over missing so much schooling. Unfortunately Child and Adolescent Mental Health Services already had too few resources and were not able to cope with the increased demand:

'[They impact on] generations to come. We know that what a young person experiences today is going to have an impact on how they parent their children.'
(Rachel Ambrose)

Finally there was harsh criticism of the Government's response to a request for the funding needed to address the damage done to children's education during the pandemic (section 4.25). It had been estimated by the Institute for Fiscal Studies that this could represent a cost to the country of £350 billion over the next 40 years, but when the Education Policy Institute proposed an initial catch-up programme of £15 billion the Government's response had been to offer 10% of that ie £1.5 billion. Given the economic and social case for funding catch up, especially for the most disadvantaged, it was 'almost impossible' to see what the justification for that decision was. Government appointee Kevan Collins had resigned in protest.*

'I really find the Government's decision on this almost incomprehensible from

* <https://www.thetimes.co.uk/article/downing-st-must-take-the-blame-say-critics-as-kevan-collins-quits-7sl879mvw>

almost any perspective.’ (Professor Jonathan Portes)

AT RISK GROUPS

‘We all face the same storm but we are not all in the same boat.’ (Dr Sonia Adesara, after Damian Barr)

The elderly (sections 4.8, 419), the disabled and those with mental health problems and learning difficulties (section 4.20, 423) were all especially at risk during the pandemic and they died in disproportionate numbers.

Witnesses emphatically rejected the Government’s claim that they put a ‘protective ring’ around care homes. On the contrary, elderly people living in care homes were 3 times more likely to die of COVID-19 than those living in the community, and it was estimated that 25% of Covid deaths had occurred in care home residents.

‘The devastation that care home residents have suffered, are still suffering, is unacceptable. It shouldn’t have happened, needn’t have happened and should never happen again.’ (Jan Shortt)

When the pandemic threatened, older people were discharged from hospital back to their care homes without being tested for SARS-CoV2. Care home staff didn’t have adequate PPE or testing available, and consequently were catching Covid and moving between homes. Care homes, like prisons and cruise ships, were ‘institutional amplifiers’ and once introduced, infection spread very quickly in them (para 4.10.3):

‘In our modern economy prisons, care homes, and immigrant detention centres are a means of monetising the storage of human beings. They have a different set

of objectives and the idea that they’re there to look after people is missing the point. They are essentially financial vehicles, which happen to have people in them.’ (Professor Martin McKee)

While the disabled make up 20% of the population, they have also been disproportionately affected by Covid, accounting for almost 60% of deaths by November 2020 (section 4.20. 4.23).

Many older disabled people and those with learning difficulties live in care homes or supported living settings. Like the elderly they suffered because patients were discharged from hospitals into these settings without being tested for Covid, and also because of a lack of PPE and poor social distancing. In addition there is a historic link between disability and poverty. Disabled people are three times more likely to live with severe material deprivation, and as a result those who worked couldn’t afford to stay at home and shield.

Lastly, long standing unequal access to healthcare for the disabled was exacerbated by the pandemic. The clinical frailty score was used ‘overzealously’ to limit disabled people’s access to hospital and ITU because the Government wanted to avoid images, such as those that came out of Italy, which suggested that they had lost control of the pandemic. Withholding treatment and keeping people out of hospital was one way of doing that:

The inquiry heard that the learning difficulties/mental health needs communities were also largely forgotten about in the pandemic:

‘It makes me angry. Boris Johnson has forgotten this whole group of people who have died at six times the rate of their peers in the general population.’ (Clare Phillips)

The disabled and those with mental health problems and learning difficulties were fearful and were driven to creating 'hospital passports' in order to persuade medical professionals that they deserved admission to hospital and life-saving treatment (sections 4.21.3). These explained the diagnosis, medications and needs of individuals, some of whom would not be able to advocate for themselves if separated from their usual support worker who knew them well.

Finally there were concerns from Covid-19 Bereaved Families for Justice that there had been a 'lack of transparency and honesty' when they sought answers about what had happened to their loved ones. In particular they felt very let down by the Care Quality Commission (CQC), who had refused to release the number of Covid-related deaths in individual care homes. They felt they CQC had sought to protect the interests of the commercial sector at the expense of the interests of the public, and in choosing to hide behind Freedom of Information exemptions their position had become 'untenable':

'We all share the one thing in common, we were looking for answers. I needed to understand, and our members need to understand why our loved ones died in a place where we expected them to be safe.' (Jean Adamson)

Adamson eventually succeeded in getting this information released by the CQC in July 2021.* The report states 39,017 people died from COVID-19 related causes in care homes from April 2020 to March 2021. This represents over 30% of the total 126, 670 deaths by end of March 2021.

* <https://www.cqc.org.uk/news/releases/care-quality-commission-publishes-data-showing-death-notifications-involving-covid-19>

MINORITY ETHNIC COMMUNITIES

We have already mentioned that Black, Asian and minority ethnic communities were more at risk, and by April 2020 30% of those admitted to ITU were of 'non-white ethnicity' despite making up only 14% of the population. The disproportionate impact of Co.vid on this population was due a combination of factors including increased exposure through crowded living circumstances and occupation, poor access to health care and a high rate of co-morbidities such as obesity, cardiovascular disease and diabetes (sections 6.1-6.7).

BMA surveys had already shown that Black, Asian and minority ethnic doctors were more at risk of discrimination and bullying and they were thus less likely to raise concerns especially around lack of PPE. Once again risk assessment had not been adequately addressed.

Dr Latifa Patel told the inquiry that minority groups were also disadvantaged when virtual platforms became the norm for the NHS (section 6.8). They didn't necessarily have good WiFi or good English and privacy was a problem in multigenerational families, with people resorting to consultations in cars and bathrooms in order to find privacy.

Finally vaccine hesitancy was commoner in this group due a historic lack of trust in the Government, combined with disparities in access to healthcare and poor messaging during the pandemic:

'Structural discrimination is an issue underlying all of this. And this is pre-pandemic. Inequitable systems, such as housing, education, employment, earnings, benefits, credit. All of this is structural discrimination that puts people

at a disadvantage – ethnic minorities and non-ethnic minorities, but more so ethnic minorities.’ (Professor Kamlesh Khunti)

WOMEN DISADVANTAGED FURTHER

The inquiry heard the conclusions of a report (Lessons Learned: Where Women Stand at the Start of 2021*). This found that while men were more likely to die from COVID-19, women had suffered a greater social and economic impact. They were more likely to be made redundant, more likely to be furloughed, had suffered a vast increase in their unpaid work, and were more likely to be in significant debt (section 6.12). There had also been an increase in domestic violence, a problem which predated the pandemic and is ‘massively underreported’.

It was also known that women were more likely to be poor, to work in sectors such as hospitality that would be affected by the pandemic, and that they carried out 60% more unpaid work than men, and that closing schools and nurseries would increase that burden. In other words, the pandemic had exacerbated pre-existing gender inequalities in society.

When Dr Clare Wenham raised concerns based on pandemics elsewhere, she was told ‘London is not Liberia, we won’t have the same problems’ (para 6.12.3):

‘Covid has highlighted problems that existed long before the pandemic ... We don’t want to go back to the way things were, we have an opportunity to do things differently, and this is the moment to do that.’ (Dr Mary Ann Stephenson)

MIGRANTS IN A HOSTILE ENVIRONMENT

Between 800,000 and 1.2 million people in the UK are classed as ‘undocumented’, also labelled by the Government and right wing press as ‘illegal immigrants’; (section 6.10). Their immigration status is checked whenever they need to access any of the services that are needed ‘to live a dignified and normal life’.

This means they are ‘incredibly fearful’ about approaching these services even when in need. The NHS for example charges some migrants up to 150% of the cost of care, and some instances of non-urgent treatment require payment upfront – i.e. if you can’t pay, you don’t get the treatment. Of particular concern to undocumented migrants is the fact that the NHS shares patient data with the Home Office.

The inquiry heard about several examples of undocumented migrants who were too fearful to seek help despite being ill with COVID-19 and who died at home as a result. The irony of this was that they were entitled to free care for Covid, but they didn’t know this as the Government didn’t publicise it.

There was also concern about the abysmal and traumatising conditions in which some asylum seekers are kept, with no possibility to socially distance and no ready access to GP services. Covid had ‘ripped through’ some of these communities:

‘The hostile environment, makes life incredibly difficult for people who don’t have the right immigration papers. And as we know, this affects not just those who don’t have legal status, but can affect people who are unable to prove that they have legal status, such as those from the Windrush scandal.’ (Aliya Yule)

* <https://wbg.org.uk/analysis/reports/lessons-learned-where-women-stand-at-the-start-of-2021/>

PUBLIC RESPOND DESPITE WRONG MESSAGING

Several witnesses talked of the Government's mistaken views of the public, including treating us as the problem and not the solution and failing to exploit a strong sense of community that people felt, including the 750,000 who volunteered to help out. Government talk about 'pandemic fatigue' and their claim that the public were 'really tired of restrictions' was nonsense – in fact the public were always 'ahead of the Government' in wanting to do the right thing. They had been observant of the rules, they had just been 'the wrong rules.' (section 4.7)

The public were generally prepared to behave 'heroically' as long as they trusted the Government but did lose faith once the messaging became confused, and trust evaporated when they saw egregious rule-breaking going unpunished.

There has also been a strong public sector ethos during the pandemic which the Government on occasion exploited, undermined or ignored.

LEGAL CONSIDERATIONS

The inquiry heard from a human rights lawyer about the legal aspects of the Government's actions during the pandemic (para 8.2.44-48). There are international laws which require states to be prepared for pandemics and to take appropriate steps when they occur. There was a question mark over whether the UK's response actually complied with some of these laws, in particular the lack of PPE and ventilators, the discharge of untested patients into care homes and the protection of patients in hospitals and homes.

Under the European Convention on Human Rights (ECHR) the Government has a duty to protect the public at large, frontline workers and at-risk groups. There was also a duty on employers to ensure the health and safety of their employees at work by providing a safe work place with necessary training and equipment (such as PPE), and that a breach of those regulations could be a criminal offence. Claims against breaches of ECHR could be brought in UK domestic courts

On the possibility of prosecuting those felt to be responsible for failings during the pandemic, the Inquiry heard that individuals can't be charged with corporate manslaughter, but an organisation, such as the Department of Health and Social Care, could be. There had been a recent opinion in The Guardian from a QC that the discharge of patients infected with coronavirus back into care homes raised 'some serious questions about whether there is liability for that department for corporate manslaughter'.

One union (the GMB) is already calling for justice for the families of workers who died, many unnecessarily, and for those who contracted long Covid through their work:

'People who think that our pandemic strategy has been a success must look at the number of deaths, the number of people suffering with long covid, but also the impact on our economy and the fact that we've had restrictions for 16 months, three lockdowns, four months of children being out of education. How is this even remotely a success?'

'The media never actually discuss the response in other countries...so people aren't aware that life could be so different had we adopted the elimination strategy last year, or even learned much later and adopted it more recently. It's very, very clear that countries that valued life,

that treated deaths as preventable are the same countries that have done best economically.'

OUR CONCLUSIONS

The Government was not prepared for a global pandemic despite warnings that one was coming. When it arrived, they ignored clear warnings of the dangers and did too little too late.

During the decade before the pandemic successive Conservative Governments had run down public services, including the NHS, public health and care services, with the result that they were already in crisis when the pandemic struck. The pandemic then shone a light on long term problems in society around inequalities and discrimination and exacerbated them. The poorest and most vulnerable were hit the hardest and died in disproportionate numbers.

The Government failed to protect its frontline workers, at risk groups and the public. It made disastrous decisions about FTTIS and NHS 111, and consistently favoured the private sector over the NHS. There was lack of transparency around these dealings and huge sums of money have been wasted.

The Government failed to consult or to heed the advice of professionals, experts, civil society including unions and the public and, what's more, actively distrusted them. They have shown themselves unwilling to learn from their mistakes and change course where appropriate. They have ignored calls for an urgent inquiry in order to learn lessons and prevent further unnecessary deaths.

The scale of deaths has inevitably invited questions about accountability. In a much-quoted BMJ editorial Dr Kamran Abbasi proposed that the UK Government had shown a 'premeditated and reckless indifference' to human life when it accepted tens of thousands of premature deaths in the hope of achieving 'herd immunity' or for the sake of propping up the economy. He used the term 'social murder' to describe 'the lack of political attention to social determinants and inequalities' which was uncovered by the pandemic, and which led to disproportionate death rates amongst the poorest and most disadvantaged.

Abbasi asked who is to blame if avoidable deaths result from politicians wilfully neglecting historical experience, scientific advice and their own statistics and modelling. Should public health malpractice count as a crime against humanity, both nationally and internationally? Some will argue that the UK was not the only country that fared badly but low death rates in countries such as New Zealand and Taiwan show that it didn't have to be like that, and to make matters worse the Government has shown no sign that it is ready to learn any lessons or accept any responsibility for (at the time of writing) 167,000 deaths.

Matt Hancock was right when he said that 'the first responsibility of any Government is to protect its citizens'. But they failed miserably and as a result tens of thousands of people died avoidable deaths. Politicians must at some stage be held to account – by legal and electoral means – for their fatal failures. A properly conducted public inquiry will be an important part of that reckoning.

During the intervening months from July until now, the People's Covid Inquiry has continued to gather and examine evidence, including the fiercely critical House of Commons Health and Social Care and Science and Technology Committees report, 'Coronavirus: lessons learned to date' published 12 October, the recent joint report 'Building a consensus for health, care and support services fit for the pandemic era' from Independent SAGE and Keep Our NHS Public, the National Audit Office report on the Government's preparedness for the pandemic, and much more.

There has been no indication from the Government that it is prepared to learn lessons from this tragedy and the significance of the ongoing death toll in the UK is currently played down in official circles. We can only agree with the words of the House of Commons Joint Select Committee report, that the pandemic has proved to be 'one of the UK's worst ever public health failures'.

That report, while outlining some mistakes in the Government's early response, attributes most of the blame to public health bodies rather than the Government itself. The attitude of Government was perhaps most clearly expressed recently when Cabinet Office minister Stephen Barclay declined to say sorry 11 times for the Government's handling of the COVID-19 pandemic.

WHAT NEXT

Since the Inquiry concluded its evidence gathering, the infection rate and death toll are going up again. On 7 July 2021 the average daily death toll from COVID-19 in the UK was 35. In late November at the time writing, the average sits at 141 COVID-19 deaths per day.

Our key findings and recommendations are based on contemporary evidence from the front line. They are even more urgent now than when the Inquiry reported preliminary findings in July 2021. This winter is predicted to be the worst ever for the NHS, with every indication that COVID-19 infection rates and deaths remain high, already NHS and care services under enormous and unsustainable pressure.

The Government's handling of the pandemic was grossly negligent and has unquestionably led to significant loss of life that could and should have been avoided. Those in charge during the pandemic showed a wilful disregard for public safety and a callousness toward the numbers of people who have died and their bereaved relatives. We ask that the Government accepts and acts on our findings, and implements the recommendations set out in our report.

It is not too late for some good to emerge from the pandemic. Lessons are clear, and can and should be learned. With political will and public support, social and health inequalities could be tackled. We could see the NHS and other public services properly funded saved from the brink of collapse. Only in this way can we keep the nation safe and protect it from a repeat of the current catastrophic public health disaster we have documented here.



FINDINGS AND RECOMMENDATIONS

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

1. CONDUCT IN PUBLIC OFFICE AND DUTY OF CANDOUR

Findings

- F1.1** There have been serious governance failures of the Westminster Government, in breach of all of the Nolan Principles: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership. These contributed to tens of thousands of avoidable deaths and suffering, and they amount to misconduct in public office.
- F1.2** Recommendations from previous pandemic planning exercises were ignored.
- F1.3** The Government failed to conduct risk assessments or act to protect key populations at increased risk.
- F1.4** An equality impact assessment of all the policies was not carried out and measures not taken to address risks identified, as should have happened.
- F1.5** The Westminster Government treated bereaved families with disrespect and ignored their questions for over 12 months.

Recommendations

- R1.1** Breaches of the Nolan principles by the Westminster Government during the pandemic must be addressed. Egregious breaches must have consequences.
- R1.2** Consideration should be given to charges of Misconduct in Public Office given the evidence available of the Government's breaches and failures and the serious consequences for the public.
- R1.3** For the future, the Nolan principles should have a statutory basis.
- R1.4** Government must acknowledge to the public and bereaved families the mistakes made in its management of the pandemic.
- R1.5** Government must make public the details of private-sector procurement during the pandemic. The NHS and public health services should publish and justify private-sector procurement data each year.

2. PANDEMIC PLANNING AND CONSEQUENCES

Findings

- F2.1** The UK has one of the highest death rates in the world from COVID-19 despite having a renowned national health service and a world reputation in public health.
- F2.2** 167,000 deaths have COVID-19 on the death certificate (ONS 5 November). Many of these deaths could have been avoided.
- F2.3** The Government failed to address the seriousness of the pandemic for several vital weeks from 23 January 2020 (Wuhan lockdown and Lancet articles published) to first lockdown on 26 March despite very clear indications this was urgent.

Recommendations

- R2.1** There must be prompt institution of standard pandemic control measures in the event of any future pandemics.
- R2.2** Pandemic planning in the NHS needs to be urgently reviewed for the future, including: the review of hospital protocols on transmission in the early stages, the NHS 111 service, the role of GPs.
- R2.3** Representatives of care homes, disabled people's organisations, relevant health, care and education trade unions, schools and bereaved families should be asked to contribute on the basis of their knowledge and experience gained during the pandemic
- R2.4** The role of behavioural scientists should be recognised in formulating clear government messages.
- R2.5** There should be an urgent review of pandemic planning for the care sector, including care in domiciliary settings. Staff, representatives of care homes and care settings, and unions should be involved in future pandemic planning.
- R2.6** There should be an urgent review of pandemic planning for disabled people in the community, in their homes and in hospitals, including representatives of disabled peoples' organisations, including those on the ground.
- R2.7** Recommendations for PPE should follow a precautionary principle and improving workplace ventilation (including schools) should be a priority.
- R2.8** The SAGE should have a gender expert, adequate public health expertise and equality impact assessments should be carried out on all future policies.
- R2.9** Public-sector infrastructure, expertise, and capacity needs to be rebuilt.

3. THE NHS HAD BEEN UNDERMINED PRE-PANDEMIC

Findings

- F3.1** The NHS had become an undermined, fractured and fragmented public service by the time it went into the pandemic, severely weakened after a decade of austerity. There is a risk of impending collapse. The NHS should have been in a position to protect the people but was not able to do so; instead, the NHS itself was in need of protection.
- F3.2** The NHS had insufficient capacity for resilience during a pandemic and was forced to become a Covid service during the first and second pandemic waves.
- F3.3** The severe weaknesses in the NHS included 100,000 staff vacancies, ITU, bed and equipment shortages, and the running down of laboratories.

Recommendations

- R3.1** Investment must urgently strengthen NHS hospital, community, mental health and primary care services, diagnostics and public health, and social care and support for independent living.
- R3.2** The NHS must have built-in capacity for continuity of emergency and elective services, including cancers and life-altering health issues, during a pandemic or other emergencies.
- R3.3** The NHS must be strengthened to a state of pre-pandemic preparedness including adequate staff, beds, equipment, testing facilities, and PPE.
- R3.4** Restoration of NHS and public health capacity must start immediately to achieve safe NHS care of all patients, to restore decayed infrastructure and increase workforce numbers, eliminate waiting lists, and improve services year-on-year in a manner fit for the 21st century.
- R3.5** It is urgent to restore the morale of NHS and care staff with a statement of commitment to public services, publicly provided and publicly delivered, backed by urgent real terms restoration of level of funding to expand the workforce and address lost real value pay.
- R3.6** Government must ensure long-term funding plans for the health and social care system are commensurate with need.
- R3.7** Specific provision must be made for assessment and management of patients with long covid.

4. AUSTERITY AND THE PANDEMIC

Findings

- F4.1** The UK Government failed to uphold its 2010 election promises to address the wider determinants of health and wellbeing. Its policies widened health inequalities, laying the basis for an increased UK COVID-19 death toll.
- F4.2** Deep social inequality contributed to a more vulnerable UK population, with increased hospitalisations, deaths and, during the first 5 months of 2020, the highest excess mortality rate across Europe.
- F4.3** The UK has the lowest sick pay in the OECD, except for Malta. Lack of sick pay and low sick pay played a role in spreading infection by forcing people to go to work to feed their families even when they had the virus.
- F4.4** Financial and other support for people needing to isolate has never been sufficient to be effective in reducing spread of infection.

Recommendations

- R4.1** The deep health inequalities heightened during COVID-19 must be addressed with focus on investment in health and social care and further research and action to correct the disproportionate impact on our Black, Asian and ethnically diverse population.
- R4.2** The social determinants of health must be tackled as a priority across all policy areas in order to reduce health inequalities.
- R4.3** Statutory sick pay should be at least at levels equivalent to European countries .
- R4.4** Statutory sick pay should be available to people having to self-isolate.
- R4.5** The £20 uplift in Universal Credit must be restored, especially in the light of escalating food and energy costs and ongoing rates of viral infection.

5. INEQUALITIES AND BLACK, ASIAN AND ETHNICALLY DIVERSE COMMUNITIES

Findings

- F5.1** The existing disparities suffered by Black, Asian and ethnically diverse NHS staff (as well as female NHS staff generally) have been highlighted and exacerbated by the pandemic.
- F5.2** When the increased risk to people from ethnically diverse backgrounds was recognised, the response was slow and insufficient to protect workers and communities adequately.
- F5.3** It is plausible that existing inequalities, and the experiences in the pandemic contributed to vaccine hesitancy.
- F5.4** There is a lack of knowledge of differential exposures and risks relating to urban living, which disproportionately affects Black, Asian and ethnically diverse groups.

Recommendations

- R5.1** There is an urgent need for research into how to prevent higher death rates in people from minority ethnic backgrounds.
- R5.2** More investment is needed into research on the health needs of BAME populations.
- R5.3** Cultural and targeted messaging must be improved, and relevant public health interventions should be directed at communities where multi-generational households are highly prevalent.
- R5.4** The 'hostile environment' for migrants should be abolished.
- R5.5** Double tax for foreign national healthcare workers through annual health surcharges and income tax and NI contributions should end.

6. PUBLIC HEALTH RESPONSE

Findings

- F6.1** The UK Government's delay in issuing advice to healthcare professionals and subsequent advice to the public to rely on NHS 111, contributed to the COVID-19 death toll.
- F6.2** NHS 111 should not have replaced primary care for COVID-19 patients. The outsourced NHS 111 COVID-19 triage had inexperienced, undertrained staff who were unable to safely interpret patient symptoms. The inadequate community and emergency NHS response to the pandemic (including NHS 111) contributed to people dying without the care they needed.
- F6.3** GPs were wrongly side-lined and could have played a greater and vital role in caring for patients, working with local public health, and assisting with measures to control the spread of infection. This was a grave error.
- F6.4** The bypassing of NHS and university laboratories delayed the required level of testing and contact tracing, which never caught up with what was needed.
- F6.5** The Government chose to ignore organisations with relevant expertise, including local authorities, local Public Health, professional bodies, trade unions, disabled people's and pensioners' organisations, all of whom had experience to offer.
- F6.6** Public health capacity and capability has been undermined at all levels, by policy decisions and funding cuts. The result is the worst public health disaster.
- F6.7** Regional public health services were progressively dismantled following the 2010 General Election, with the loss of vital expertise in England.
- F6.8** UK public health policy was out of step with the WHO, and ignored information from China in January on infectivity and mortality. It displayed complacency and 'English exceptionalism'. The Government's responses during the pandemic have been slow and costly of lives and not routinely 'based on the science' as they should have been.
- F6.9** Westminster policy was wrongly based on a misplaced application of 'herd immunity'.
- F6.10** The Government failed to establish the core public health measures of 'Find, Test, Trace, Isolate, Support' (FTTIS). In England there is still no effective coordinated system, the WHO bedrock of pandemic response. A privatised Test and Trace was and is a costly failure.
- F6.11** Delay in declaring each of the three lockdowns resulted in the deaths of tens of thousands. Despite being a precondition of ending lockdown safely, each was lifted without an effective FTTIS being in place.

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- F6.12** Several countries that responded with rigorous tried and tested public health measures avoided lockdown or had shorter periods of lockdown and school closures.
- F6.13** The UK government followed an incoherent and dangerous pandemic strategy, failing to learn valuable lessons from other parts of the world (e.g. South Asia; New Zealand) where more effective strategies were pursued.
- F6.14** The UK Government did not impose border controls in time. They encouraged large sporting events to go ahead facilitating spread of infection.
- F6.15** Government messages were often confused and contradictory, and sections of the population were wrongly blamed.
- F6.16** The Government was secretive about the existence and findings from potentially mass life-saving pandemic modelling: several exercises had been conducted for both flu and coronavirus pandemics, two key ones were Exercises Cygnus and Alice in 2016.
- F6.17** Ignoring pandemic planning exercise findings meant that stocks of PPE, testing capacity, border controls and contact tracing were not in place when coronavirus appeared. These measures would have saved lives.
- F6.18** Vital time was wasted in establishing essential measures: the sourcing of PPE, creating and distributing diagnostic tests, creating guidelines for sections of the population most at risk.
- F6.19** There was, and remains, a misplaced over-reliance on vaccines alone. The WHO policy is one of vaccines plus public health measures.

Recommendations

- R6.1** There needs to be recognition that much is to be learned from the WHO and from other countries in terms of best practice in fighting a pandemic.
- R6.2** The UK must support a global vaccination programme including waiver of intellectual property agreements for COVID-19 related technologies, and help poorer countries with their pandemic response if the pandemic is eventually to be brought under control.
- R6.3** The pandemic is not over. A broad public health strategy must be agreed and initiated in conjunction with the vaccination programme in the UK.
- R6.4** GPs and primary care must be resourced and empowered to look after their own patients in a future pandemic or health crisis, working closely with local public health.
- R6.5** GPs and local public health teams must be put at the heart of any pandemic response and given the necessary funding to fulfil this role.

- R6.6** The UK government should commit to reinstate and adequately fund a comprehensive public health service, led by public health experts independent of government.
- R6.7** All pandemic advisory bodies should be led by those expert and trained in public health.
- R6.8** Resilience must be built into public services to meet future health emergencies.

7. POLICY OF PRIVATISATION AND OUTSOURCING

Findings

- F7.1** 'Just-in-time' procurement failed the NHS and other services and showed itself to be fundamentally unsuitable for public health emergency planning.
- F7.2** The emergency situation demanded that decision-making and the usual tendering processes be streamlined, but public sector experience was recklessly neglected. Centralised decision-making without transparency has cost lives.
- F7.3** 'Find, Test Trace Isolate and Support' was never adequately established. The outsourced 'NHS' Test & Trace Service should have been an NHS and local public health-led service from the start – publicly provided and led by clinical teams with sufficient expertise and resources, and supported to integrate and coordinate nationally.
- F7.4** Public service responses have been exemplary, always going the extra mile. In contrast, private testing companies did not send results to GPs because it was not in their contract and outcomes have been very poor.
- F7.5** Pandemic strategy was to outsource contracts rather than to invest in public services. 'Eye-watering' payments for private contracts sit badly alongside the need for investment in NHS and care services. This has not been in the public interest.
- F7.6** The NHS is undermined by the Westminster relationship with the private sector which appears to have been based on ideology.
- F7.7** The pandemic has been used to underwrite the private healthcare sector with public funds, in preference to building NHS capacity.
- F7.8** Pandemic private contracts relating to patient data have been secretive and deeply flawed, with absent safeguards against breaches of data protection and commercial exploitation. This has damaged public trust.

- F7.9** Government contracting to the private sector during the pandemic has been tainted by cronyism and conflicts of interest, and has heightened the risk of profiteering.
- F7.10** The NAO has confirmed that contract processes have been poorly monitored, indefensibly costly, and at times unlawful.

Recommendations

- R7.1** National policy in England should return to one based on public provision for essential services: the NHS, public health, social care and supported living.
- R7.2** Public health planning and services at regional and local level must be publicly provided by public health teams, the NHS, primary care, and local authorities and not be outsourced to private contractors.
- R7.3** Public health capacity nationally and locally must be rebuilt as an integrated public service.
- R7.4** Public reaffirmation in the NHS as a national, integrated and publicly provided health service will restore NHS morale.
- R7.5** The preferential funding of private hospitals in place of building NHS hospital and primary care capacity must stop.
- R7.6** NHS and public health procurement for the NHS and pandemic planning should be returned to public hands.
- R7.7** Just-in-time procurement must end. Pandemic planning must never again rely on 'just-in-time' supply management.
- R7.8** Personal health data must remain under the control and ownership of public bodies to retain public trust, and must not be used for commercial exploitation
- R7.9** Outsourcing of health services to the private sector should end and public funds should be preferentially directed towards public sector providers of health and social care services, including clinical support such as pathology and diagnostics.

8. NHS, CARE AND FRONTLINE WORKERS

Findings

- F8.1** Health and safety risks for key workers were not addressed in timely fashion. Frontline staff were inadequately protected and supported and as a consequence suffered greater illness and death rate than the general population. In the NHS and care sector, over 1500 staff have died from COVID-19.
- F8.2** The failure to maintain the NHS and social care meant that services were already understaffed and under stress before the pandemic hit.
- F8.3** The NHS responded to coronavirus but was unable to maintain usual elective and some emergency services; it did not cope.
- F8.4** Staff have been faced with clinical situations where, through no fault of their own, they were unable to provide the standards of care they knew to be safe. Staff witnessed greater deaths and injury and were unable to respond. Many experienced 'moral injury' and their mental health suffered.
- F8.5** The dangerous level of low staff morale, stress and burnout is apparent. This results from exhaustion, moral injury, burnout and PTSD. After nearly two years of intense pressure and contradictory responses from Government and some members of the public, any sense of wellbeing has been steadily eroded.
- F8.6** There is immediate danger that many exhausted staff are leaving or waiting for the opportunity. Morale is further impacted by the below-inflation pay offer, cutting real pay value further. Staff note in contrast the unprecedented diversion of funds into the private sector.
- F8.7** In many cases there were inadequate risk assessments and failure to listen to staff concerns and involve staff in improving workplace safety. The well-established 'precautionary principle' (take no risks) was abandoned, resulting in unavailability of appropriate PPE; failure to acknowledge the importance of airborne spread of virus and to implement mitigating safeguards; failure to adequately report and investigate infection possibly acquired at work, meaning there were missed opportunities to learn lessons.

Recommendations

- R8.1** Comprehensive policies to protect key workers in their workplaces must be developed to protect against future pandemics, learning from the experience of COVID-19, and working with the trades unions to develop these. COVID-19 should be classed as industrial disease.
- R8.2** Workplace union safety representatives should be actively involved with regular review of safety measures and risk assessment.

- R8.3** The supposition for high-risk workers who contract COVID-19 should be infection has been acquired at work rather than in the community, and notification made to the HSE for further investigation.
- R8.4** HSE need to be funded to the level needed to investigate the volume of reported cases fully so that important lessons can be learned.
- R8.5** Support services must be provided to support the long-term mental health difficulties faced by many staff and the long covid symptoms they have.
- R8.6** Health and care staff must have a way to report conflict and stress from 'moral injury' and managers must respond.

9. SOCIAL CARE

Findings

- F9.1** Lessons from pandemic exercises were not implemented for care settings. There was a lack of adequate foresight and planning for a fragmented and privatised care service. Barriers were created to accessing hospital treatment.
- F9.2** There was a failure to ensure care homes were adequately prepared for the pandemic with sufficient staff, isolation capacity, testing, PPE and training. This also applied to those receiving care at home.
- F9.3** The discharge of 25,000 untested patients into care homes played a major role in the deaths of the 47,000 residents who died in care homes. Provision for testing and isolation only took place after most outbreaks had already occurred.
- F9.4** The underfunded, fragmented and privatised nature of social care played a key role in allowing viral transmission. Many staff are on zero hours contracts and work across multiple residential or domiciliary settings increasing the risk of contracting and spreading infection.
- F9.5** Care workers on very low rates of pay were expected to work without PPE and take risks with their own health and that of their own families and those they cared for.
- F9.6** As a result, in the first 18 months of the pandemic the UK experienced the highest number of care home deaths in Europe. Thousands of people also died at home without medical care, both from COVID-19 and non-coronavirus conditions.
- F9.7** To reduce pressure on hospitals, some older people in some care homes and hospitals were restricted from access to critical care and life-saving treatment by application of blanket DNAR policies, until this was challenged.

Recommendations

- R9.1** Social care services should be urgently overhauled and restructured, towards a national service that can provide care, support and independent living with training, career structure and pay to support care staff.
- R9.2** Collection and utilisation of data for those who receive social care at home should be funded and improved.
- R9.3** Review of pandemic planning must address the failures to protect the elderly requiring care and support during this pandemic.

10. PALLIATIVE CARE AND HOSPICES

Findings

- F10.1** The hospices, who rely on charity funding, fell between the definitions of NHS hospitals and care homes, and were denied PPE supplies via the NHS. They were immediately on the point of running out of PPE. Government help lines went unanswered and they had to source their own PPE.
- F10.2** Patients requiring palliative care were terminally ill, sometimes acutely unwell. Many felt abandoned.

Recommendations

- R10.1** Palliative care should be funded by government as an essential public service and part of the NHS.
- R10.2** Sufficient palliative care specialists and beds should be funded to meet the needs of an ageing population and to allow people to die in a dignified manner of their choosing.

11. DISABLED PEOPLE

Findings

- F11.1** There was a shockingly high differential death rate for disabled people: six out of ten deaths (59.5%) involving COVID-19 in England from March to November 2020 were disabled people. Disabled people form only 16% of the working age population, and represent 45% of people over pension age.
- F11.2** There was a lack of planning to address the health risks for disabled people in the community, in their homes and in hospitals, even though these could have been anticipated.
- F11.3** Disabled people were severely affected economically by the pandemic; many were on legacy benefits and were excluded from the £20 uplift given to those on Universal Credit.
- F11.4** Access to community support, shopping, and PPE for disabled people was very delayed and often remained unavailable to those not connected digitally.
- F11.5** Some disabled people were restricted from access to critical care and life saving treatment through the application of DNAR policies.
- F11.6** In order to try and ensure that medical staff understood their needs and saw them as valuable members of society who deserved equality of treatment, disabled people had to take 'passports' into hospital with them.

Recommendations

- R11.1** Inequalities in benefits available for disabled people must be addressed.
- R11.2** Benefits uplift during a pandemic should equally be added to benefits received by disabled people.
- R11.3** Digital access for disabled people, particularly older people in the community should be reviewed and their needs assessed.
- R11.4** Do Not Attempt Resuscitation notices must not be automatically applied to disabled people but good practice processes followed.
- R11.5** NHS staff training must be updated on the human rights of disabled people.

12. IMPACT ON WOMEN

Findings

- F12.1** The existing disparities suffered by women have been highlighted and exacerbated by the pandemic.
- F12.2** The differential impact on women of pandemic conditions, including lockdown, is known from research: the impact of increased caring responsibilities, childcare responsibilities, forfeiture of paid work, increase in vulnerabilities to mental health issues and domestic violence. This was not adequately considered by Government.
- F12.3** The Government and its advisers did not consider or anticipate the impact that the closure of schools and nurseries would have had on women's ability to carry out paid work.

Recommendations

- R12.1** The differential impact on women in pandemic conditions must be addressed in emergency planning and policy. The SAGE should include an expert on gender inequality.

13. MENTAL HEALTH

Findings

- F13.1** The levels of mental health distress and referrals have outpaced available resources for all ages, putting even greater stress on services poorly resourced pre-pandemic.
- F13.2** Referrals of children and young people to mental health services for crisis and non-crisis treatment soared because of the pandemic with resources failing to match the need. This affects not only children and young people, but also their families.

Recommendations

- R13.1** Expansion of provision to meet the mental health needs of children and young people should be urgently addressed.
- R13.2** Funding and support for child and adult mental health services must match the expansion of need.

14. SCHOOLS AND CHILDREN

Findings

- F14.1** The consequences of schools being effectively closed for most students – between 25 March to September 2020, and January to March 2021 – were disastrous, particularly for the least advantaged.
- F14.2** The school system has been fragmented through academies and the political aversion of Government to local authorities. This left an unwieldy, over-centralised communication route via the DfE, undermining the potential for local coordination to control the pandemic in schools.
- F14.3** The Westminster Government failed to sufficiently liaise with Local Authorities and large education unions who were ideally placed to understand the very varied situations of schools throughout England.
- F14.4** Schools have acted as ‘institutional amplifiers’ of coronavirus infection, with large groups of children and staff gathered in unventilated places (most recently November 2021). The Government has downplayed the risks of both long covid and repeated school absence.
- F14.5** National guidance for mask wearing in English secondary schools, introduced in March 2021 and standard in most European countries, was ended in May 2021 without any scientific explanation.
- F14.6** School space is finite and often cramped, yet no attempt was made nationally by the DfE to attempt to reduce transmission of the virus: by the adoption of additional space where possible, the introduction of ‘half and half teaching’ on alternate weeks, or to fund schools to install better ventilation.
- F14.7** Many schools could not afford to fund safety measures: spending per pupil in England had fallen by 9% in real terms between 2009–10 and 2019–20, the largest cut in over 40 years.
- F14.8** The Government initially refused to provide meals for children on Free School Meals during lockdown and school holidays, then moving to hard-to-use voucher system, before a U-turn after a campaign by the footballer Marcus Rashford.
- F14.9** A faster, fully achieved laptop roll out and connectivity provision could have played a more significant role in preventing increased isolation and the further growth of inequalities for many pupils. Provision was slow and patchy, taking until June 2021 to reach its target.

Recommendations

- R14.1** WHO and European health guidance for mitigation of virus spread in schools should be adopted immediately.
- R14.2** Mask-wearing should be re-introduced into secondary school for the duration of the pandemic.
- R14.3** National Education Union guidance for safe schools and emergence from the pandemic, should be considered immediately by Government.
- R14.4** Planning for future pandemics should include specific measures for schools including rotation teaching, mask-wearing, outside teaching, expanding space by use of non-school buildings.
- R14.5** Local authorities and local public health should be part of future pandemic planning.
- R14.6** Financial support should be provided for schools to install ventilation and carbon dioxide monitoring equipment for classrooms.
- R14.7** Funding should be allocated to schools to supply laptops and wireless routers for all children who need them for use at home.
- R14.8** Children who receive Free School Meals should receive them during school holidays, as of right.
- R14.9** School funding should be increased to help schools reduce class sizes, employ extra teachers and teaching assistants, and ensure the possibility of children catching up in the broadest sense.

15. GOVERNANCE IN THE PANDEMIC

Findings

- F15.1** The public was not well served by the Westminster Government. From outcomes in deaths and economic decline, it is clear that the UK got things badly wrong in managing the pandemic.
- F15.2** Public messaging was confusing, unclear, contradictory and lost public trust. The Chancellor's disastrous 'eat out to help out' scheme in summer 2020 ignored scientific advice about the risk of airborne spread.
- F15.3** The population very largely abided by the rules in spite of rather than because of Government messages, and the rule-breaking behaviour of prominent individuals.

- F15.4** The Government's communications throughout the pandemic have not been inclusive enough to reach higher risk communities.
- F15.5** Westminster cabinet government failed to impose limitations on prime ministerial power.
- F15.6** The Westminster Government's own public health advice was inadequate: it was coming from spokespeople for public health who were civil servants and therefore not independent. Too often they colluded with edicts from the centre, rather than representing the best available public health advice.
- F15.7** The Chief Medical Officer was not an experienced and independent public health voice at the beginning of the pandemic.
- F15.8** The willing appearance of the top scientists alongside political leaders in Government briefings diminished their independence from political messaging.
- F15.9** Independent scientific advice to government was compromised in the early part of the pandemic and not routinely made public for the first six months.
- F15.10** The scientists on the SAGE did use their freedom to speak publicly, aided once meeting minutes were made public.
- F15.11** Senior civil servants were found wanting in fulfilling their role of 'speaking truth to power'.
- F15.12** There was an ignorance of, or failure to apply, the lessons from the past.
- F15.13** Back office civil servants, notably in HMRC and DWP worked hard to deliver rapid responses to the urgent need to support the incomes of millions of people.
- F15.14** Arm's length bodies like the CQC and the Health and Safety Executive failed to act independently to protect those vulnerable people they were established to protect.
- F15.15** A cadre of local authority leaders played a crucial role in protecting the population, despite the decade of drastic cuts and downgrading of local government (an indication of how things might have been done better).
- F15.16** The hollowing out of the role of local government in school education over the last decade could not be filled by the DfE centrally with few contacts to rely on to protect children in the pandemic. Many schools served their communities despite rather than because of the DfE.

Recommendations

- R15.1** The future public inquiry must investigate the Cabinet Government's failure to counter a decision-making model centred on the prime minister and whether the Whitehall model for the civil service is so broken that it needs to be fundamentally changed.

- R15.2** A parliamentary committee for national emergencies should be set up before which the Prime Minister should be required to appear at least annually.
- R15.3** The independence of scientific advice must be strengthened. The appointment of the Chief Scientific Adviser and the Chief Medical Officer should be subject to Select Committee approval and their advice published.
- R15.4** The centralised public health structure in England should be reviewed and should be headed by a senior and respected public health specialist, independent of government, leading a team which includes public health doctors and specialists working at local and regional level, and whose primary allegiance is to the public health agency.
- R15.5** In the light of misconduct in relation to contract allocation, the public inquiry must examine whether civil servants were asked or instructed to act against the law.
- R15.6** Persistent failure to comply with the requirements of the Public Accounts Committee or the other relevant committee on national emergencies and resilience should lead to their resignation.

A healthcare worker, likely a nurse, is shown in profile, facing right. She is wearing a light blue surgical mask, a clear plastic apron over her teal scrubs, and teal gloves. Her hair is tied back. The background is a blurred outdoor setting with a wooden trellis structure. A large, semi-transparent blue triangle is overlaid on the left side of the image, containing the text.

1. HOW WELL PREPARED WAS THE NHS?

Inquiry Session 1

**PEOPLE'S
COVID
INQUIRY**

Learn lessons, save lives.



1.0 INTRODUCTION

1.0.1 The UK Government slogan '[Stay home, protect the NHS, save lives](#)'^{1.1} was developed by the advertising agency, Mullenlowe, and launched following Prime Minister Boris Johnson's announcement on 23 March 2020 of the first national lockdown. The focus of Session 1 of the People's Covid Inquiry was to ask how prepared the NHS was to deal with a pandemic, why, and the extent to which, the NHS needed protecting, and whether the UK Government advice 'Stay home, protect the NHS, save lives' did indeed save lives. We asked how Government policy over the last decade affected the resilience of the NHS as the pandemic struck, UK social care and public health systems, and ability to deliver continuity of core NHS services.

1.0.2 The UK public knows the NHS is there to protect them. This recognition and their gratitude and pride, have been shown in innumerable ways, not least the opening ceremony at the 2012 Olympic games that paid homage to the NHS, the description of the NHS in the 2018 [BBC2 'film-poem'](#)^{1.2} marking its 70th anniversary, as 'the most radical and beautiful idea we've ever realised', and the Clap for Our Carers social movement created as a gesture of appreciation for NHS workers. The NHS is a complex organisation, but the UK public understand that it consists of primary care provided by general practitioners, hospital care, and community support. They also know that social care is closely interrelated with healthcare, but is organisationally separate from the NHS, and has needed reform for many years. The public also know that the UK death toll from COVID-19 is among the highest in the world.

1.0.3 For these reasons, the People's Covid Inquiry invited Jo Goodman

(founder of '[Covid-19 Bereaved Families for Justice](#)')^{1.3} Professor Sir Michael Marmot (internationally recognised health researcher and author of a number of national and international reports including '[Build back Fairer, the COVID-19 Marmot Review](#)'),^{1.4} Holly Turner (Learning Disability Nurse in Child and Adolescent Mental Health Services), Professor Gabriel Scally (academic and former Director of Public Health in the UK), and Dr John Lister (health policy researcher and investigative journalist) to provide witness accounts in session one (see also witnesses King, Costello, Clarke and Dawson who also addressed the questions posed in this session; their evidence is presented in chapters 2, 3, 4 and 7).

1.1 BEREAVED FAMILIES

1.1.1 The public were not protected: Jo Goodman lost her father to COVID-19. She described his experience when he attended a cancer unit on March 18 (see also report section 3.3). He was asked to attend hospital even though the appointment could have been conducted by phone and waited for over an hour in a crowded waiting room with no ventilation, or physical distancing, and with PPE used by neither staff nor patients. He returned to hospital on 24 March to receive chemotherapy, became unwell on 29 March, and died of Covid-19 three days later. It is highly likely he became infected in hospital.

1.1.2 Jo Goodman also described having received innumerable reports from bereaved families about the responses from NHS 111 (see also report para 2.71, 2.72, 4.52). Callers with symptoms that might be attributable to COVID-19 were directed to a particular section of the service. They were asked very fixed,

scripted questions about COVID-19 which often meant that they were told to stay at home, even if they had other severe symptoms that would normally have resulted in them going to hospital. The questions were not sufficiently discriminatory. An example is that black people were asked if their lips were blue; this is not an appropriate way to identify low oxygen levels in these populations.

1.1.3 Jo Goodman described liaising with an investigative journalist who found that at the outset of the pandemic, the NHS 111 COVID-19 Clinical Assessment Service was outsourced to a number of companies and implemented with staff having received very limited training. Members of Bereaved Families for Justice who made complaints about NHS 111 found that patient calls were often not recorded, so there was no way of reviewing the quality of the advice provided.

1.1.4 Jo Goodman spent much of 2020 speaking to other bereaved families, trying to understand their experiences and ensure that lessons are learned. Bereaved Families for Justice have been campaigning for a statutory public inquiry into the handling of the pandemic since early summer 2020, with a rapid review phase so that lives could be saved quickly, ahead of the second wave. From initial promise, it took the Prime Minister 400 days to meet with families.

1.2 NON-HEALTHCARE DETERMINANTS OF HEALTH

1.2.1 Professor Marmot began by explaining that a healthcare system is absolutely vital to caring for people when they become unwell, but the key determinants of health and health inequalities lie outside healthcare systems and are a consequence of the conditions in which people are born, grow, live, work and age.

Government reneged on commitments

1.2.2 In the Marmot Review 2010, Sir Michael made recommendations in six areas to improve health and reduce health inequalities: early child development; education and lifelong learning; employment and working conditions; having enough money to lead a healthy life; healthy places in which to live and work; and taking a social determinants approach to prevention.

1.2.3 Sir Michael explained the Conservative-led coalition government elected in 2010 committed, in a White Paper, to reducing health inequalities and addressing the wider determinants of health. However instead, the Government cut public expenditure progressively, reducing this from 42% of Gross Domestic Product in 2010, to 35% by 2019. In parallel, Government spending was inversely proportional to need – the opposite to what was needed. As a result, people in the bottom 10% of income, received a further income reduction of 20%, and health inequalities widened, rather than becoming narrower during the last decade. Sir Michael also emphasised that NHS funding did not increase in line with inflation, and hence in real terms was

equivalent to reduced funding.

1.2.4 He underlined that population health is a good measure of how well a society is functioning. He pointed out that inequalities in COVID-19 mortality overlap considerably with the causes of inequalities in health more generally. COVID-19 disproportionately affected deprived communities. Additionally, not only did the UK have a very high COVID-19 mortality compared with other countries, but also the largest excess mortality – i.e. deaths indirectly attributable to COVID-19.

1.2.5 He explained that the clear link between the poor health record of the UK at the start of the pandemic and the ‘disastrous record of managing the pandemic’, could work in four ways: 1. ‘the quality of governance and political culture’; 2. social and economic inequalities; 3. ‘disinvestment in the public sector’; 4. poor population health (‘we weren’t very healthy’).

Flawed government priorities

1.2.6 Sir Michael pointed out:

‘Any government that had equity in health and wellbeing in its sights, would not have pursued public policy the way it did from 2010 on ... would not have spent the better part of three or four years arguing about Brexit and doing nothing else ... where was the social policy trying to improve Britain?’ (Marmot)

He reflected on the UK public health system that though ‘the envy of many other countries’ was side-lined, with the Government turning to their ‘buddies’ to set up a test, trace, and isolate system, who ‘failed miserably’.

1.2.7 He was excoriating on the issue of lack of accountability, stressing he spoke

not from a party-political viewpoint but through the lens of health and health equity. He provided several examples of how government policy could have improved the wider determinants of health (e.g. child poverty, education, child development, employment, working conditions, and food poverty), and had they done so, the death toll from COVID-19 might have been less.

1.2.8 He reminded the inquiry that pitting the economy against public health is a false trade-off, evidenced by data showing that ‘the smaller the mortality from COVID-19, the smaller the hit to the economy’.

1.3 WORKING IN CAMHS

1.3.1 Holly Turner works in Child and Adolescent Mental Health Service (CAMHS). She explained that though working conditions have always been hard, and mental health services staffing and resources inadequate, ‘things have definitely gone downhill over the last 10 years’.

1.3.2 Holly Turner explained that a lot of the children she works with ‘rely on support from other sectors’ and many are ‘living in extreme deprivation’ and on waiting lists for a very long time. The result is that a lot of children are referred into acute mental health services when a large part of their problems arise from the social and environmental factors they face.

1.3.3 At the start of the pandemic there were no discussions about pandemic preparedness. Then, in addition to schools closing, respite services for parents, outsourced to private providers, ceased, adding to the strains upon families dealing with extremely challenging children:

'All the things that support them being emotionally stable, and everything was just completely taken away from them, their school, their respite, their carers coming in to help these families at home. And they just went into complete crisis.' (Turner)

Claps for carers

1.3.4 What Holly Turner found particularly difficult is that staff had been crying out for support and managing with shortages, for a very long time. She said it was great to have people showing appreciation (somebody washed her car; delivered pizza). But it was also very sad that it took a pandemic for people to appreciate the work she and others have been doing in incredibly difficult situations for a very long time. A lot of NHS workers have felt nobody really listens or pays attention to their situation.

1.3.5 Holly Turner and many others have been supporting the vaccine rollout locally on her days off. She says the success of the vaccine rollout has been down to the NHS:

'... it's evidence of when the NHS has the resources available to get the job done, they can do it ... it shows the dedication of the staff that a lot of NHS workers I know are doing this on their days off, because they want it to be a success. And we know that we need to get through this.' (Turner)

Holly Turner's husband is a crisis mental health nurse; their children are aged two and six. They didn't get a school place for their son even though they are both nurses because the school was 'at capacity'. Both Holly and her husband contracted COVID-19.

1.4 EXERCISE CYGNUS AND OTHER PRE-PANDEMIC PLANNING

1.4.1 Professor Scally explained that Exercise Cygnus was a 2016 training exercise centred around a scenario involving pandemic influenza, which resulted in a report with a number of relevant recommendations. There had also been other contingency planning such as in relation to the UK Foot and Mouth Disease outbreak, following the emergence of Middle East Respiratory Syndrome virus, and the 2006 Foresight report – '[Infectious Diseases, Preparing for the Future](#)'^{1.5} from the Government Office for Science. Professor Scally added:

'Ironically, one of the photographs included [an image] of large colonies of bats carrying virus with potential for transmission to humans. So this should not have come as a surprise to anyone that this sort of thing would happen.' (Scally)

Dispersal and loss of public health expertise

1.4.2 However, from 2010 onwards, with the election of the Cameron-led Coalition Government, a number of changes were imposed on the structures and organisation of many of the services relevant to pandemic preparedness. These included the abolition of government regional offices, Strategic Health Authorities, regional development agencies, Public Health groups and Primary Care Trusts.

1.4.3 Following the 2012 Lansley Health and Social Care Act, the NHS moved to a commissioning and contracting model. The public health structure was decimated, Directors of Public Health left the NHS,

were transferred into local authorities, and had a much-reduced role and depleted resources. This left the huge expertise in public health dispersed across structures. Regional functions disappeared and local functions were 'left to themselves and told to make their own arrangements for cooperation one with the other'. Local authorities were required to take a leading role but simultaneously had resources stripped from them.

1.4.4 Public Health England was created with staff centralised, becoming civil servants, and losing the very direct connection with local and regional activities. During this period, the UK moved from having a strong Public Health voice at the heart of government, to a situation where at the outbreak of the pandemic only one of the four UK nations had a fully trained, experienced, public health physician as their Chief Medical Officer.

1.4.5 Then, mid-pandemic, Public Health England was abolished and replaced, in an 'ill-judged' move, instead of in a 'planned and structured way', with the National Institute for Health Protection in an attempt many have suggested was to place responsibility for the poor handling of the pandemic onto Public Health England. Professor Scally pointed out that 'in fact, the seeds of that failure had been set long before by many of the changes that had taken place'.

An ideological issue

1.4.6 Professor Scally indicated that the changes to the organisation of public health structures were likely to have been a consequence of government having no real interest in improving the health of the population. Evidence of deteriorating population health is to be found in a range of public health indicators, the loss in 2016

of the status of having eliminated measles, falling vaccination and cancer screening rates, and rising rates of sexually transmitted diseases and drug-related deaths.

1.4.7 The UK Test and Trace system has been a recognised failure. In addition, there has been little co-ordination at local level between local authorities, the police, emergency services, nor engagement with communities, all of which are essential for successful contact tracing, testing, and isolating. Much public health activity during the pandemic was also counter to WHO guidance. Instead of working with local communities and helping them take control of their situation themselves, the Government has largely confined its action to telling them what to do. This failure is being played out in, for example, the vaccination hesitancy issues that are prevalent in some communities.

1.5 NHS RESOURCING

1.5.1 The period from 2000 to 2010 was a decade of increased spending on the NHS but was followed by a progressive squeeze commencing with the actions of the Cameron-led Coalition Government. The earlier investment had told in terms of a reduction in waiting times, improvement in staff pay, conditions and numbers, and performance indicators. This appeared to show what many had argued for a long time, namely that market-type 'reforms' were not helpful, and that the NHS performed best when frontline staff were provided with the resources needed to deliver services.

1.5.2 However, what occurred from 2010 onwards was an increase in funding settlement of between 1.5-2% each year (during which period the population rose by around 3 million) compared with around

3.9% average yearly increases over the previous 40 years. This was effectively a real-term freeze on spending which meant the NHS could not keep pace with demand, led to decay in capital infrastructure, created a growing waiting-list, damaged staff morale, and compromised the quality and safety of patient care

1.5.3 At the start of the pandemic, the target for 95% of accident and emergency patients to be seen or treated within four hours had not been met for the prior five years; the waiting list had risen to 4.5 million with 15% waiting for more than more than the 18-week target time; the number of hospital beds had fallen from 144,000 in 2010, to 128,000 by 2019; in particular, NHS hospital beds for mental health patients were being replaced by increased dependence on private hospital beds, quite often a long distance away from where people actually needed care. Staff shortages stood at 100,000 in total, including around 40,000 nursing vacancies: 'it was an NHS under pressure and in all fields'

Social care

1.5.4 Long-term social care for older people was originally part of the NHS but was effectively privatised in 1993 with the Thatcher reforms. Progressively, more of the responsibilities for long-term care of the elderly were transferred to local government, who were also having their funding reduced and who therefore means-tested charges. People with levels of need that might have been manageable at home with support, are now getting nothing until they reach crisis point, and this in turn leads to a growing number of people receiving no support at all.

Lack of accountable use of public funds

1.5.5 The Government has refused to say how much money has been spent on the transactional costs of the present semi-marketised NHS. When the market in healthcare first began to be introduced under the Thatcher reforms in the 1990s, there was deliberately no baseline drawn, to prevent examination of the change in transactional costs. Spending on bureaucracy, senior management, and administration did significantly increase at that time and continued into the Blair government as clinical as well as non-clinical care was increasingly contracted out. The consultancy culture has returned, with management consultants brought in to advise and design systems involving private contractors, instead of utilising and growing public sector expertise (see report para 7.1.11).

1.5.6 Before the market system was introduced, it was estimated that 6-7% of NHS spending was on administration and management. In fully marketised systems, the equivalent figure is upwards of 20%. The UK is currently somewhere in the middle, not a fully marketised, fully privatised system, but with growing private elements. It is difficult to establish how much money is being spent on private procurement, but it is clear that it is hard to see what benefit this has achieved.

1.5.7 The evidence points to a reduction in quality. For example, when contracting out began in the 1980s, the intention was to go to the lowest tender in order to make savings. That led to a destruction of the quality of hospital cleaning services, falling hygiene standards, and a rise in hospital-acquired infections, notably MRSA. This was

'... basically ripping off the lowest paid, and most exploited sections of the NHS workforce by dumping them into real cowboy companies that actually were going to reduce their pay, their hours, and increase the amount of work they're expected to do ... the NHS paid a really heavy price for privatisation.' (Lister)

Vested interests

1.5.8 Dr Lister was asked if there was a link between the politics of governance and the private market in the health industry. His response was 'yes', but not universally. Not all MPs from the governing party are involved with private companies but it is a matter of public record that a large number of contracts have been awarded to friends of MPs in the private sector during the COVID-19 pandemic and there are ongoing court actions to try to reveal the details. If a government 'doesn't care about equalities and really doesn't care about the poor people, doesn't really care what the impact of its policies are' it is very difficult to get it to invest seriously in an NHS capable of meeting both the needs of a pandemic and the existing needs of the population.

1.5.9 However, instead of investing in the NHS, the Government has announced it will be spending £10 billion over the next four years on contracting out to private hospitals. During the pandemic hundreds of billions of pounds have been spent, without due scrutiny, when this investment should have been directed at strengthening the NHS. (See report section 7.2)

Illogical policies

1.5.10 The NHS has been shown time and again to be the most cost-effective

healthcare system in the world. Yet instead of building on this success, government policies have meant that investment in the NHS has been reduced, public health systems decimated, and levels of ill health driven up, creating an increased burden on the health and social care systems: 'we're creating a no-win situation'. This makes no sense unless the purpose is to provide excuses to bring in private solutions, rather than improving the NHS as a publicly funded and publicly delivered health and care system.

2. HOW DID THE GOVERNMENT RESPOND?

Inquiry Session 2

GOV.UK

Coronavirus (COVID-19): what you need to do

Guidance for households with possible coronavirus infection

Guidance

Stay at home: guidance for households with possible coronavirus infection

Updated 16 March 2020

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2.0 INTRODUCTION

2.0.1 This session was about the UK government's response to the COVID-19 pandemic. The witness testimony covered the public health response to the pandemic, clinical management of COVID-19 cases in the community, and how the Government's response impacted vulnerable groups such as older people, key workers, and people in minority ethnic communities.

2.0.2 Professor King talked about the importance of a rapid response to a new pandemic threat to prevent the spread of infection by applying basic public health principles of surveillance and detection through an effective testing programme, with contact tracing and isolation of cases and contacts. This was also covered by Professors Costello and Baker in session three. They talked of government delays in taking the necessary steps to protect the population, including delayed lockdown, which allowed the pandemic to spread leading to the UK having one of the highest death rates in the world.

2.0.3 Dr Helen Salisbury, GP, gave evidence about the clinical management of cases in the community, with reference to the role of GPs and NHS 111. She argued that GPs were side-lined but could have played a vital role in both caring for patients and assisting public health measures to control the spread of infection.

2.0.4 Oluwalogbon (Lobby) Akinola, whose father died of Covid, talked of the devastating impact of losing a loved one. His father was a key worker supporting people with learning difficulties and had kept working during lockdown. Lobby talked about failings in the NHS 111 service: the vulnerability and lack of

protection for key workers and the effect of the pandemic on the black community. He also spoke about the experiences and hopes of the group he had joined COVID-19 Bereaved Families for Justice.

2.0.5 Jan Shortt talked about the failure to protect the elderly, especially those in care homes, and the failure to have invested in and supported essential services such as the NHS and social care, leaving them in a weakened position to face the pandemic:

'The NHS has been eroded by different governments. The health of the nation hasn't been looked after for decades and we're in a position now, where the NHS is on its knees.' (Shortt)

2.1 PUBLIC HEALTH STRATEGY

2.1.1 Despite advice and warnings from the World Health Organisation and several countries that had been the first to deal with COVID-19, the UK Government did not take prompt action to protect the population of the UK from the pandemic. Borders stayed open, people moved freely around the country, testing and contact tracing was stopped very early. When it was resumed in May it was ineffective.

2.1.2 The Government pursued a covert 'herd immunity' policy of allowing and facilitating viral spread through the population until mounting evidence of the large scale of deaths that would ensue forced it to change tack. Yet even then, when it was clear that efforts to contain and limit the spread of infection threatened to overwhelm the population and the NHS, the Government was late to instigate lockdown. This pattern of under-reacting and doing things ineffectually and too late was to repeat itself throughout 2020 and 2021.

2.1.3 The UK Government was first alerted to the threat of a pandemic in late January 2020. On 24 January *the Lancet* published a paper from China about the new coronavirus infection that had appeared there in Wuhan in December 2019. This was to be named COVID-19:

'The details were made available by Chinese scientists who published an extraordinary paper in the British journal, the Lancet, on 24 January, so that the whole world could be aware of the infectivity rate, the death rate, etc. of this new virus.' (King)

2.1.4 The paper reported on 41 COVID-19 patients who had been hospitalised in Wuhan: half had severe breathing problems; a third needed intensive care; and six died. They calculated the R number to be 3 (the R number refers to the number of people each case infected on average: an R number > 1 means exponential growth of cases).

2.1.5 Professor Ferguson of Imperial College made a similar calculation from his modelling and shared this with the first COBRA meeting on 24 January 2020. At that point the UK had all the information it needed to promptly prepare for a serious pandemic, which is what many other countries did. Boris Johnson who would normally be expected to chair the COBRA meetings was absent. It was chaired by the Secretary of State for Health, Matt Hancock who said after the meeting the risk from COVID-19 was 'low'. The Chief Medical Officer Chris Witty reassured everyone that the UK had a strong track record in managing new forms of infectious diseases and global experts were monitoring the situation round the clock. No prompt action was taken at that point and no effective plans were made to prepare for the pandemic in the UK.

Containment, Surveillance, Testing and Tracing

2.1.6 On 22 February 2020, the World Health Organisation director general (Dr Tedros Adhanom Ghebreyesus) emphasised the need for speed in controlling pandemic spread. He said that the window of opportunity was narrowing, so one needed to act quickly before it closed completely. He was referring to measures to detect and isolate cases to stop the infection spreading. Yet in the early weeks of the pandemic when it could have made a difference to the spread of the pandemic, the UK did not implement an effective testing and tracing programme.

2.1.7 Remarkably it halted all community testing and contact tracing on 12 March 2020. There is no record of all those who had COVID-19 or who died from it at home in those initial weeks. GPs were unable to test their patients even when they had symptoms of COVID-19. Accident and Emergency departments were not permitted to test people for SARS-CoV-2 unless they were admitted to hospital. Retrospective modelling by Imperial College, London, suggests that by 5 March, the day of the first UK death from COVID-19, there were already 10,000 cases in the UK.

Ports of entry

2.1.8 Controlling entry points for those who may have the disease is also a basic public health response to a global pandemic. Yet the UK government did not institute any border control in the initial months of the pandemic. People were not tested or quarantined and allowed to travel on through the UK. Thousands of people entered the UK from countries

where COVID-19 cases had occurred. For example in late January after Chinese New Year, a large number of Chinese students returned to the UK. 190,000 passengers flew to the UK from Wuhan and other high-risk Chinese cities between January and March, of which it is estimated that 1900 would have been infected.

2.1.9 In March thousands of football fans flew to Liverpool from Madrid (where cases were very high) and thousands returned from skiing holidays in Italy, where the rate of infection was high, in the last week of February. This is in contrast with countries like South Korea, Greece, Australia and New Zealand, which closed borders to incoming people early on. It is likely that the large number of cases imported into the UK this way overwhelmed the initial test and trace system and rendered it useless, leading to its cancellation on 12 March.

Herd immunity strategy

2.1.10 Professor King said that even when the Government realised the threat was real, it still did not act promptly to take effective measures to contain the virus. By early March 2020 it was known in the UK that the number of people getting COVID-19 was doubling every three to four days. Each week of delay would lead to a quadrupling of cases.

2.1.11 Yet large public events, such as the 10 March Cheltenham horse-racing Festival, attended by 60,000 people over four days, and the 11 March football match in Liverpool against Atlético Madrid, with thousands of fans flying in from Madrid* were allowed and encouraged to go ahead.

* At that time Spain had about six times as many Covid19 cases as the UK. All La Liga football matches were being held behind closed doors with no fans present to prevent spread of infection. Atlético fans came to Liverpool from Madrid, the worst affected part of Spain.

2.1.12 Professor King said a possible explanation for this approach was that the government intended large numbers of people to get infected as it was pursuing a 'herd immunity' strategy. This was alluded to by the Prime Minister when he spoke on TV of allowing the disease to spread and 'taking it on the chin'. Herd immunity was subsequently referred to in the media by government advisers, including the Chief Scientific Officer, Patrick Vallance.^{2.1}

2.1.13 Dr Salisbury agreed that the government appeared to adopt a herd immunity strategy:

'Firstly they did not try to contain the virus, and therefore they did not institute a test and trace programme. Instead they adopted a strategy that allowed the pandemic to spread, perhaps with the aim of achieving herd immunity.'
(Salisbury)

Lockdown

2.1.14 China and other countries had demonstrated that the mortality rate from the virus was around 1%. Modelling by Imperial College and the London School of Hygiene and Tropical Medicine showed that a herd immunity strategy, whereby the majority of the population is infected, could lead to 660,000 deaths.

2.1.15 As it became clear that the disease was spreading rapidly and that a herd immunity strategy would lead to an unacceptable number of deaths and the NHS being overwhelmed, the government belatedly instituted a lockdown on 23 March. It had been strongly advised by its scientific advisers to do so several weeks earlier.

2.1.16 King said lockdown is a blunt instrument to be used initially before the public health isolation process has been

put in place. It was used successfully by China in February 2020 to manage the outbreak in Wuhan. Some countries that had reacted quickly with effective FTTIS such as South Korea, did not have to institute a lockdown, and other countries such as New Zealand did early and brief lockdowns:

'If you want to give people a short lockdown you do it very quickly and come out of it very quickly.' (King)

2.1.17 The justification for delay - that there could be population 'pandemic fatigue' if the Government brought in measures too soon - was the opposite of reality: doing it earlier would have meant less transmission, fewer cases and easier-to-control outbreaks; doing it later meant there were many more cases to try to bring under control, requiring a longer lockdown.

2.1.18 The other argument used by the Government, claiming it was following scientific (i.e. SAGE) advice, was that controlling the spread of the virus too early would lead to a second and worse wave of the virus in the autumn and winter. This was not borne out by the experience of other countries that instituted effective early control measures. From an infection control perspective it did not make sense. Getting cases down would allow testing and tracing and other public health measures to keep numbers low and help prevent a second wave while buying time for vaccine development.

2.1.19 Finally, the argument was used that avoiding lockdown would protect the economy, but even the World Bank advised that the best way to protect the economy was to control the pandemic.

2.1.20 Professor King believes that had the UK gone into lockdown on 3 March (2020) instead of 23 March (3 weeks later) at

least 20,000 lives out of the 35,000 dying in the first wave could have been saved.

2.2 PERSONAL PROTECTIVE EQUIPMENT AND VENTILATORS

2.2.1 PPE had been in very short supply throughout the first months of the pandemic, leading to the deaths of many health and care workers. King said that the NHS should have been prepared but was not. All stockpiles of PPE and hospital equipment were depleted and the work that was done to prepare for a pandemic was lost. Even when the threat of the pandemic was recognised, the UK was late in ensuring it had enough PPE and ventilators for its hospitals and staff so that on 23 March when the country went into lockdown, the NHS did not have enough PPE and hospital equipment in place. The UK had seven ventilators per 100,000 population compared with Italy's 14 and Germany's 29. It also had far fewer hospital beds for its population than comparable European countries.

2.3 FIND, TEST, TRACE, ISOLATE AND SUPPORT

2.3.1 Lockdown did not remove the need for a public health strategy around FTTIS. Indeed it continued to be necessary because it could allow the country to come out of lockdown when case numbers were low and controllable by case-finding and isolating. In May 2020 the Government, having stopped all contact tracing, finally listened to advice and set up a test and trace system. The contracts were given to a group of private companies including Serco, bypassing local NHS GPs, local public health structures and hospital laboratories.

2.3.2 The programme was a huge and costly failure.^{2.2} The system was inefficient and ineffective, overly centralised and impersonal, and did not win the public's trust. Many people with the disease and their contacts were not contacted and did not isolate. Its total cost is estimated at £37 billion.

2.3.3 The lack of a support system for those who needed to self-isolate contributed significantly to this failure. Many people from low-income families were not given adequate financial support so could not afford to stop work. People living in multi-generational households, where they couldn't isolate themselves from others who were at risk, were not offered alternative accommodation. People living alone lacked essential support for everyday needs.

2.3.4 King said effective contact tracing requires 'shoe leather' – local contact tracers to make personal contact with people and ask them if they are able to isolate at home and what support they needed to do so:

'It's no use getting some call person to phone up an individual who has been found to have the disease or has been in contact with someone and simply tell them to isolate. That does not work. Even Baroness Harding said that a very high percentage of people have not isolated.' (King)

2.3.5 Both King and Salisbury believe the test and trace programme should not have been given to the private sector, as they did not have the necessary expertise, local connections or community trust. Instead, it should have been given to local public health services and NHS GPs, working together. Salisbury pointed out that this is what happens with other serious contagious diseases:

'In the middle of the biggest pandemic for over 100 years in this country, the test and trace system, the most important way of managing the pandemic, was given to private companies without any competition, and with no healthcare experience, to run from scratch. I believe that was a disastrous decision.' (King)

2.4 PUBLIC HEALTH MESSAGES

2.4.1 Salisbury believes public messaging was very poor. There were problems both with the messages themselves and the way they were conveyed. For example, early on Boris Johnson and Matt Hancock conveyed the message that COVID-19 was a mild infection that was little worse than flu and we could just 'take it on the chin'.

2.4.2 The confused and ever-changing messaging reflected confused government strategy, or lack of strategy, and this lost public trust. For example, in relation to Christmas, or schools reopening after Christmas, the government ignored scientific advice and said it was safe for people to gather over Christmas, and for schools to reopen, only to backtrack at the very last minute, or in the case of schools open them for a single day:

'There was a huge spike of completely avoidable deaths that happened in January 2021 because of that failure to listen to the scientists saying that this was going to be dangerous.' (Salisbury)

2.4.3 Despite the confusing message Salisbury was impressed by how observant of the rules most people were. However she believes some of those rules were wrong and this again reflected the failure of the government to listen to scientific advice. So the dominant message was about keeping surfaces clean, even when

we knew the virus was airborne. This led to lack of attention to preventing airborne spread, a particular danger in enclosed spaces. She pointed out how this led to the disastrous Eat Out To Help Out scheme in the summer, which led to increased infections:

'We knew even last summer that the virus was airborne. That's when the Chancellor decided that it would be a really good idea to get people into restaurants together, which almost feels as if he's working to promote the virus because it's so clear that would be something that would lead to spread. And it did. There's some work I think that comes from Warwick showing between 8 and 17% of case rises at the end of the summer were due specifically to the eat out to help out scheme.' (Salisbury)

2.5 COMMUNITY HEALTH CARE RESPONSE

2.5.1 In a pandemic, as well as a public health response to control spread of infection, there is a need for health services to manage cases of people with actual or suspected disease and to care for them in appropriate places whether that be in hospital or the community. This requires adequate infrastructure and staffing, adequate equipment, training and support for staff. It is the government's role to ensure those services are in place, staff properly trained and equipped and adequately supported.

2.5.2 Much of this should have been planned and prepared for prior to the pandemic but was not. The disastrous lack of planning, resources and health care strategy led to a situation where a record number of people died at home without medical care both from COVID-19 and

non-coronavirus conditions. By the end of June 2020 there were 59,000 excess deaths compared with previous years, of which 25,200 were in private care homes.

Health services for people at home

2.5.3 Our witnesses considered these failings were caused by a combination of not having enough staff or resources, lack of understanding in the initial weeks about how COVID-19 symptoms present and signs of deterioration, and directives from the government, transmitted by NHS management, to minimise admissions to hospital so as not to overwhelm the NHS. People were instructed by the government to contact NHS 111 if they felt ill and not to contact their GP, dial 999 or attend hospital.

2.5.4 The public got the message 'not to bother the GP or burden the hospitals'. Unfortunately this meant that many people who were ill with COVID-19 were denied medical care and left to die alone at home, and many other people with other life-threatening illnesses did not contact their GPs or stayed away from hospital, from fear of contacting COVID-19 or from concern not to burden the NHS.

2.6 GENERAL PRACTICE

2.6.1 Dr Salisbury said the skills that GPs could have brought to bear were not used, or only used very late. From the beginning of the pandemic, patients who thought they had COVID-19 got the message that their GP was not available to them. They were told not to contact their GP or dial 999 but to ring 111. This was really hard for patients and meant that GPs didn't fulfil the role they should have:

'There's a weird time when it first started when we were actually under-employed.'

There was a decision that all the Covid inquiries should go through 111 ... There was a lot of fear, so people stayed away from us ... I'm very, very angry. Because so many people have died who needn't have died ... People who died at home because they didn't get the medical attention they needed quickly enough.' (Salisbury)

2.6.2 GPs were not only side-lined but also shackled in their ability to help their patients. The most basic step in a GP's diagnosis and management of any disease is the ability to test for the disease. Yet GPs were never able to arrange SARS-CoV-2 tests for their patients. Even worse, for many months, GPs were not notified if any of their patients tested positive. That meant they could not monitor them or give them advice, as they would normally do for sick patients at home.

2.6.3 When the testing system was brought in eventually, the system was difficult to use, tests had to be arranged by the patients themselves, and the full range of symptoms suggesting COVID-19 was not recognised by the booking system so many patients who should have been tested were not able to get a test.

2.6.4 Dr Salisbury acknowledges that GPs were on a steep learning curve in how to respond to the new viral infection. It presented very differently from other infections that doctors were familiar with such as pneumonia. For example many patients with COVID-19 could be dangerously short of oxygen, but not feel breathless. But she believes that had GPs been more involved in their patients' care from the start they may have learned this sooner, leading to better assessments of severity of illness. Instead GPs were side-lined and as a result Salisbury believes lives were lost.

2.6.5 Later, as described in session 3, GPs would develop systems to support their patients with coronavirus infection, but this took several months and they had little support from the Government to do so.

2.7 NHS 111

2.7.1 Lobby Akinola's father became ill in early April and deteriorated over two weeks. He called the NHS 111 service and his GP several times to get advice on what to do and whether he should go to hospital. Each time he was advised to stay at home. The GP prescribed antibiotics. He died at home shortly after receiving the antibiotics, without ever having seen a doctor. Akinola believes that if his father had seen a doctor his death could have been prevented:

'As well as my father, many members of the (bereaved families) group report contacting 111 in the lead up to the death of their loved one. The service rarely recommended people to go to hospital unless it was an emergency, but by then it was too late.' (Akinola)

2.7.2 The [COVID-19 Bereaved Families for Justice Group](#) estimates that a fifth of its 2,000 members' relatives died after calling 111 and being told by an initial call handler that they were safe to stay at home. There were several possible reasons for the failure of NHS 111 to respond adequately including lack of training and experience; symptom check lists that under-estimated severity; and government policy to keep hospital admissions to a minimum to 'protect the NHS'.

Lack of training and experience

2.7.3 Dr Salisbury did not believe that the NHS 111 or 999 first responder call handlers had sufficient training. This view is supported by the nurse whistleblowers working for 111 reported in the Guardian who^{2,3} said they had had only a few hours training and were not equipped to diagnose and evaluate serious clinical conditions. An audit in July 2020 of the service they had worked in showed 60% of calls were “unsafe” due to inadequate clinical assessments by inadequately trained staff. They relied on algorithms and were not able to recognise when someone was seriously ill.

2.7.4 Subsequently the service was changed to include only experienced clinical staff but by then many thousands had contacted the service and been given inadequate advice that may have led to deaths at home. Dr Salisbury believes that if some of those patients had got to speak to their GP in time, their lives might have been saved.

Underestimating severity

2.7.5 Dr Salisbury said that NHS 111 and ambulance first responders were using checklists that underestimated the severity of COVID-19 symptoms so they failed to summon a response to attend to patients who were actually very ill. One of the reasons was that breathlessness was used as one of the signs of severity in the scoring scales that were used by 111 and 999. The lack of breathlessness in people with dangerously low oxygen levels (as explained above) led to an underestimation of risk.

Symptoms and signs in Black people

2.7.6 Lobby Akinola believes a possible reason for the high COVID-19 death rate in black people was a failure on the part of health services to understand the signs of severe COVID infection. For example, when his mother had COVID she called 111 for advice and was asked if her lips were blue. She asked her family if her lips were blue but they were unsure.

2.7.7 Akinola does not think the health workers knew whether or not black people's lips turn blue from lack of oxygen. He linked this to other examples of ignorance about the specific ways that health problems present in black people. In some cases this ignorance can lead to conditions being poorly treated, and even to death. Akinola gave examples of beliefs that black people are more tolerant of pain so get less pain relief, and the higher maternal mortality rate in black mothers.

2.8 PROTECTING THE POPULATION: THE ELDERLY AND THOSE IN CARE HOMES

2.8.1 Jan Shortt, representing the million strong National Pensioners Convention (NPC), said that at the start of the pandemic her members could see what was happening across the world and were becoming worried and scared, but there was a lack of communication with older people from the government from the very beginning of the COVID epidemic.

Age discrimination

2.8.2 Shortt said there was a failure to protect the most vulnerable older people, especially those in care homes, as well as discriminatory policies against older

people based simply on age. She criticised the policy whereby people over 70 were supposed to stay isolated to protect themselves, leaving their jobs, voluntary roles and family caring responsibilities while little was being done to control the spread of the pandemic.

2.8.3 Age was used to deny care to older people. There were policies to refuse people hospital admission, either from their own homes or from their care home, based mainly on age criteria and other imprecise concepts such as 'frailty'. GPs were pressured to rate people according to their frailty in order to decide who would and would not be admitted to hospital.

2.8.4 They were pressured to get older or frail patients to agree to Do Not Attempt Resuscitation (DNAR) orders and agree not to be admitted to hospital if they became seriously unwell. Some care homes were pressured to issue blanket DNAR orders. Ambulance services raised their threshold for admitting patients and their risk ratings put an undue emphasis on age, which led to many older people being denied care purely on the basis of age.

Care homes

2.8.5 Shortt did not agree that the government had put a 'ring of steel around care homes' (Matt Hancock). In fact the opposite occurred. In March and April 25,000 hospital patients were discharged into care homes without having a SARS-CoV-2 test. Many of them were infected without it being known. This followed a 17 March letter to English hospital trusts from the NHS chief executive Sir Simon Stevens, urging them to discharge all inpatients who were medically fit to leave hospital.

2.8.6 In addition hundreds of patients who were known to be SARS-CoV-2

positive were discharged into care homes. Shortt noted that there was alternative accommodation where those people could have been looked after such as the Nightingale hospitals, but they were hardly used, because they didn't have the staff to run them. COVID-19 thus entered the care system with infected patients passing it to staff who in turn passed it to other residents. Soon thousands of residents would be infected and dying:

'... we saw that contagion raging through care homes leading to the number of deaths, which I think are coming to about 25% of the total now, in care homes.'
(Shortt)

2.8.7 Between beginning of March and 17 April 2020 there were 10,000 excess deaths in care homes. The care homes themselves were ill-equipped to deal with the pandemic and its impact on their residents and staff. Shortt said that care home staff were doing a hugely responsible job but were not valued. They were not provided with personal protective equipment so they were both vulnerable to infection and could spread infection to others.

2.8.8 The chronic understaffing of care homes was exacerbated by staff being off sick or having to self-isolate at home. Agency staff, many on zero hours contracts who could not afford to self-isolate even if sick, were employed and were moved between care homes, spreading the infection. By August 26,000 more people had died in care homes than was normal for that time of year.

Blanket do not resuscitate orders

2.8.9 Shortt described the shock that she and her group experienced when they discovered that blanket DNAR orders were being imposed on people in care homes. While they understand that for some people such DNAR orders are appropriate this should come as a result of individual assessment and discussion. Such a significant decision should not be a blanket policy, applied indiscriminately.

2.8.10 There was also a policy not to admit care home residents to hospital. Care homes were advised not to call 999. Research by the Health Foundation^{2.4} found the number of people admitted to hospital from care homes fell during the pandemic with 11,800 fewer admissions during March and April compared with previous years.

2.8.11 An Amnesty International report^{2.5} concluded that the Government had violated the human rights of care home residents by imposing blanket DNAR orders on residents in many homes and restricting their access to hospital.

Pre-pandemic crisis in care homes

2.8.12 Shortt said that even before the pandemic hit, care homes were struggling. A crisis had been developing over the past decade with £16 billion having been taken out of care funding over that period. Many, facing financial difficulties and bankruptcy, were sold off or closed, and those that remained struggled to provide sufficient staffing levels and quality, resulting in understaffing and dependency on unqualified staff.

2.8.13 Along with other organisations such as Age UK, the NPC had been saying to the government for a long time they

need to deal with the crisis in care, by funding it properly and reforming it. But the government, throughout the last decade, had not listened or acted. At the start of the pandemic the NPC wrote to Boris Johnson about their concerns but he never replied. Had the care sector been properly funded Shortt believes they would have been in a better position to deal with the pandemic, with more staff and resources including PPE:

'The devastation that care home residents have suffered and are still suffering is unacceptable. It shouldn't have happened, needn't have happened and should never happen again.' (Shortt)

2.9 PROTECTING THE POPULATION: BLACK, ASIAN AND MINORITY ETHNIC COMMUNITIES AND KEY WORKERS

'The pandemic has highlighted what I believe are the socio-economic inequalities that exist in society, and we consequently have the black community especially affected by the pandemic.' (Akinola)

2.9.1 Lobby Akinola pointed out that Black, Asian and Ethnic Minority communities had a much higher death rate from COVID-19 than the white population. This may partly be because a high proportion of people from these communities are key workers in public facing roles, and lacked adequate PPE, putting them at high risk of infection.

2.9.2 Akinola said that his family members, along with other key workers who had to keep on working in public-facing roles, had no access to PPE. People from BAME communities are also more likely to be living, as did Akinola's family, in multi-generational households, making it

difficult to isolate (see report sections 2.3; 7.5).

2.9.3 Akinola said the role of Government is to protect the population:

'I believe that the role of the Government and the Prime Minister is service; I believe that leadership is service, and his role is to help protect and care for the people of this country in our hour of need.' (Akinola)

2.9.4 He disputed Johnson's claim that the Government had done its best. In particular Johnson and his government had failed to protect the population, vulnerable groups and front line workers. He responded to the pandemic and his duty to protect the public and health care staff with arrogance and insensitivity:

'They didn't procure PPE; we didn't go into lockdown soon enough because scientific advice was being ignored time and again.' (Akinola)

2.9.5 He noted that doctors, nurses and other health workers were undervalued:

'Johnson called on them to risk their lives to protect the country but didn't provide the support they needed. We saw the pictures of doctors and nurses using bin bags to protect themselves, instead of PPE.' (Akinola)

2.9.6 Boris Johnson's levity where he called the ventilator procurement programme 'operation last gasp' made him angry: people were dying and Johnson was cracking jokes. Akinola felt this displayed arrogance and insensitivity that was grossly inappropriate for a leader at a time of national crisis:

'My family had to sit and watch my dad die for two weeks and then you see the leader of the country stand up and

make jokes about the fact that people are being robbed of their breath. That is something that is very difficult to see and it's not something that I think you forget.' (Akinola)

2.10 CALL FOR A PUBLIC INQUIRY

Akinola explained that COVID-19 Bereaved Families for Justice, is calling for a public inquiry to understand what went wrong in responding to the pandemic, to learn from mistakes to prevent them happening again, and to hold the government to account:

'When we say we're looking for justice, it's a sense that the people who have been responsible for how the Government responded to this pandemic are held to account or made to take responsibility for their actions and that those actions don't go without consequence.' (Akinola)



3. DID THE UK GOVERNMENT ADOPT THE RIGHT PUBLIC HEALTH STRATEGY?

Inquiry Session 3

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

3.0 INTRODUCTION

3.01 Session three explored whether the UK government adopted the right strategy in response to the COVID-19 pandemic, what alternative strategies might have been more effective and whether the UK could have learned from other countries as well as its own experience, to change course. These questions were posed in the context of the UK having one of the highest COVID-19 death tolls in the developed world, especially compared with other Western European countries and with Asia Pacific countries.

3.02 Given the poor comparative outcomes it is clear that many other countries pursued more effective public health strategies. What is it we can learn from countries that were more successful and can we use that learning to adopt a more effective strategy going forward – one that would save lives, and protect people, vulnerable communities and the economy?

3.03 This session had a particular focus on New Zealand which pursued a successful elimination strategy and benefited from the insights of Professor Michael Baker, specialist Public Health physician and a member of the New Zealand Ministry of Health COVID-19 technical advisory group.

3.04 The session began with Professor Anthony Costello recapping the standard pandemic strategy advocated by the WHO that was outlined by Professor King in Session 2. Most of the countries which managed the COVID-19 pandemic more successfully than the UK followed to a greater or lesser extent the WHO strategy.

3.05 Later in the session we heard from Rehana Azam, General Secretary of the

GMB union, about the lack of protection for key workers and how this could be improved, and then from Janet Harris about a more effective locally based strategy for communicating with, engaging and supporting people in communities that have been affected by COVID-19.

3.1 WORLD HEALTH ORGANISATION GLOBAL PANDEMIC STRATEGY

3.1.1 The WHO announced on 29 January 2020 that COVID-19 was a public health emergency of international concern, spreading worldwide with great speed and with a high mortality rate. It published detailed guidance on public health interventions that could reduce or interrupt transmission of COVID-19, based on the measures that had been successfully employed in China, which at that time were the only measures proven to interrupt or minimize transmission chains in humans.

3.1.2 The WHO recommended immediate case detection and isolation, rigorous contact tracing and quarantine, and direct population and community engagement with measures to control spread. Above all it advised a speedy response as there was only a brief window of opportunity to control the pandemic.

3.1.3 Speed was of the essence not only to get on top of the virus but to preserve the economy and allow people to return to normal lives as quickly as possible:

'We've also seen the economic damage that countries that have not suppressed the virus, like us, have suffered, compared to those who are now having pretty normal economies and lives because they acted quickly.' (Costello)

3.2 LESSONS FROM OTHER COUNTRIES

'We should have learned from other countries that were successfully suppressing the virus like China and South Korea, but we did not.' (Costello)

3.2.1 States such as South Korea, Taiwan, Japan, Singapore, China, Hong Kong, Vietnam, Thailand, New Zealand, Australia and to some extent Finland, Greece, Norway and Denmark, achieved suppression of the virus through effective public health measures.

3.2.2 Sweden, by contrast, which had adopted minimal public health protections to allow the virus to spread in the hope of achieving natural immunity and protecting its economy actually did much worse than its neighbours Norway, Denmark and Finland, in terms of deaths and adverse economic impact.

Contact tracing: a vital initial response

3.2.3 South Korea, Taiwan and China set up testing and contact tracing very quickly in early 2020. In Wuhan, China, 9000 contact tracers were deployed within two weeks for an 11 million population. South Korea introduced intensive testing, tracing and isolation in February 2020 when they had just five deaths. They mobilised 70 field teams to do intensive testing in two provinces where cases had emerged, had all the cases isolated, supported and carefully monitored by clinicians and community health workers. Families were financially supported to ensure compliance with isolation. The epidemic was suppressed within three weeks, with just 250 deaths. A year later they had a death rate of 33/million population, compared with 1860/million in the UK.

3.2.4 In many of these countries people had been able to return to near normal lives and go about their daily business in a relatively short time and their economies suffered less economic contraction and recovered much more quickly than ones that had allowed COVID-19 to spread. Yet, despite knowing such a strategy had worked in all the countries that had adopted it, the UK government failed to follow WHO advice.

Lockdown

3.2.5 Several countries managed to control the pandemic without lockdown and others had either partial lockdowns or brief early lockdowns that were effective:

'We should remember that most of the countries that went for an intensive elimination strategy had no national lockdown, their economies are thriving and their people look forward to their vaccines with little local mutation risk.' (Costello)

China had a rigorous regional lockdown in Wuhan, but no national lockdown. Several European countries, such as Iceland and Finland and to a lesser extent Norway, managed to control the spread of the virus through partial lockdowns and intensive finding of cases, testing, contact tracing and isolation. Some faced minor flare-ups of infections over the winter, which they rapidly suppressed. New Zealand had an intense early seven-week lockdown, and some regional lockdowns subsequently.* New Zealand's experience will be explored later in the session. Several of those economies experienced economic growth and none experienced anything near the decline in GDP that afflicted the UK.

* New Zealand had a second brief national lockdown in August 2021 and a regional lockdown in Auckland may continue into December 2021

3.3 THE UK RESPONSE TO THE PANDEMIC

3.3.1 The UK government adopted a very different approach to that advocated by *WHO*, based on the idea of British exceptionalism. The Deputy Chief Medical Officer claimed that advice from *WHO* applied only to underdeveloped countries, not to the UK. Details of the UK response to the pandemic were reported in session two and reiterated in this session.

Standard public health strategy and WHO advice not implemented

3.3.2 The UK prided itself in having an advanced and sophisticated public health system yet it failed at the first hurdle. It did not institute a Find, Test, Trace, Isolate and Support (FTTIS) programme to prevent onward transmission to the population, despite WHO advice and disregarding expert evidence to the first SAGE meeting (27 February 2020) of a reasonable worst case scenario in which 80% of the UK population could become infected with a 1% fatality rate, causing hundreds of thousands of deaths.

3.3.3 No convincing reasons were ever given for failing to institute an early FTTIS system. The government said they did not have the laboratory capacity, yet they ignored the 44 labs run by Public Health England, as well as university labs that could have been used. Professor Paul Noble had no government response to his offer of the Crick Institute labs.

3.3.4 An effective public health pandemic strategy starts long before a pandemic. There should be sufficient laboratories and public health resources to be able to institute a prompt test and trace system in a country that prides itself on having one

of the best public health systems in the world. However, public health laboratories had been closed or privatised in the years leading up to the pandemic.

3.3.5 The government also failed to recruit and deploy sufficient contact tracers. For example, extrapolating from the effective contact tracing efforts of other countries, the UK would have needed 50,000 contact tracers. This would have been possible as they could have used some of the 750,000 people who volunteered to support the pandemic response, of whom 40,000 were retired health workers.

3.3.6 Having left it too late to track down cases the UK government decided, on 12 March 2020, to stop all attempts at testing and tracing. The failure to institute a FTTIS system right from the start allowed the virus to multiply rapidly across the country leading to a peak of cases and deaths in April when hospitals became overwhelmed and there was de facto rationing of intensive care.

Did the UK follow the wrong pandemic plan?

3.3.7 Costello believed one of the UK Government's initial errors was to follow a pandemic influenza plan, as modelled by the 2016 Exercise Cygnus, which may have led the government advisory body SAGE not to advocate strongly for an early FTTIS system. Costello explained there were important differences between influenza and COVID-19 and we should have learned from previous coronavirus epidemics such as SARS, as the East Asian countries did. Not only did COVID-19 have a much higher fatality rate than flu but, like SARS, it took longer to pass from individual to individual than flu so it could be controlled by testing, isolation and contact tracing:

'The experience of China and other countries like South Korea showed us that the COVID-19 coronavirus was different from flu. It had a longer generation interval and could be controlled by testing, isolation and contact tracing. This was the advice from the WHO that the UK government ignored.' (Costello)

Failure of containment

3.3.8 The failure to contain entry into the UK and the spread of the virus led to an exponential growth in cases. As this happened, Johnson announced an action plan on 3 March 2020. The plan adopted a delay and mitigation strategy which meant efforts to slow down but not eliminate transmission: some of the elements of the plan might have helped if they had been implemented straight away but the plan was not put into place following its announcement. Instead there were just messages about washing hands and advice to stay at home if at all possible.

Failures in the Find Test Trace Isolate and Support strategy

3.3.9 Eventually, in late spring 2020, a privately run FTTIS system was set up. It was an extremely expensive failure:

'The cost of the programme has been astonishingly expensive with £37 billion spent or set aside. It was described by a former permanent secretary to the Treasury as "the most wasteful and inept public spending programme of all time." (Costello)

3.3.10 Surveys show that few people actually self isolated, often due to poverty and lack of financial support, rendering the programme ineffective. Costello believes that the FTTIS system failed because it

was given to the private sector that had no experience in running such services and had no connection with local public health or GP systems. For example SARS-CoV-2 positive results were not shared with GPs so they did not know which of their patients were infected and could not follow them up:

'... people were being told that they had a potentially fatal disease, but the GP was not being told, and they were not being linked together.' (Costello)

3.3.11 He believes a system using local public health and GP networks with local contact tracers would have been much more effective. This echoes the views of Dr Salisbury in session two. Currently public health is not adequately resourced for this work, having had its funding cut in recent years. Some local public health departments have done very good work on their own initiative without the benefit of any of the £37 billion that had been given to the private test and trace providers. Costello recommended investing money in local authority public health, giving them the contact tracers they need, linking testing information into general practices, primary care networks and public health, so that there is an integrated response locally.

Herd immunity strategy

3.3.12 As described in Session 2 evidence began to emerge that the reason for the government's reluctance to take effective measures to control the virus early on was because it was implementing a 'herd immunity' strategy,^{3.1} without the usual requirement for a successful herd immunity strategy - which is an effective vaccine:

'Basically, we "took it on the chin". And the results are there to see. I think we're up to 147,000 deaths.' (Costello)

3.3.13 The herd immunity strategy was challenged by scientists who pointed out several serious flaws: the millions contracting the disease, the tens of thousands of deaths, and the impossibility of separating and protecting the 'vulnerable' for any significant period of time. Imperial College London modelled that a natural herd immunity approach could lead to 250-500,000 deaths. In addition it was not known how long natural immunity lasted, especially in older people.

Lockdown in the UK

3.3.14 Although the government appeared to drop the herd immunity approach, it did not develop an effective alternative strategy throughout 2020 to deal with the virus, relying on the hope of a vaccine at some point to see it through. There followed a series of restrictions and lockdowns that were not as effective as several other countries' lockdowns, mainly because they were instituted too late and lifted too soon, without other measures in place to control the virus and stop it resurging.

3.3.15 For example, scientists advised a 'circuit breaker' in September but nothing was done until November. This was relaxed before Christmas leading to a surge in cases and calls for a further lockdown in early 2021, which was again delayed until cases and deaths had reached another peak:

'The government has now failed four times to implement a successful test and trace programme: in February/March, July, September and December 2020. As a consequence we have suffered three

national lockdowns with severe economic impacts, especially on the poorest citizens of our country.' (Costello)

3.3.16 The strategic argument that the longer one delays lockdowns the higher the case numbers and the longer and more damaging any subsequent lockdown will be, both to the population and to the economy, was ignored by the government. Instead the UK had ineffectual lockdowns, instituted too late and lifted too soon, that did not prevent ongoing viral transmission, high numbers of new cases, hospitalisations and deaths, even with significant numbers protected by vaccination from early 2021.

Reasons for failure of UK strategy

3.3.17 Costello attributes the failure of UK strategy to a variety of factors, including:

- Failure of leadership and lack of government responsibility and accountability
- Political leaders underplaying the severity and risk of the pandemic
- Failure to take on board lessons from other countries and WHO advice
- Errors in advice given by SAGE; lack of independent public health expertise
- Failure to mobilise test and trace response in February 2020
- Early adoption of a herd immunity strategy
- Late lockdowns
- Giving contracts to private sector, bypassing public sector

Given the failures of the UK strategy it is worth looking at successful strategies in other countries to see what we can learn

from them. One such country is New Zealand, which adopted an elimination strategy.

3.4 NEW ZEALAND: A CASE STUDY

3.4.1 COVID-19 began in New Zealand as an imported disease, like all countries outside China. The first case was in February 2020. Scientists modelled the likely impact of a poorly controlled pandemic in New Zealand when it was clear the virus was highly transmissible, was spreading locally, and that cases would increase exponentially.

3.4.2 Professor Baker explained that like most countries across the globe, New Zealand started off with a pandemic influenza plan that had mitigation (allowing transmission but trying to slow it down and protect the vulnerable) as its dominant model, but by early March there was well-documented evidence of Asian countries containing the virus and a very helpful report from the World Health Organisation joint mission to China by Professor Aylward and colleagues.^{3.2}

Decisive action, learning from others

3.4.3 From looking at what had happened in China and other countries, it was clear that an elimination strategy was possible and would be the best way to protect the population. They advised the New Zealand government that there was a brief window of opportunity to eliminate the virus. So they acted quickly and decisively and New Zealand went into an intense lockdown.

3.4.4 That was a courageous move by the government because at the point they made the decision, New Zealand had only 102 cases and no deaths. They weren't

sure about how effective this strategy would be, or the consequences, but their political leaders followed the science.

3.4.5 Baker was surprised that every country with the resources did not follow the success of China in trying to eliminate coronavirus, and he believes the UK could have done so had it acted promptly. That could have reduced the global burden of infection and helped those countries less able to protect their population.

What is zero Covid?

3.4.6 Professor Baker explained that New Zealand aimed for and achieved elimination of the virus, also known as a 'Zero Covid' strategy, defined as 28 days without any case in the community, monitored through high volume testing. Professor Baker said the day he gave evidence to the Inquiry was very symbolic because, exactly one year previously was 'elimination day' for New Zealand.

3.4.7 He explained that elimination was not a new idea but has been core to infectious disease thinking for three decades. The WHO uses that framing consistently in relation to other infectious diseases, such as polio and measles, and more recently the Ebola outbreak in Africa, and it is universally understood. Elimination is not the same as eradication as that would require a concerted global effort that would take time, but it does mean trying to reduce to a minimum viral transmission within a country and dealing robustly with any outbreaks or imported cases that do occur. In other words there is 'zero tolerance' of viral transmission. In a BMJ article Professor Baker explains in detail the meanings of the different terminologies for pandemic control measures^{3.3} (see also glossary).

What public health methods did New Zealand use?

3.4.8 New Zealand moved quickly to quarantine all arrivals. They were tested three times before being permitted into the country. This allowed about 120,000 people to safely cross the border into New Zealand. There were some cases due to quarantine failure, but they were manageable. The New Zealand system, based on quarantine of all visitors, not only helped contain the virus but helped prevent new variants developing as a result of transmission within the country.

3.4.9 New Zealand introduced a four level alert system that was adapted from the system used in Singapore, but instead of increasing the alert levels as the pandemic got more intense they started at the highest level of containment to eliminate the virus, and reduced it as cases diminished.

New Zealand lockdown

3.4.10 Compared with other countries like the UK, Sweden, the US and Australia, New Zealand spent very little time in lockdown. It lasted only seven weeks after which life returned virtually to normal. They have had to use focused local lockdowns subsequently to try to prevent imported cases spreading:

'We emerged after seven weeks with no virus in New Zealand that you could detect.' (Baker)

3.4.11 In response to a question about the fear that there may be lack of compliance with lockdown and a risk of 'pandemic fatigue', Baker replied that those concerns did not arise because there was public support for the proposal to have a short intense lockdown early so that they could

achieve zero Covid in the community. Baker said the elimination strategy had proven to be very effective at allowing the return of normal economic, social and educational activities in New Zealand. As noted in the article in the British Medical Journal^{3,4} the countries that have achieved elimination have protected public health and also had less economic contraction.

Vaccination

3.4.12 Professor Baker wrote in the BMJ that

'A goal of eliminating community transmission of the pandemic virus causing COVID-19 (SARS- CoV-2) is achievable and sustainable for some jurisdictions using non-pharmaceutical interventions and will be facilitated by the introduction of effective vaccines.' (Baker)

He regarded the development of vaccines as a great accomplishment that would make a huge difference to the course of the pandemic. He reminded us that vaccination is a means to achieve herd immunity, one of the cornerstones of infectious disease control.

3.4.13 New Zealand embarked on a programme of vaccinating its population both to help limit the risk to the population from the outbreaks due to case importations that evade quarantine, and to allow the country to open up again to international travel. However Baker believes that the availability of vaccines does not reduce the need for public health measures to reduce to a minimum the level of virus transmission.

3.4.14 Baker warned that if the virus is allowed to spread in the community before sufficient numbers are vaccinated, this creates selective pressure for variants

that are more transmissible, or resistant to vaccines. The virus is less stable than, say Polio or Measles, and multiple new variants are emerging around the world. Furthermore, as long as there is still a lot of virus transmitting through the population even those who have had the disease or been vaccinated remain at risk because immunity from natural infection and vaccination is not 100% and can decline.

3.4.15 A continued elimination strategy through public health measures can reduce these risks, giving New Zealanders a better chance of getting ahead of viral evolution and achieving herd immunity.*

Was New Zealand in a unique position?

3.4.16 In response to the question whether the geographical and population density differences between New Zealand and the UK mean that different strategies for COVID-19 were justified, Baker acknowledged that New Zealand had some advantages due to geography, and a bit more time to work out an optimal approach.

But he pointed out that many countries in Asia, with high population densities and long borders with their neighbours, have also succeeded with elimination approaches:

'Vietnam, I think is a remarkable example, obviously mainland China, also Taiwan, Laos, Cambodia, Singapore, all have already done very well at minimizing the impact of the virus.' (Baker)

He believes elimination can work very well in a huge diversity of countries with different geography, demographics, and economic development.

Postscript: has elimination been vindicated in New Zealand?

3.4.17 Since the completion of the People's Covid Inquiry and Professor Baker's evidence, New Zealand has indicated a shift in policy from elimination to suppression. In a paper entitled 'Covid-19: Is New Zealand's switch in policy a step forward or a retreat?'^{3.5} Professor Baker wrote:

'The elimination strategy has operated from March 2020 until now and has enjoyed huge support here. It gave New Zealand the lowest COVID-19 mortality rate in the OECD, a high level of freedoms, and above-average economic performance. If we had experienced the same mortality as the UK (around 2000 per million) we would have had 10 000 deaths. Instead we had 28 (5 per million).'

The government's COVID-19 strategy was mapped out in August in its Reconnecting New Zealanders to the World plan and was one I supported. It included continuing with elimination until we had high vaccine coverage and then cautiously opening up to greater inbound travel while keeping case numbers low. This stage was expected to be reached in early 2022.

Delta has forced us to move beyond elimination sooner than we wanted to.

* Since the Inquiry, New Zealand has experienced an increase in cases due to the Delta variant that has required a return of measures to protect the population, including a prolonged lockdown in Auckland that has recently been slightly lifted. Nevertheless the impact of COVID-19 on New Zealand is still very small, thanks to their elimination approach, putting them 18 months ahead of the rest of the world and in a good position to benefit from vaccination and new developments in treating COVID-19. As of 5 November 2021, NZ has had a total of 7,138 cases and 29 deaths from the virus since the start of the pandemic. It is hoped that the roll out of vaccination in New Zealand can get ahead of the growing number of cases, especially in the Maori and Pacific Islander communities.

When delta arrived here, we were only partially immunised. We almost got it under control, from 80 new daily cases or so down to the low tens of cases. But elimination was never an endgame: it was only a strategy until you had a good vaccination. Fortunately, now we do.

Elimination certainly appears to be the optimal initial response to a new pandemic. With the availability of safe and effective vaccines, the optimal strategy is probably now swinging towards suppression, with high vaccination coverage.

There's still insufficient information to know the optimal long-term strategy for managing COVID-19. If we get more effective vaccines and antivirals in the future, elimination may again become the optimal strategy, as it is now for polio and measles. This approach would also be more important if long Covid turns out to be as serious and common as some evidence suggests.' (Baker)

3.5 WHAT STRATEGY FOR THE UK NOW WE HAVE A VACCINATION PROGRAMME?

3.5.1 The UK missed opportunities many times to embark on an effective elimination strategy, but with the vaccination programme it may not be too late. It's worth recalling that elimination does not mean eradication – that would require a sustained global effort which is a long way off – but it means trying to reduce viral transmission to a minimum through ongoing public health measures and responding vigorously to control any local outbreaks. This is much easier with an effective vaccination programme. Such efforts can complement the vaccination strategy and make it more effective.

Continued role for public health measures

3.5.2 Professor Costello stated that vaccination is a vital part of a Covid elimination strategy. As Costello and Baker explained in an article in the Guardian: vaccination and public health measures are complementary.^{3,6}

3.5.3 Therefore Costello advocates for equal emphasis to be placed on vaccination and other public health measures such as continued contact tracing efforts and support for people to isolate (FTTIS), ventilation in enclosed spaces, social distancing, allowing people to work from home if possible, and mask wearing in public indoor spaces.

3.5.4 An elimination strategy protects against some of the weaknesses of a vaccine-only strategy. If the UK were to rely solely on vaccination, it risks having another surge later in the year, whether because of a new variant or because of persisting numbers of people who are unvaccinated, or because of the waning effect of vaccination. Deaths are likely to be much lower because the most vulnerable have been vaccinated, but many people will still be vulnerable. So there could be large numbers of people going back into hospital, and quite a few going into intensive care units.*

* This has been borne out by subsequent developments in the UK. As of 5 November there are over 37,000 daily cases, over 9000 people in hospital and over 200 daily deaths.

3.6 GLOBAL VACCINATION

3.6.1 Costello believes global vaccine equity is immensely important. No country is truly safe until all are safe:

'We need the money, and we need the mechanisms to ensure that everyone in the world who needs it can get a vaccine. We're all in this together, and if we're not going to provide the funding and the access to vaccines which touches on all issues around intellectual property and voluntary agreements and the like, then we're going to be in this for a very long time. It's been disappointing to see that the G20 have not come together to really pull together a strategy and the finance, to ensure that this happens.' (Costello)

3.7 EFFECTIVE COMMUNITY BASED PUBLIC HEALTH

3.7.1 As several witnesses have testified, community based strategies for controlling the pandemic can be very effective. Janet Harris is a retired public health professional, currently working with a group called the Sheffield Community Contact Tracers. She previously helped develop community based contact tracing during the HIV epidemic in Massachusetts, USA.

3.7.2 Harris emphasised that good communication and effective contact tracing was core to the success of any FTTIS system. When she and others in her locality with public health expertise realised that the top-down national test and trace programme was failing to control the spread of COVID-19 they recruited and trained volunteers to do pilot studies which demonstrated that community and hospital-based contact tracing was feasible. When later in the pandemic local

authorities were given more responsibility for contact tracing her group sought ways to support what they were doing, including training link workers from within local communities, and exploring better ways of conveying key messages about the pandemic within communities.

3.7.3 This included support for those having to self-isolate, and building trust in communities that traditionally distrust government, including immigrant, refugee and low-income groups. They explored the underlying reasons for this lack of trust and developed ways to restore trust so that people would co-operate with contact tracing, vaccination and public health messages.

3.7.4 They found the best way of spreading public health messages in these groups was listening to their concerns, involving them in co-producing public health messages, and spreading these messages by various means including word of mouth, which was one of the most effective methods and absolutely depended on the involvement of local people and local knowledge for its success. There are lessons there for every area that wants to improve community participation in and control of effective local public health initiatives.

3.8 PROTECTING KEY WORKERS

3.8.1 An important aspect of any pandemic strategy is support and protection of key workers, especially those delivering health and care services. This matters not only because such workers are more vulnerable because they are more likely to be public-facing, but also to maintain essential services which is one of the goals of a sound pandemic strategy. This was touched on in Session 2 when we heard from Oluwalogbon (Lobby) Akinnola

whose father, a key worker, had died of COVID-19. What strategy did the UK government adopt in relation to this, what were its consequences, and could it have done better?

3.8.2 Rehana Azam who has been organising the GMB industrial response to COVID-19 since February 2020, said the government was simply not prepared for the pandemic. It had no plan to protect key workers. There was a failure to provide adequate PPE across the NHS, social care, schools, transport and other public-facing sectors; to ensure workplaces were safe; and to support workers to self isolate.

Personal Protective Equipment

3.8.3 Advice about PPE changed 40 times in six months. Some paramedics on the front line had no protection at all. Azam believes that many workers contracted COVID-19 because they had no PPE and were exposed to risk as front line workers.

Workplace safety

3.8.4 Some employers shirked responsibility for making workplaces safe, even though that was their duty under the Health and Safety at Work Act. The government failed to enforce regulations requiring employers to do workplace and individual risk assessments and to protect their employees. It was up to trade unions to establish COVID-19 safe environments and to look at risk assessment especially for ethnic minority workers. Azam believed this was where trade unions had really come into their own in the past year as they collated resources and trained their representatives so they understood what a COVID-19 safe workplace looks like, enabling them to challenge employers to make changes to protect employees,

and consider what jobs could be done in different locations.

Lack of support to self isolate

3.8.5 Many GMB members are women and from ethnic minorities, working on minimum pay and conditions. They felt they couldn't afford to self-isolate as they would only get statutory sick pay of about £95, which was not enough to live on:

'We urgently need government to either up the value of statutory sick pay, or just step in and underwrite wages of workers who have to self-isolate.' (Azam)

Disproportionate impact of deaths across BAME communities

3.8.6 The GMB Trade Union recognised the disproportionate impact of deaths across our Black Asian and Minority Ethnic communities, and joined with other groups in summer 2020 to call for an independent inquiry into this. Professor Fenton was tasked by the Government to do a review into why there was this disproportionate impact of deaths on BAME communities. The report was delayed and when it was published it was redacted with no real recommendations for how to protect BAME workers on the front line. Lobby Akinola in Session 2 referred to this as one reason for the lack of trust in the government within BAME communities:

'... and I find that, even today, when I'm talking about it, it makes me very very angry because the government could have stepped in at any point and said okay, we're going to try and get this PPE challenge under control, we're going to shore up people's wages, so people don't have that impossible choice of do I go to work or not. And we're going to try and

protect staff as much as we can, and they didn't do any of that.'(Azam)

Call for public inquiry

3.8.7 The GMB is calling for justice for the families of workers who died and for those who contracted long Covid through their work. It wants to see a public inquiry into the governments handling of the epidemic:

'Because the government was too slow to protect workers, we've sadly lost workers unnecessarily. And we do need to get justice for their families.'(Azam)

A more effective strategy to protect key workers and front-line staff

3.8.8 Azam outlined the changes her union would like to see, going forward, both to help workers who have suffered and to prepare better for future emergencies, and these are listed in the recommendations:

- Safe workplaces with updated and enforced health and safety legislation
- Improved funding for public health and public health emergencies
- Support services for staff affected by COVID-19, including long Covid and mental health problems
- COVID-19 to be classed as industrial disease; this would enable assessment of the degree to which working conditions contributed to people getting COVID-19, follow up the long term impact of COVID-19 on workers, and help in developing safety recommendations in future
- Bringing privatised health and care services back into public ownership; the privatised and fragmented

system contributed to the difficulty in responding appropriately to the pandemic, in care homes especially

- An economic recovery plan that puts workers at its heart
- A pay rise for frontline staff in health and social care; frontline staff were central to maintaining services throughout the pandemic but were undervalued. On average, NHS workers have lost about 15% and local government workers 23% in real terms pay cuts over the past decade
- Key worker status for all key workers, including migrant workers:

'Never again should our workers be on the frontline in a pandemic and not have the protection they need put in place right from the start. We want the value of key workers be recognised. We want local government workers to get back the wages that they've lost over the past year and we need to stop the exit of workers out of the NHS and social care sector. That's why we are calling for NHS staff to get 15% as a pay rise, and care staff in the private sector to get parity with the public sector.'(Azam)



4. IMPACT ON THE POPULATION

Bereaved families, care homes and older people, palliative care, disabled people, children and young people, and schools

Inquiry Sessions
4 & 8

**PEOPLE'S
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4.0 INTRODUCTION

4.0.1 The COVID-19 pandemic has been a national tragedy for the population of the UK. From March 2020–November 2021 there have been officially 167,927 deaths which mentioned COVID-19 on the death certificate.^{4.1} It is likely that the numbers are higher than this, because many of those who died were not tested for SARS-CoV-2. To put the number of deaths into context: over the six years of World War 2 (1939–45) there were 67,100 civilian deaths in the UK. In the eighteen months of the first phase of the pandemic the numbers were more than double. This number is rarely mentioned by members of the Government. The COVID-19 Bereaved Families for Justice group have been driven to create their own monument of hearts at Westminster to mark the scale of the losses.

4.0.2 The UK is the fifth largest economy and has a publicly accessible National Health Service. This is no longer a universal service given that free access is denied to almost one million migrants and undocumented people (see report section 6.10). Despite this, the Government's actions outlined elsewhere have resulted in a level of deaths per million which along with the US, Italy and Belgium is one of the highest for a major world economy.^{4.2}

4.0.3 The Inquiry did not have the scope or time to hear witnesses on all the possible themes relating to the impact on the population. The following topics were covered and are summarised below: deaths and bereavement; Government messaging and the population's response; the impact on care homes and the elderly; the crisis in palliative care; the impact on disabled people; the impact on young people, schools, and education.

4.1 UK DEATH RATE

4.1.1 Martin McKee, Professor of European Health at the London School of Hygiene and Tropical Medicine discussed why the UK death rate was so high. The countries which did best were those that implemented restrictions early, but the UK locked down late. Boris Johnson, the UK prime minister, was absent from the first five COBRA meetings when time was of the essence because the infection was spreading exponentially:

'Models that we have done indicate that we probably would have saved about half of the lives lost in the first wave by locking down a week earlier.' (McKee)

4.1.2 In addition to deaths from COVID-19, the pandemic has led to millions of displaced NHS operations, appointments and diagnoses including for cancer, heart and other serious conditions, a serious rise in mental health issues, and the growing toll of long covid, now put at two million. A sharp rise in unemployment and the increase in households with food and financial insecurity (having to access food banks for example), a lack of access to many health and social care services which altered their access procedures, and closure of many community services such as libraries and day centres, created millions of crises for individuals and families, in addition to deaths and bereavements.

4.2 FURTHER EFFECTS ON THE POPULATION

4.2.1 The pandemic led to a fall in GDP of 9.8% which was 'unprecedented in modern times'.^{4.3} By mid-2021 there were signs that the economy was recovering, though still below February 2020 levels. 95% of the UK

private sector workforce are employed in small and medium companies which were more vulnerable to the economic crisis.^{4.4} However, the Government's support for the business sector meant that unemployment, although rising to 4.8% in January to March, with a greater effect on 16-24 year-olds, did not rise as far as predicted by economists.

4.3 BEREAVED FAMILIES: THE IMPACT OF PREVENTABLE DEATHS

4.3.1 Government unpreparedness and slowness to lock down, as discussed elsewhere, added significantly to the number of those who died. Sir David King in Session 1, spoke of an additional 20,000 people who had died because of the delay in locking down in the first wave of the pandemic in March 2020 and others have spoken of an estimated 35,000 more people who died as mistakes were repeated in the second wave. Each of the people who died left family members and friends to grieve, with the added burden of realisation that their loved one's death could have been prevented and that mistakes were being repeated:

'I thought (my Dad's) death was preventable. It's really heart-breaking to see many of the same mistakes being made time and time again.' (Jo Goodman, Covid-19 Bereaved Families)

4.3.2 According to representatives from the COVID-19 Bereaved Families for Justice Group, the failure of the NHS 111 service, lack of access to GPs, and the discharge of elderly patients into care homes without testing, materially contributed to their family members' deaths.

Catching COVID-19 in hospital

4.3.3 40% of members of the Bereaved Families for Justice group believed their loved ones had contracted COVID-19 in hospital. Jo Goodman told the Inquiry what happened to her father during a hospital visit:

'Despite the fact that there was known, widespread community transmission at this point (March 2020), no precautionary measures had been put in place – staff had not been provided with PPE and the waiting room he had to sit in for an hour was crowded and poorly ventilated. He received his diagnosis, went home, and came back for the beginning of his chemotherapy treatment on the 24 March. In the early hours of 29 March, he developed a high fever and lost his lucidity. He was taken to hospital by ambulance, and initially it was thought that he had an infection related to the chemotherapy treatment. The next day he returned a positive Covid test. It was a matter of three days from that point to him passing away. Thankfully, unlike many other families at that time, we were able to visit him in his final days, something we will be eternally grateful for.' (Goodman)

4.3.4 She felt this was not the fault of NHS staff. There had been a lack of urgency in locking down, a failure to issue guidance, failures by scientists and NHS leaders to learn from other countries about the airborne nature of the virus. All these factors meant that the NHS was less prepared than it could have been.

4.4 FAILURES OF THE NHS 111 SERVICE

4.4.1 Bereaved relatives thought there had been serious failures in the NHS 111 service. Investigative journalist David Conn

of *The Guardian* newspaper established that the COVID-19 Clinical Assessment Service (CCAS) had been outsourced at the outset of the pandemic. He found that nearly 6,000 people were recruited as call handlers for a dedicated operation within NHS 111.^{4.5} Most of this service was staffed and operated by private corporations contracted on behalf of the NHS. Medical personnel who worked for the CCAS included nurses and Allied Health Professionals (e.g. paramedics and physiotherapists), and some did not feel qualified to take decisions about life-threatening situations. Hundreds who needed hospital treatment were told to stay at home and take paracetamol, and consequently many got to hospital too late, or died at home.

4.4.2 There had been very limited training for staff, with inflexible scripted questions for those calling the service which did not take account of the often severe and very varied symptoms of COVID-19:

'So for example, people passing out, skin discoloration, real distress in people, you know, people saying "this is the worst I've ever seen them", "I've never seen them this unwell", being told to give them water and paracetamol. And also, we had reports of questions that weren't particularly inclusive. So for example black people being asked if their lips were blue, which is not a way that low oxygen levels would show in black people.' (Goodman)

4.4.3 *The Guardian* interviewed three people who worked for the CCAS at different sites across England who said 'they were given the job after a relatively brief conversation with a recruitment agent and negligible training'.^{4.5} This claim was dismissed by NHSE and by the South Central Ambulance Service (who had

responsibility for CCAS), both insisting that call handlers were 'carefully selected, screened and trained'. *The Guardian* reported that the employees who worked for Teleperformance, one of the companies involved, had only had a brief induction, 'mostly about the company they were working for and the building, and involved minimal training in COVID-19 symptoms or handling calls from the public'.^{4.5}

4.5 LACK OF ACCESS TO GPs

4.5.1 At the height of the pandemic the public were asked to call NHS 111, rather than contact their GPs or attend hospitals, in order to prevent doctors and A&E departments being overwhelmed. This led to situations where people died without seeing a doctor.

4.5.2 Oluwalogbon (Lobby) Akinola's father Olufemi contracted COVID-19 and died on 26 April 2020 aged 60. The Inquiry heard that

'He was a black man who exercised regularly and had no known underlying health conditions. He was a key worker, working for the charity Mencap, assisting people with learning difficulties. The family had been concerned about the Government response to the pandemic and had resolved to take precautions as much as possible, because many of them worked in public-facing roles.' (Akinola)

Lobby's father became ill in early April. Over the next two weeks, he deteriorated and sadly died. During that period Lobby's father called the NHS 111 service several times and also spoke to his GP about what he should do and whether he needed to go to hospital. He was advised to stay at home (see also report sections 2.7; 2.9):

'It was thought he might have a lung infection and he was prescribed antibiotics, but he died at home shortly after receiving them, without ever seeing a doctor.' (Akkinola)

4.5.3 GP, Dr Helen Salisbury told the Inquiry, NHS 111 had 'lacked the capacity to respond to calls, not only in an appropriate timeframe but also with the necessary expertise'. Some of the clinical features of COVID-19 were unexpected and differed significantly from other respiratory infections: in particular, the 'lack of subjective breathlessness experienced by patients at rest, even with dangerously low oxygen levels, was entirely new'. Subtle assessments of fatigue and exercise tolerance were needed to form accurate judgements of disease severity over the phone. Although this was an evolving area of knowledge, Dr Salisbury felt that it is fair to assume that fewer lives would have been lost in that initial wave if there had been more direct contact between patients and their GPs (see also report section 2.6).

4.6 GRIEF

4.6.1 Zahra Ali, a 17-year-old school student, gave voice to her personal grief in a poem which she read to the Inquiry in Session 8. The poem is a eulogy to her grandparents who died within a short space of time from COVID-19, both in their 60s. Zahra had been very close to them both and relied on them.^{4.6} The poem expresses the sad story of just one of those bereaved among the relatives of the over 160,000 who lost their lives:

'On the day of the funeral I could not attend because I had to self-isolate. So I sat alone in the room and told myself the story ... A long time ago in a small village in Bangladesh, there lived a young

boy called Hanif Ali who loved to ride his stallion, Mon'bahadhur (Braveheart). At the age of seven, he lost his father – the breadwinner of his family. At the tender age of 14, he was offered the opportunity of a lifetime, to come to England. He did not speak a word of English yet he worked tirelessly day and night providing for his mother and family. He faced many challenges, racism, homesickness, he was just a little boy who missed his mother ... I know that grief is not something that I can escape, I know some days you will drown me and other days you will walk with me side by side ...' (Zahra Ali)

4.7 THE POPULATION'S RESPONSE TO LOCKDOWN AND GOVERNMENT MESSAGING

4.7.1 Government messaging in the pandemic was important because it shaped the population's response. However, the Government chose to ignore the advice of its own behavioural scientists, and messages became increasingly contradictory and damaging.

4.7.2 In March 2020, the Government delayed lockdown for three weeks, justifying this by invoking the dubious concept of 'behavioural fatigue' – the notion that British people would not be able to tolerate rules and restrictions, in contrast to the populations for example of China or Korea. According to Professor Stephen Reicher, a member of SPI-B committee providing advice to the Government during the pandemic, the Government narrative was that the population would be 'psychologically incapable of dealing with the rigours of strict covid containment measures for any length of time and therefore (they) should not be used until absolutely necessary'.^{4.7}

Reicher stated that the Government claim that it had been 'listening' to behavioural experts was not true and was belied by people's actions.

4.7.3 There is an additional question: was lockdown fatigue used as a cloak for pursuing the strategy of 'herd immunity'? Letting the virus rip through the community in order to establish natural immunity had, according to Sunday Times journalists Jonathan Calvert and George Arbuthnott, gripped Boris Johnson and leading scientific advisers during February and March and had contributed to the delay in lockdown measures in March 2020, leading to greatly increased preventable mortality from COVID-19.^{4.8}

High levels of adherence

4.7.4 Far from showing 'behavioural fatigue', research from King's College^{4.9} cited by Reicher showed that early on there were 'very high levels of adherence' – at least for measures for 'which people had the necessary resources':

'This wasn't because people found it easy. Of the 92% who were adhering to "stay at home" advice during the lockdown, nearly half (44%) were suffering economically or psychologically. Certainly, they were fatigued and badly wanted lockdown to end, but fatigue did not stop adherence.'^{4.9} (Reicher)

4.7.5 A further report of a survey of 70,000 people in January 2021 revealed that adherence to the rules had actually increased. Majority compliance (with some 'bending' of the rules) was being reported by 96% of people; an improvement since the start of the autumn across all demographic group.^{4.10} The Government's concept of 'behavioural fatigue', used to

fatally delay lockdown, was unsupported by the evidence available.

Government messaging and a question of trust

4.7.6 Lack of clarity, saying one thing and doing another, and doing things to people rather than with them, were powerful themes in the Government's behaviour and messaging throughout the pandemic. Reicher criticised the 'paternalism' which saw the public as panicking and needing to be shielded from the truth, an approach he described as 'the very worst thing one could do'. Reicher told the Inquiry that general behavioural theory shows that in emergencies, people tend to come together to support each other. This is known as 'collective resilience' and was demonstrated in practice when an estimated 12 million volunteers and over 4000 mutual aid groups came forward in response to the pandemic. A community response was in fact essential given the scale of the pandemic, coupled with cuts to the apparatus of state, lack of resources for a disaster this size, not enough police officers, local government officers etc.

4.7.7 A series of publicly available papers from Spi-B had advised the following rules for communicating with the public: co-production – the Government should bring people on board, to not do things to them, but with them; clarity – any communication should be clear so that after people listen to it they know what they're supposed to do (e.g. polling showed that 96% of people understood 'stay at home', but only 31% 'stay alert'); mixed messages – If you describe a visit to the pub as 'freedom day', Reicher said, 'and yet tell people to be 'a bit careful' it sends a message that things can't be too dangerous.' messaging should about

what you do as well as what you say. The Government did not heed this advice.

Do as I say, not as I do

4.7.8 Initially, around 80% of people reported trust in the Westminster Government and believed it was probably doing as well as it could. Later, this fell dramatically to about 30% because of incidents which created a sense of ‘one law for us and another for them’. One high-profile example involved the Prime Minister’s adviser Dominic Cummings, who contravened rules by driving to Northumberland with his infected wife together with their children, at a time when people were unable to see loved ones, visit dying relatives in hospitals and care homes, or attend funerals.

4.7.9 This angered the public, as did Cummings’ later claim that the family had driven to Barnard Castle nearby to ‘test his eyesight’. The Prime Minister’s refusal to criticise Cummings’ actions led to a dramatic fall in public support in May and June. According to surveys carried out by YouGov, less than half of people in Britain trusted the Government in June – down from two thirds in mid-April. This prompted the director to comment: ‘I have never in 10 years of research in this area seen a drop in trust like what we have seen for the UK government in the course of six week.’^{4.11}

4.7.10 Reicher contrasted levels of trust in the Westminster Government with the Government of Scotland and their leader Nicola Sturgeon who had exhibited much greater consistency and openness in her messaging. In Scotland, ‘There was not a fall in trust. Indeed, at the end of September 2020, trust in the Scottish Government stood at 61% while the corresponding figure at the UK was as low as 15%.’

Narratives of blame accompanied by lack of support for key workers

4.7.11 Very large sections of the workforce had to go to work, either because of the nature of their work, or because they could not afford to stay at home. At various times, however, senior politicians explicitly or implicitly targeted sections of the population including NHS staff, sections of the BAME community, care home staff, young people and union members for criticism. Despite tens of thousands of complaints about unsafe workplaces, there were no prosecutions by the Health and Safety Executive for breaches of safety laws (see also report sections 5.6, 5.7, 5.8).

4.7.12 Boris Johnson spoke to the House of Commons on 22 September 2020:

‘There is nothing more frustrating for the vast majority, the law-abiding majority that do comply than the sight of a few brazenly defying the rules.’^{14.12}

4.7.13 Reicher told the Inquiry: ‘The Government narrative of responsibility is effectively saying, “We wash our hands of this, it’s over to you, and if things go wrong, it’s your fault.” In reality, the blame was largely misplaced. Many workers had to go out to work because of the nature of their job, despite facing risks to their own and their family’s health. They were infected because they were more exposed to the virus, due to work or living circumstances, or because they were more vulnerable. An early study showed that poorer people, and those from ethnic minorities were three to six times more likely to break the lockdown due to having to go to work and care for their families.

4.7.14 ONS figures from mid-February 2021, showed that in the middle of the second ‘lockdown’, 46% of the working

population were travelling to their workplaces, while 20% of employees who could have worked at home were not being allowed to.^{4.13} The Government never supported people to do the right thing, never gave people the support they needed to be able to stay at home, to self-isolate if infected. The answer was not to blame, threaten and fine people. Self-isolation was difficult for the low-paid in particular. There were very limited resources made available for support.

4.7.15 In the UK only about an eighth of adults were eligible for the government £500 self-isolation grant. In addition, a freedom of information request in June 2021 revealed that more than six out of 10 applications for payment were being refused.^{4.14} Even when self-isolation was attempted this could prove impossible to manage in a normal family home. New York City had operated a 'take care' scheme offering money, hotel accommodation, food and medicines, and mental health services, and achieved very high levels of compliance with isolation. This illustrated the principle that support, rather than sanctions, was a far effective strategy.

4.8 LOWEST LEVEL OF STATUTORY SICK PAY IN EUROPE

4.8.1 The UK has the least generous mandatory sick pay system in Europe, replacing little more than a tenth of average earnings for someone who is ill for a fortnight. In the UK, 43% of people who had contracted Coronavirus or been a close contact could not afford to stop work and yet TUC analysis found that extending statutory sick pay (SSP) protection to all workers, by removing the 'lower earnings limit', would have cost the same as 1% of

the budget provided for the NHS Test and Trace programme.^{4.15}

4.8.2 Rehana Azam, National Secretary of the GMB Union told the Inquiry that the unsatisfactory level of SSP presented workers with the 'unbearable dilemma of having to choose between going to work ill and potentially endangering their colleagues, and those they care for, or staying at home and not being able to put food on the table'. The case for ending the three-day wait before payment was first made had been put strongly by the Labour Party, the GMB and other unions. This issue had not been addressed swiftly enough by the Government. Failure to fully underwrite pay is really a health and safety issue, for thousands of workers on minimum terms and conditions who cannot afford to self-isolate on SSP.

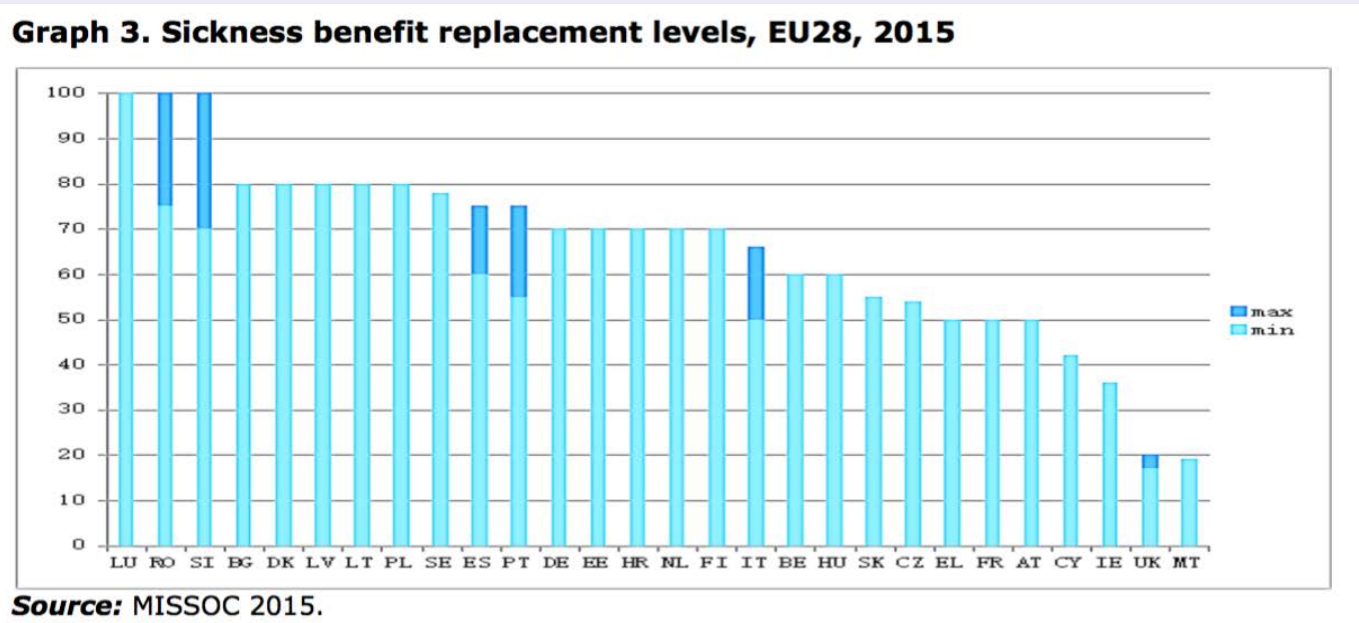
4.8.3 Economist Professor Jonathan Portes told the Inquiry that failure to raise the level of SSP or put in place an effective system of sick pay had been 'an obvious policy error' by the Government. In an article submitted as evidence he wrote that such a change would have incentivised people who are sick, might be sick, or have symptoms, or have been contacted officially or unofficially, to take time off work to self-isolate.^{4.16} Portes described government inaction as a false economy that had clearly inhibited the effectiveness of Test and Trace, therefore prolonging the pandemic unnecessarily.

4.8.4 He described the furlough scheme for income support as broadly appropriate. However In terms of sick pay replacement rates, compared to average earnings, he observed: 'We are not only lower than anywhere, I believe anywhere else in the OECD, but lower by quite a long way, than in almost all of our obvious major comparators.'

4.8.5 Figures published by the European Commission show the UK second from bottom in the league table of member states, with only Malta providing a lower level of support to ill workers. Britain's SSP rate is just £94.25 a week, on average covering just 20 per cent of a worker's income, whereas in some European states up to 80% of income is covered, although duration of that low level continues in the UK longer than in some countries. The UK is also one of only four countries where self-employed people are not eligible for any sick pay.^{4,17}

Source: The UK's sick pay rate is among the worst in Europe (European Commission) (16)

4.8.6 Portes argued that if the government had replicated the furlough scheme in terms of sick pay (and the self-employment income support scheme), by paying 80% of wages/earnings for those needing to self-isolate, this would have cost perhaps £1,000 per person covered, and would have brought the scheme up to roughly the typical level of generosity of other developed countries. Changes to sick pay in Germany, as well as in some Scandinavian countries, had demonstrated that financial incentives mattered in terms of increasing compliance with self-isolation. Inadequate support to workers who did not receive sick pay or who were receiving it at minimal levels may have contributed to the spread of the virus as people could not self-isolate and were forced to continue to work despite being exposed to or even having the virus.





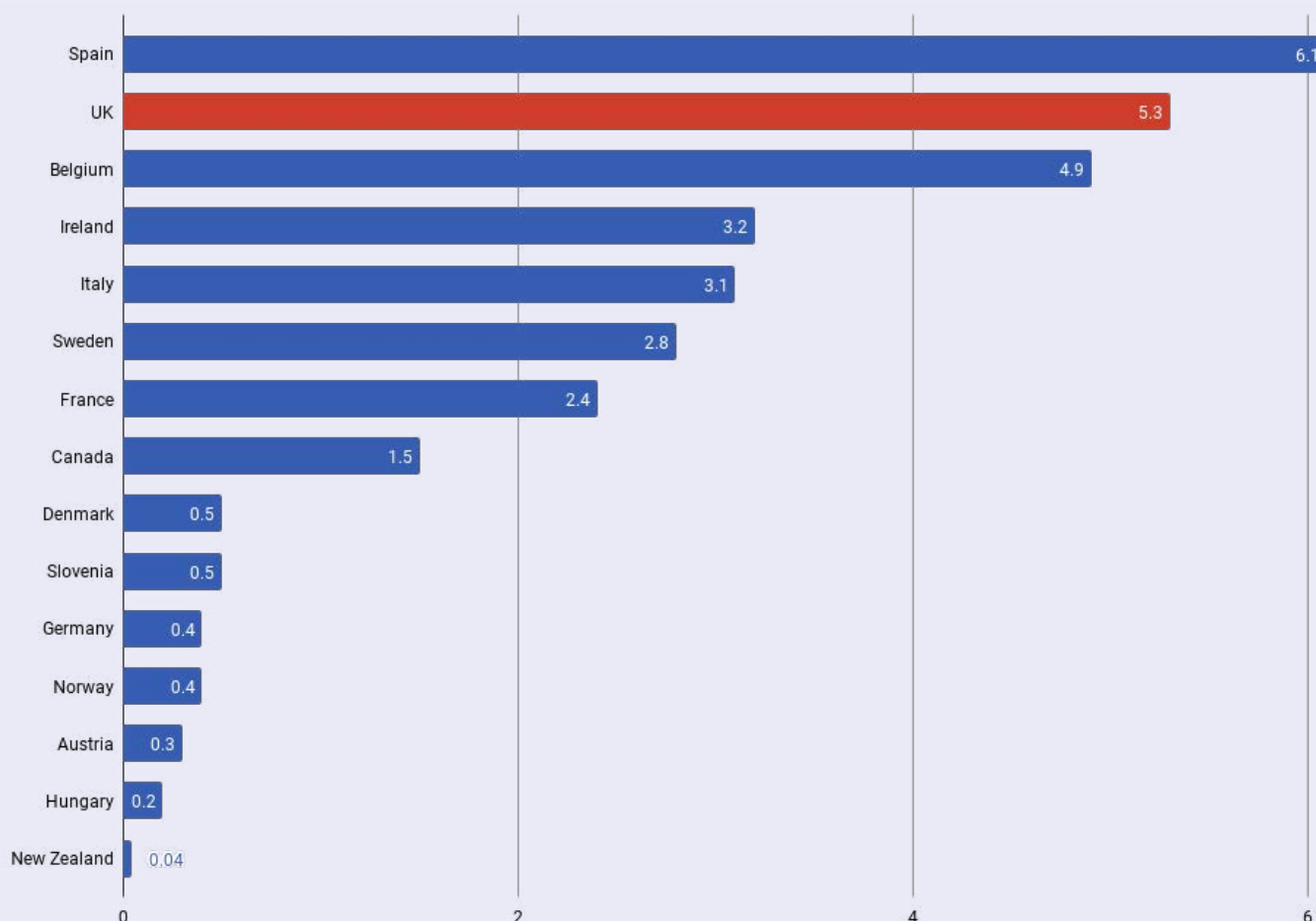
4.9 THE IMPACT ON SOCIAL CARE AND OLDER PEOPLE

4.9.1 At the Downing Street press conference on 15 May 2020, Secretary of State for Health, Matt Hancock declared that ‘Right from the start, it’s been clear that this horrible virus affects older people most. So right from the start, we’ve tried to throw a protective ring around our care homes.’ In fact, 47,000 people in care homes died in the first 18 months of the pandemic.

‘So we’ve been left as a family, bereft, of course, and the grief has been compounded by the lack of clarity, and we’ve been left with wanting answers to why. I need to understand why, and our members need to understand why, our loved ones died, in a place where we expected them to be safe.’ (Jean Adamson)

4.9.2 There was a series of fatal failures and errors at Government level. The high rate of deaths can be attributed to the following: the longstanding failure to address the crisis in the social care system, including a decade of cuts to local authorities’ budgets; failure to attend to previous pandemic planning and to recognise the inherent dangers for care homes as ‘institutional amplifiers’ of the disease; failure to assess current dangers and to provide a coherent plan for the care sector; the discharge of untested patients from hospitals to care homes; delayed test provision; delayed advice on testing and isolation regimes in care homes; failure to supply adequate PPE; the movement of untested and unprotected staff between care homes; the low value placed on the work and lives of care workers.

One in 20 care home residents have died due to coronavirus



Source: The Guardian 28 June 2020 4.18

4.9.3 Information on older people and the care system came from a number of witnesses including Jan Shortt Secretary of the NPC (see report section 2.8), Martin McKee, Professor of European Public Health, COVID-19 Bereaved Families for Justice member Jean Adamson and two care workers, Lisa and Marielle. We have also drawn on a detailed and wide-ranging article written by Martin McKee and colleagues.

High numbers of deaths

4.9.4 Older people and disabled people formed large percentages of those who died from COVID-19. People living in care homes numbered 410,000 at the beginning of the pandemic, of whom 47,000 died

accounting for approximately one third of all COVID-19 mortality. The proportion of care home residents who died in the UK was second highest in Europe.^{4.18}

4.9.5 In addition to deaths of people from COVID-19 in care homes, a report from the UK Home Care Association (UKHCA) revealed that more than 25,000 people reliant on home care died during the pandemic in England and almost 3,000 in Scotland, with the majority of deaths being unrelated to COVID-19 but potentially due to the unavailability of NHS and care services.^{4.19} The same report points out that this number represents a rise of 49% in England and 70% in Scotland compared to the previous year, as reported to England's Care Quality Commission (CQC) and the Scottish Care Inspectorate

between April 2020–March 2021. This contrasts with a 22% rise in deaths in England's wider population during the same period, according to figures from the ONS:

'The work undertaken by The Bureau of Investigative Journalism highlights the lack of publicly available, complete and consistent data sets related to homecare, as in so many other areas of social care, which would help illustrate trends. We believe that it would be extremely helpful for the Government to consider the data it collects in relation to social care. People isolated in their own homes were out of sight and out of mind.' (UKHCA)

4.10 WHY WERE DEATHS IN CARE HOMES SO HIGH? A CARE SYSTEM IN CRISIS

4.10.1 What took place in care homes reflected not only the attitude of Government to those residing in care homes, but also to those who were taking care of them (see report section 2.8). Jan Shortt, NPC Secretary told the Inquiry that the high number of deaths in care homes during the pandemic had exposed the already poor state of the social care system. She stated the NPC believed that for a long time prior to the pandemic the NHS, residential care and care-at-home services were already in crisis. This was due to decades of privatisation, underfunding and cuts to budgets, leading to fragmented services, bankruptcies, home closures, and homes being sold off.

4.10.2 Successive governments had continued to ignore academic, professional and public outcries to fully fund health and social care which meant the UK would never be properly prepared for a

pandemic. The NPC has published its own policy, which calls for a National Care Service, alongside the NHS, free at the point of need, funded by taxation, publicly owned and delivered, and publicly accountable.

4.10.3 Professor Martin McKee spoke about the privatisation of the care home sector (and other systems such as prisons) and the need for a radical rethink in the future:

'... in fact, for many people, if you read the financial pages and you look at the companies that are owning many of ... these facilities, they've actually sold them off to property companies somewhere else, and they're paying a maintenance charge to somebody in the Cayman Islands. I mean this was what happened with Southern Cross ... essentially in the modern economy that we live in, prisons and care homes, and immigrant detention centres, and so on, are a means of monetising the storage of human beings.' (McKee)

4.11 LACK OF PLANNING

4.11.1 The Government and the NHS failed to pay heed to previous pandemic planning, for example as in Exercise Cygnus, which had included warnings about care homes. Calvert and Arbuthnott write:

'A key warning that should have been heeded was a particular concern expressed over the social care sector. The report found that care homes would be unable to cope with the large numbers of old people who would be discharged to them from hospitals in the rush to free up beds for pandemic patients. Marked "Official – Sensitive" the document was filed away and never

made available to the public. When quizzed, ministers would refuse to reveal the report's findings.'^{4.20}

4.11.2 Older people in care homes formed a very large, identifiable and vulnerable group, who early on were shown to be more prone to contracting COVID-19. As pointed out by McKee, it was clear that care homes would act as 'institutional amplifiers' for the spread of the disease, as had been the case with cruise ships at the start of the pandemic.

4.11.3 The first cases of COVID-19 in care homes in England were reported in the second week of March 2020. By the end of July there had been nearly 7,000 care home outbreaks in England, with more than three quarters occurring before the end of April. Between weeks 11 and 26 (ending 26th of June), mortality in care homes compared to previous years had increased by 79% in England, 62% in Scotland and 66% in Wales.^{4.21}

4.11.4 In addition, Jan Shortt told the inquiry, blanket DNACPR orders were issued in some care homes and hospitals, without consultation and without due diligence (see report section 2.8). She regarded this as a direct violation of the right to life, and while the complexities of resuscitating those with complex health issues are understood, the process for such orders has to take into account the human rights of the individual and their family.

4.12 DISCHARGE OF UNTESTED PEOPLE TO CARE HOMES

4.12.1 Testing should have been the key element in the discharge of elderly patients to care homes. SAGE had identified the potential for asymptomatic transmission of the virus as early as 28 January 2020; this

information had also been published in *The Lancet* in January 2020. On 17 March, four days after the WHO declared COVID-19 a global pandemic, the Government ordered the discharge of 25,000 patients from hospitals into care homes, including those infected or possibly infected with SARS-CoV-2.^{4.20}

4.12.2 Freeing up of beds was ordered by the Chief Executive of NHSE, Simon Stevens, on 17 March. The order was backed by the Government's emergency Covid legislation, under which hospitals were cleared of indemnities against clinical negligence. Arbuthnott and Calvert write:

'The scramble to free up beds would have a particularly ill-thought-out and reckless consequence for the care homes. There was no mandatory requirement to test patients before they were discharged into the care sector, even though the spread of the virus in hospitals was becoming a big problem at the time. It was an expedient decision because there was a practical difficulty: there simply wasn't enough testing capacity for 15,000 patients. It meant that hundreds of infected people were sent to care homes ... On 2 April, the same day that the WHO confirmed the existence of pre-symptomatic cases of COVID-19, the Government reiterated its guidance for hospital discharge that "Negative tests are not required prior to transfers / admissions into the care home."'^{4.21}

4.12.3 Jan Shortt believed that the decision to discharge people from hospital into care homes without a negative test was the biggest reason for the devastating and tragic deaths of staff and residents. She added: 'The lack of respect and value for older people's lives is shown starkly in this one act of arrogance.' She also

commented that 'many staff in care homes fell sick; many homes used agency staff who moved between care homes, so infection rapidly spread. There was a lack of PPE: staff were using bin bags as aprons and sharing masks. Care staff do a hugely important job, and this was not their fault'.

4.13 SHORTAGE OF TESTS, SLOW TO ISOLATE

4.13.1 There were problems because tests were in short supply. The Government had wasted weeks in February and early March when it failed to address the seriousness of the pandemic. Testing capacity was acquired too slowly, there were not enough even for NHS staff, and the Government failed to recognise the urgency of the testing in care homes.

4.13.2 Widespread testing was discussed for care homes in March and April but it was not until 28 April 2020 that the government announced whole-home mass testing for all care homes containing older residents and those with dementia, by which time nearly 80% of all outbreaks that were to be recorded by mid-July, had already taken place. Whole-home testing, according to McKee and colleagues,^{4.22} was not fully implemented until June, and only 40% of care homes represented in their survey had accessed any testing for asymptomatic residents by the end of May and early June when the peak had passed and reopening had already begun.

4.13.3 Isolation precautions were initially based on plans for influenza. Care homes had been reassured that it was safe to receive patients without testing and before 2 April 2020 patients who were admitted were not required to isolate and it is certainly the case that this resulted in increased transmission. After that

date, advice on reporting symptoms and mandatory isolation of admissions was introduced,^{4.22}

4.13.4 An Adult Social Care plan was published on 16 April that acknowledged the difficulties in isolating residents. In contrast, in Singapore, where only three deaths were recorded amongst care home residents up to this point, special quarantine facilities were provided to isolate suspected cases in long-term care facilities. Difficulties with testing in some care homes continued to be given a low priority. The government announced that by July all staff and residents in care homes for over 65s or those with dementia would be regularly tested for COVID-19. This guidance was changed after a few weeks to confirm that this would not in fact be feasible until September 2020.

4.14 PPE SUPPLY AND COSTS

4.14.1 One of the main difficulties facing care homes was lack of access to PPE in the face of rising world demand, and rising costs. Unlike the NHS, care homes and other care settings had to fight for it individually. The Inquiry also heard of hospitals, hospices, and individual doctors and nurses driven to sourcing PPE for themselves. Clare Phillips, an Operations Manager in Supported Living Services for Adults with Learning Disabilities in the charitable sector working in a London Borough pointed out that as well as living in care homes, many disabled people live in supported living contexts. She told the Inquiry in Session 4 that PPE was not available to supported living services, neither via the NHS, nor from care home routes. The service had to improvise and had to rely on donations from restaurants, catering firms, construction and elsewhere.

4.14.2 She added that her service had

spent many extra thousands of pounds on PPE at the outset. They could now access PPE via the NHS portal, but only very recently, over a year into the pandemic (April 2021).

4.14.3 For care homes, it was not until 10 April 2020 that a PPE plan was published, alongside guidance that recommended use of PPE for contact with any residents, regardless of symptoms, because of the dangers of sustained community transmission.^{4.22} However, to back up the new guidance, the Government issued only 300 free masks from the stockpile to every CQC registered care home. Plans for more PPE to be released via local resilience forums and a Parallel Supply Chain operated by the army were then downgraded to an emergency supply only. PPE was obtained by individual care homes and companies because care managers paid inflated prices. 79% of care homes had struggled to source facemasks, and around half encountered challenges procuring gloves, aprons and hand sanitizer. Prices.^{4.22}

4.15 POOR GUIDANCE, FREQUENTLY CHANGED

4.15.1 According to care managers, guidance was often published late, and was often contradictory. Infection control guidance was first published in early January and was updated 30 times by mid-June, sometimes daily. Frequent changes in infection control guidance were reported by 74% of managers as particularly challenging, with 67% of managers reporting inconsistencies in government guidance, and conflicts with many local health and social care departments, who often had their own policies.^{4.22}

'Government guidance was difficult to

understand, changed frequently, often arriving at the end of the day, and had to be interpreted for supported living as opposed to care homes. Sudden changes to PPE for example are requested without consultation either with providers or people with learning disabilities.' (Phillips)

4.16 CARE STAFF NOT SUPPORTED

4.16.1 At the beginning of the pandemic there were 120,000 vacancies for care staff. The vacancies reflected the low wages, the challenging nature of the work, poor training and terms and conditions. During the first wave of the pandemic, care workers were included in the 'claps for carers' weekly events but pay and conditions have not improved. This can be attributed to the privatised and fragmented nature of the care service, poor funding, cuts to local authority budgets, and the failure of this and previous governments to address the issue of social care. But it is also a reflection of what NPC Secretary Jan Shortt referred to as the lack of respect and value for older people's lives and those who care for them (see report section 2.8).

4.16.2 Workforce shortages were a challenge for care home managers who had to use agency staff to cover absences. There were press reports of the anxieties and guilt felt by care home staff:

'We're told we are unsung heroes, but we feel manipulated and scared...I'd been kept awake sobbing and worrying about residents at the care home where I work. I was due on shift at 7am and was anxious I wouldn't make it ... I stayed on after shift and sat with a dying woman. Through my gloved hand I held hers and tried to channel all the love a human being can send another. When I came back on shift the next day, the cleaner

told me she had died.'^{4.23}

4.16.3 A care worker, Marielle, submitted video evidence to the Inquiry which reflected serious concerns about her own, her family's and care home residents' health. She told of care workers being expected to carry on working despite health vulnerabilities, including having had organ transplants:

'As a care agency they didn't reach out to any of the employees to ask if they were vulnerable or if they had underlying health conditions ... We didn't have the appropriate PPE. I normally work with just one family, but I was being sent to many different clients with different staff members. Clients weren't adhering to social distancing all the time. Other co-workers weren't always adhering to social distancing, so it was just a really tough situation to be in ...' (See Appendix 3)

4.16.4 Lisa, also a care worker, described how she had given up her care job after nine years, due to lack of PPE and advice on protection against coronavirus. She states that she had had to go on benefits, had lost her car, and would possibly lose her home. She had felt that her own and her family's lives were at stake and had been crying on the phone to the agency, feeling 'guilt ridden':

'I'm not blaming the care services. I'm not blaming the agencies, I'm blaming the Government ... (Covid) went off in Wuhan, then it went off in Italy. So I'm wondering why by the time it got to the UK ... at minimum, there should have been PPE supplies. And I felt devastated about coming to work ... I put the telly on and it's out there – there's plenty of PPE. But there's not, there's not at all. I can't face it if I'd gone into service and I found out the next week, someone had passed away, knowing where I had just been. I could

have potentially passed that onto them ...Because I had no protection, I had no advice, no one said here is the plan.' (See Appendix 3)

4.16.5 According to both care workers who gave video evidence, lack of PPE was the factor which tipped the balance, in terms of leaving work, representing a lack of care for both service users and themselves as workers who were being expected to risk their own and others' lives.

4.17 CARERS AT HOME

4.17.1 The Inquiry did not have the scope to address the impact of the pandemic on the millions of unpaid carers in the home of children, young people and older adults. In the UK, approximately 26% of the population (around 13.6 million people) have informal caregiving roles. This figure includes a reported 4.5 million new carers since the start of the pandemic.^{4.24} Home carers are as vital to society as paid care givers and their already unmet needs for emotional, social, practical and financial support increased during the pandemic and many felt abandoned.

4.18 ACCOUNTABILITY

4.18.1 Jean Adamson, a member of the Covid-19 Bereaved Families for Justice Group told the inquiry that her father had died alone in a care home which had been very difficult for her and her family to come to terms with:

'The doctors had given him three to six months to live [after a stroke]. But he subsequently went on to live for another 18 months, until the time when he contracted Covid and died. He was a strong man, very robust in his physique, and also strong and very robust in

character. He was a Windrush pioneer, you can describe him as such, he came here in 1956 from Barbados, and was hard working, spent most of his life working here. And he loved to play music in his spare time - he would play the guitar and the piano and serenade his grandchildren in his later years. And he meant everything to us as a family. And it feels as if he was taken away from us so cruelly, we didn't have an opportunity to say goodbye.' (Adamson)

4.18.2 Jean Adamson has a professional social care management background. She told the Inquiry that the Care Quality Commission, the health and care regulator for England, had refused to release the number of COVID-19 related deaths for individual care homes to her. Members of the Covid-19 Bereaved Families for Justice had the national numbers but what they had needed as families was to understand what had actually happened in the care homes where they lost their loved ones.

4.18.3 While recognising that the number of deaths was not the only indicator of the quality of care, Jean Adamson told the Inquiry that she felt it was an important factor, and that the CQC had 'really let down bereaved family members'. She could not understand why such vital information could not be released. She told the Inquiry:

'The CQC had sought really to protect the commercial interests of the care sector, rather than be open and honest and transparent to us, bereaved families and the public in general, and to protect the public from unsafe practices in the health and social care sector ... We feel very let down by the Care Quality Commission. As the health and social care regulator for England, we thought they would be supportive of relatives, bereaved families.'

Eventually, following pressure from Jean

Adamson and other bereaved relatives, the CQC published the figures on 21 July 2021.^{4.25}

4.18.4 While it is understood that the pandemic unfolded with unprecedented speed, in most vital aspects in relation to care homes the Government acted slowly or did not act at all until it was too late. Far from putting 'a protective ring' around care homes, the Government failed to protect these vulnerable members of our community, leading to thousands of unnecessary deaths. However, Boris Johnson sought to blame the care homes: 'Too many care homes didn't really follow the procedures.'^{4.26}

4.19 THE CRISIS IN PALLIATIVE CARE

4.19.1 Palliative care had been underfunded and ignored as a sector for decades, described by palliative care doctor Rachel Clarke as a 'Cinderella' service. This disregard was brought to light during the pandemic when staff had to provide the PPE needed for their own hospice.

4.19.2 Dr Rachel Clarke works in a hospice but also worked in her local hospital during the pandemic. She is an author; her latest book *Breathtaking* describes the first few months of the pandemic.^{4.25} The government message of 'protect the NHS' meant patients with non-COVID-19 conditions including those with terminal illness requiring palliative care, or those with symptoms of cancer requiring urgent diagnosis and initiation of treatment, did not always have their needs addressed:

'There was no concern or responsibility for these very patients who were dying, and who were facing eviction from our hospice through lack of PPE.' (Clarke)

4.19.3 A directive had been issued from

NHS England saying that all staff who were patient-facing should wear Fluid Resistant Surgical Masks type masks. Dr Clarke told the Inquiry that hospices were classed as care homes and were therefore given a very small initial supply of PPE – a box containing a roll of plastic aprons, several hundred pairs of gloves and 300 FRSM. Her hospice had been using around 150 masks a day, so this meant potential closure and discharging very sick and dying patients to hospitals, sending them via A&E.

4.19.4 This was an issue with all hospices. The hospice had tried the 24/7 hotline promoted by Matt Hancock, and the DHSC, but there had been no answer, nor any response to emails. Finally Rachel Clarke had managed to contact a charity that had sourced supplies from building contractors. She described the PPE fiasco as a 'complete dereliction of duty' by the Government.

4.19.5 Rachel Clarke considered that if the NHS was underfunded and in a vulnerable state at the beginning of the pandemic, this was even more true with palliative care services. Those in palliative care had done the best they could, redeploying staff to where need was greatest. She told the Inquiry that the public are often unaware that the vast majority of palliative care services are not funded by the Government or the NHS but are funded predominantly by charitable donations to independent hospices.

4.19.6 She stated that there are too few palliative care specialists and beds to allow people to die in a dignified manner of their choosing. Patients with metastatic cancer or other terminal diagnoses felt as though they were 'second class' patients and were caused great distress. The public narrative and reconfiguration of hospitals focused

almost entirely on patients with COVID-19 in the early days. Other patients felt:

'... scared and abandoned and left to fend for themselves. We started seeing very late diagnoses of cancer appearing in the summer of 2020 onwards – patients whose scans had been cancelled or who were too scared to present to a hospital, and who, hence, received their diagnosis when it was too late to attempt curative treatment.' (Clarke)

A woman cancer patient is quoted by Dr Clarke in her book:

'Here I was, a middle-aged woman dying from metastatic cancer. I wasn't the cute child or the vibrant twenty-year-old who would have everything thrown at them. I was very low down the list. I was the lowest priority. I understood that this was a real time of crisis. You triage, you have to make decisions. Some level of prioritisation is necessary, and if I were a doctor, I would have done the same. Therefore, it was incumbent upon me to do what I could to protect myself. I wasn't self-pitying, I was realistic. You are way down this list, and you are going to have to do what you can to protect yourself ... I believed I was effectively being told not to waste NHS resources ... I felt as though someone had opened a bin and just chucked me in it ... I was terrified. I was losing my dignity. I started begging my family to call Dignitas. I would have taken my life right then if I could have done.'

4.19.7 Dr Clarke argued that palliative care needs to be funded in a more meaningful way: 'the NHS is meant to be cradle to grave but the grave bit is sorely neglected. Palliative care is a vital service, but underfunded and undermined was unable to safely meet the needs of patients and staff when faced with the pandemic.'



4.20 IMPACT OF THE PANDEMIC ON DISABLED PEOPLE

'There seemed to be no awareness of the actual needs of older and disabled people in disaster planning ... I want the Inquiry to say to the Government, you've got to rethink your disaster planning, and listen to those on the ground who self-organise, who live the day-to-day experiences of having to deal with their health conditions, their impairments and the social environments we have to negotiate. We know the barriers and isolation better than most people.'
(Williams-Findlay, video testimony)

4.20.1 The Inquiry heard of long term discrimination and serial neglect of disabled people which was exacerbated by their experiences during the pandemic. Evidence was heard of the failure of Government to consider the risks to disabled people in all settings – those in residential care, those receiving domiciliary

support and those receiving support for independent living.

4.20.2 Ellen Clifford, author and member of the national steering group of Disabled People Against the Cuts (DPAC) gave evidence to the Inquiry. She has worked in the disability sector for more than 20 years, specialising in service user involvement and is herself a mental health service user.^{4.28} Two disabled activists presented evidence in video form: Bob Williams-Findlay and Sandra Daniels, Chair of Reclaim Social Care (now renamed Action 4 Inclusion). Evidence was also heard from Clare Phillips, a care manager for disabled people living in supported accommodation.

4.20.3 Ellen Clifford explained to the Inquiry that there were different models of disability – the legal/medical model and the

social model. She stated that the disability movement favours the social model, which focuses on the external barriers which disabled people face, as a result of the way society is structured and organised, and how disabled people experience socio-economic oppression in the ways they are excluded from society.

Factors which led to disabled people being disproportionately affected

4.20.4 Deaths of disabled people made up six out of ten deaths involving COVID-19 in England from March to November 2020.^{4.29} Figures from the Office for National Statistics (ONS) show that of the 50,888 deaths from January to November 2020, just over 30,000 (59.5%) were disabled people; they form 16% of the working age population, with higher rates of 45% above pension age.^{4.30} Ellen Clifford pointed out that gaps in the ONS data mean the mortality rate of disabled people compared to non-disabled people is likely to be higher. She explained that the rate also varied between different impairment groups:

'People with learning difficulties were found to be six times more likely to die of COVID-19 than non-disabled people, with younger people with learning difficulties up to thirty times more likely to die of COVID-19 than non-disabled people of the same age; disabled women under the age of 65 were found to be 3.5 times more likely to die of COVID-19 than non-disabled women of the same age.' (Clifford)

4.20.5 She told the Inquiry that over a third (35%) of disabled people who died from COVID-19 lived in residential care homes, rising to almost half of those with Downs Syndrome. A quarter (25%) lived

in supported living settings. Her evidence discussed general factors, independent of health or age, which were having a significant impact on disabled people in the pandemic.

Deprivation

4.20.6 Deprivation was the biggest factor accounting for the increased risk of contracting and dying from the virus. Disabled people are three times more likely to live in severe material deprivation than non-disabled people. Clifford described severe situations during the pandemic, exacerbated by the failure to extend the £20 uplift applied to Universal Credit to those on 'legacy benefits' (i.e. those not on Universal Credit). Three quarters of the 2.2m people on legacy benefits are disabled people. DPAC had called for the £20 uplift to be made available to these people as well, because of increased costs during the pandemic. In addition, disabled people who were employees had often been forced to continue to go into workplaces and situations which had compromised their safety and put their lives at risk.

Discharge of patients with coronavirus into care homes

4.20.7 The NAO had found that the government's testing strategy and lack of capacity led to some patients being discharged to care homes without being tested for Coronavirus between mid-March and mid-April. On 15 April 2020, the policy was changed to test all those being discharged into care homes. Before the new policy of testing patients was implemented, around 25,000 people were discharged from NHS hospitals to care homes.^{4.31}

Delayed and inadequate provision of PPE

4.20.8 Inadequate provision of PPE affected residential care settings as well as disabled people living in their own homes and those reliant upon daily personal care support. It was not until 21 April that the DHSC finally published guidance for disabled people who employ their own personal assistants. Guidance for disabled people in this situation had been produced by the DHSC more than five weeks later than written advice for the wider social care sector and seven weeks after the publication of the first COVID-19 action plan (on 3 March 2020).

Treatment rationing guidelines and use of Do Not Attempt Cardio-Pulmonary Resuscitation orders

4.20.9 Treatment rationing guidelines and DNACPR orders restricted disabled people from access to critical care and life-saving treatment. The Joint Committee on Human Rights has stated that 'decision-making relating to admission to hospital, in particular critical care, for adults with COVID-19 has discriminated against older and disabled people'.^{4.32} Disabled campaigners were able to pressure NICE into revising their rapid COVID-19 critical care guideline by threatening legal action; however, the revision had failed to establish equal access to healthcare.

4.21 POOR PROVISION FOR THOSE IN DOMICILIARY SETTINGS

4.21.1 Clare Phillips, Operations Manager for Supported Living Services for Adults with Learning Disabilities told the Inquiry that there had been little provision for the needs of the many people with learning

and other disabilities who are supported in the community in their own flat or shared accommodation, as opposed to living in care homes. Care workers who support people with learning disabilities had continued to go into their homes despite lack of access to PPE. Guidance that eventually came out from the Government was directed at care homes and did not relate to supported living.

4.21.2 Sandra Daniels confirmed in her video evidence that disabled people living in the community receiving personal assistance or direct payments, had nowhere to get PPE and that it had taken local authorities a long time to provide it. Clare Phillips told the Inquiry that she had been incredibly angry at comments by Boris Johnson that care homes had broken some of the rules. Her service had been doing the best they could do and had been left to get on with it without adequate PPE, or guidance that made sense. Her service had put into practice extra measures that had gone way beyond government guidance.

Need for 'hospital passports' and human rights to health

4.21.3 'Hospital passports' were needed by disabled people admitted to hospital in order that complex needs could be communicated in the absence of their carers. These were also aimed at persuading medical professionals that disabled people contributed to society and deserved life-saving treatment. Clare Phillips told the Inquiry that

'Everybody with a learning disability supported by their service already had a hospital passport which is an up-to-date record of all the essential information about an individual: their diagnosis, health needs, how that person

communicates, next of kin details, important things around eating and drinking, what support the person needs. Sometimes people with profound and multiple learning disabilities are not able to advocate for themselves in a hospital environment. The concern is that even prior to COVID-19, people with learning disabilities were not getting the right kind of care. Even with a hospital passport and all the information about somebody's medication, that might be lost or mislaid – things don't get handed over to the right people.' (Phillips)

4.21.4 Clare Phillips also told the Inquiry that her service had worked with some local authority teams to include a statement about the human rights of people with learning disabilities, stating that they should be assessed in the same way as everyone else; and that the clinical frailty scale should not be applied just because a person has a learning or other disability.

4.22 COMMUNITY SUPPORT

4.22.1 Sandra Daniels, Chair of Reclaim Social Chair and Bob Williams-Findlay, a longstanding disabled activist, gave video evidence about the way in which disabled peoples' organisations had been ignored by the Government. Bob Williams-Findlay stated:

'There was a failure by the government to pay due regard to the needs of people in the lockdowns and they didn't work closely with community organisations and structures that need to be in place. I had to go and do my own shopping. In the early days there were massive queues. I was expected to go to the back of the queue and stand for 20-25 minutes. And slots for shopping were often taken up. This was a PR exercise

that older and disabled people might get time to shop or use online services. In reality that did not happen.' (Williams-Findlay)

4.22.2 Sandra Daniels confirmed that people simply did not know what was possible, they were cut off. There was nothing there, no infrastructure, support was very hit-and-miss, and made even more difficult for people who were not online:

'I think at the beginning it did seem as though the government was going to support people by helping them to buy food and even get food parcels. But very few people received any support whatsoever. People were very dependent upon the community, support that sprung up from the pandemic, but even accessing and getting that was difficult unless of course you were online. It was difficult even if you were a person who was on the Internet or could use the Internet and social media. But for a lot of older people they didn't even know that was happening.'

4.22.3 The Government and the Minister for Disabled People had failed to talk to disabled people's community organisations who had on-the-ground information. They had failed to recognise how important it is to forge these links and the negative consequences for disabled people when their voices are ignored.

4.23 WHY WERE THE DEATHS OF DISABLED PEOPLE DISMISSED?

4.23.1 Ellen Clifford told the Inquiry that she felt that the dominant narrative concerning disabled people's disproportionate deaths from COVID-19 was to present their deaths as somehow inevitable and less significant than

the deaths of those who are without underlying health conditions or younger. There was alarm from the outset over the narrative and the language that the government had used around herd immunity and the clinically vulnerable when it was not clear what these terms meant.

4.23.2 After the 1980s, although disabled people had moved out into the community, attitudes of many members of the public continued to be influenced by eugenic ideas that see disabled people's lives as worth less than those of others. Provision of care support for disabled people had been from the beginning based on availability of resources, operating in an opposite way to the founding principle of the NHS where resource had followed need. Public service delivery began to improve following the introduction of the Disability Discrimination Act in 1995. However, this has been affected by underfunding in the NHS:

'Discrimination and abuse experienced by disabled people within the NHS need to be understood within a context of underfunding and resourcing pressures even before the pandemic. These negatively impact on the ability of universal health services to work with patients who have additional/complex social and communication needs.' (Clifford)

4.23.3 Sweden had been much talked about in the press at the beginning of the pandemic, as an example of a country that had not locked down, an idea praised by sections of the Conservative Party and parts of the media. In the Summer of 2020, Anders Tegnell, the Swedish Chief Scientific Advisor, and an advocate of 'herd immunity' had been present at a meeting with Boris Johnson and had possibly affected Johnson's judgement

on a proposed firebreak in October 2020, recommended by his medical advisers, but ignored by Johnson with disastrous consequences.^{4.33} Sweden had later held an inquiry into its own high number of deaths particularly in care homes, and admitted that policy mistakes had been made, including the mismanagement of risk in care homes.

4.23.4 Secretary of State for Health, Matt Hancock, had withheld the issuing of guidance on the equal right to life for disabled people in order to disguise the difficult conditions in the NHS, due to a decade of cuts, and the fact that it was becoming overwhelmed by the pandemic. This had forced difficult choices on medical professionals. NICE had reviewed treatment guidelines after an outcry from disabled people and added 'at the medical professional's discretion' in guidance on decision-making after the clinical frailty score had been calculated.^{4.34} Government rhetoric and the media succeeded in shifting attention away from the degree to which the higher mortality rates of disabled people could have been avoided.

4.24 THE IMPACT ON CHILDREN AND YOUNG PEOPLE, SCHOOLS AND SCHOOL STAFF

Mental health of children and young people

4.24.1 There are 12.5 million children and young people under 16 in the UK, 19% of a community of 66 million. They have suffered badly during the pandemic from two long lockdowns, severe disruption to their education and exams, and the loss of the friendships and security that school can bring. One of the greatest effects of the pandemic on children and young people, particularly from school closures and lockdowns, has been on their mental health. Referrals of children and young people to mental health services for crisis and non-crisis treatment soared as a result:

'The pandemic has had a devastating effect on the nation's mental health, but it's becoming increasingly clear that

children and young people are suffering terribly.' (Dr Elaine Lockhart, chair of the Faculty of Child and Adolescent Psychiatry at the Royal College of Psychiatrists)^{4,35}

4.24.2 The analysis of NHS Digital data from The Royal College of Psychiatrists found that:

- 190,271 0-18-year-olds were referred to children and young people's mental health services between April and June this year (2021) up 134% on the same period last year (81,170) and 96% on 2019 (97,342)
- 8,552 children and young people were referred for urgent or emergency crisis care between April and June this year,

- 340,694 children had been in contact with children and young people's mental health services at the end of June, up 25% on the same month last year (272,529) and up 51% on June 2019 (225,480)

4.24.3 The RCPsych information supports the evidence of two experienced Child Adolescent Mental Health Service (CAMHS) nurses, Holly Turner and Rachel Ambrose who gave evidence to the Inquiry. Rachel Ambrose, spoke to the Inquiry about her experience of an increase of severe mental illness during the pandemic:

'So we're definitely seeing a significant increase in numbers of young people with eating disorders, of self-harm, and suicide attempts ... some of these issues, obviously, are exacerbated because of isolation and not being able to have access to ... professionals. Actually, children have gone months without going into school, and having access to their teachers and their support workers who would have previously been able to refer them to mental health services and been able to access support much sooner than what we're seeing at the moment ... Families and young people already identified as having mental health difficulties experienced a reduced service at a time when anxiety, isolation and bereavements were exacerbating their issues. Community appointments had to be carried out over the phone or [via computer] which can be beneficial but can also make engagement more difficult especially for those with communication difficulties.'

4.24.4 Ambrose summarised for the Inquiry the many ways essential support structures for children needing help had been withdrawn or reduced. These included:

- Access to education and primary care services where early issues could be flagged up had been reduced
- Lack of access to pastoral care and early intervention programmes had led to more severe crises in mental health
- Pressure on inpatient provision had led to children and young people in severe crisis having to remain at home, resulting in further pressures on both young people and their families
- Access to gyms, swimming pools and group activities that can be helpful in maintaining a person's wellbeing were closed during lockdown
- Access to opportunities for engagement and friendship with others were significantly reduced leading to surging rates of loneliness
- Access to Speech and Language Therapy, Educational Psychology, Occupational Therapy etc were significantly reduced even when schools were open, due to changes to schools visitor policies and infection control
- Young people who were placed in residential schools were unable to have the regular access to family visits they needed more than ever at such a difficult time due to inconsistent rule changes, lack of appropriate PPE and guidance

4.24.5 CAMHS outpatient and inpatient services were at crisis point even before the pandemic:

'It was so difficult – I can't even explain what the families we work with have been through over the last year. Obviously, schools closed, with all the special schools in my area as well, for

all the children we work with. These children rely on routine and continuity, predictability. That's all the things that support them being emotionally stable. And everything was just completely taken away from them, their school, their respite, their carers coming in to help these families at home. And they just went into complete crisis. And it was very difficult to manage because a lot of children with underlying physical health needs, of course, you can't go in and see these children because the risk of COVID-19 is just too high to some of them.' (Turner)

4.24.6 An article in *The Lancet* reported on isolation and family stress particularly.^{4.36} At these times, many parents were juggling home schooling with work demands and domestic commitments, and more than 60% of parents reported that they did not feel able to meet the needs of both their child and their work. It is notable and unsurprising that stress was reported as being particularly high among single-adult households, among low-income families, and where children had special educational needs or neurodevelopmental disorders.

4.24.7 The RCPsych cite evidence from a parent whose teenage daughter relapsed into anorexia during the pandemic:

'The pandemic has been devastating for my daughter and for our family. She has anorexia and was discharged from an inpatient unit last year, but the disruption to her normal routines and socialising really affected her recovery. She was spending a lot less time doing the things she enjoys and a lot more time alone with her thoughts. Unfortunately, she relapsed, becoming so unwell she was admitted to hospital and sectioned. After 72 days in hospital with no specialist

eating disorder bed becoming available, we brought her home where I had to tube feed her for ten weeks ... My daughter urgently needed specialist help for this life-threatening illness, but services are completely overwhelmed because so many young people need help. It's a terrifying situation for patients and families to be in.'

4.24.8 The report concluded by saying that while more children than ever before were being treated by eating disorder services, an unprecedented number are also waiting for treatment. In 2020, 16% of children aged 5 to 16 years were identified as having a probable mental health disorder, compared with 10.8% in 2017.

4.25 IMPACT OF PANDEMIC ON PUPILS, STAFF AND SCHOOLS

4.25.1 Government decision-making about schools and education during the pandemic affected a large proportion of the population and was therefore critical. There are over 8.9 million school-age children together with parents and carers (many of them working), and almost a million school staff.

4.25.2 It is basic public health knowledge that schools play an important role in community transmission, as millions of children and school staff come together every day. The government, in wanting to pursue at all costs its policy of minimising the impact of the virus on society and the economy, refused to accept that transmission between children and from children to the community and back, might play a role.

4.25.3 The only serious way of working in a pandemic, to stay ahead of the virus, would have been to face that uncertainty, to have worked with local public health

and with schools and unions, and to observe and react to the potential risks and the reality playing out in schools. But the Government refused to listen. As time wore on, it became clear that not only was there a risk from long covid for hundreds of thousands of children, but also that uncontrolled transmission was seriously damaging children's education.

4.25.4 It is understood that policy had to be developed in the most difficult circumstances during the pandemic, yet the Government made mistakes not only at the beginning but continued to make the same mistakes throughout the second and third waves. Two long school lockdowns led to a lost year of education. There was uncertainty for students, and rising inequalities, particularly for those facing public examinations. Even the provision of school meals for hungry children became an ideological battleground for the Government.

4.25.5 Kevin Courtney, Joint General Secretary of the NEU since September 2017 gave evidence to the Inquiry. The NEU is the largest education union in the UK with over 460,000 members. In this section of the report we have drawn substantially from his oral and written evidence and on the report *Schools and Coronavirus*, by Nicholas Timmins, published by the Institute for Government^{3.37} and from other publicly available reports and articles:

'So much more could have been done, and much earlier, to prevent the spread of infection. Had our calls for smaller classes, additional space, earlier mask wearing, an autumn circuit breaker, smaller bubbles and improved ventilation been heeded then it is likely that disruption and community transmission would have been less.' (Courtney)

4.25.6 There are nearly 8.9 million pupils attending 24,400 schools in England in 2020/21. 20.8% of children are eligible for free school meals, representing 1.74 million pupils; 48% of teachers work in nurseries and primary schools, 46% in secondary schools and the remaining 5% in special or pupil referral units.^{4.38} The full-time equivalent of 963,000 people work in state-funded schools in England. Of these, nearly half are teachers. 12,603 schools are Local Authority maintained and 9,444 are Academies, answerable directly to the Department for Education.^{4.39}

4.25.7 Courtney told the Inquiry that the NEU and other unions had been involved in regular meetings with Ministers and senior DfE officials, but a consistent problem had been the unwillingness of Ministers to listen or proceed in line with the views of the profession. He stated that it had been an extremely difficult year for all education staff who have been in the eye of the storm from the start of the pandemic:

'We should have been listened to, as time and time again we made the right call while the Government made repeated mistakes, acted late (for example in relation to wearing of face masks in classrooms by secondary students) and let opportunities pass by to make schools and colleges safer, whether by investing in improved ventilation, additional premises, smaller class sizes, an effective test and trace system and prioritising vaccination for education staff.' (Courtney)

Local authorities side-lined

4.25.8 The potential role of local authorities in managing the pandemic in schools was largely ignored by Government. According to Nicholas Timmins' report *Schools and*

Coronavirus,^{4.37} consultations with both head teachers and DfE insiders showed that they believed this was due not only to structural but also to ideological factors.

4.25.9 The main political thrust of Conservative education policy has been to remove schools from the control of local authorities and to create academies that are answerable to the DfE. With the onset of the pandemic, there was a deep-seated reluctance to engage with local authorities. The academy network had expanded exponentially under the Conservative Government, from 200 at the end of Labour's term in 2010 to 8,700 in 2020. Therefore as the pandemic began the DfE was directly responsible for thousands of schools without an adequate structure for local management of the pandemic, especially given the wide geographical and socio-economic differences that exist between schools.

4.25.10 Although two thirds of primary schools and almost a quarter of secondaries were still maintained by Local Authorities, the Government chose to communicate centrally via the DfE with all schools. There was cooperation with Local Authorities in some areas of the pandemic but reportedly, in relation to education it was particularly poor:

'One highly experienced academy leader put it to us this way: ... "the Department did not really have a communication network which was functional for the vast majority of schools. That led to very prescriptive decision making, because if your only real way of communicating with people is in writing a guidance document, it is difficult to get over your broad intentions and purpose, and you fall back on rules and stipulations. It does raise a much bigger issue about how the school system is configured. Whether

you are in the local authority or the academy."' (Timmins p9^{4.37})

4.25.11 Timmins quotes another source from the academy sector as saying that Ministers could have used local authorities much more, but they had generally refused to clarify their role in the system and refused to engage with them. The source added: 'There is nothing intrinsic in our current set-up that would stop this from happening.' A Government insider quoted by Timmins said:

'My ministers absolutely hate local government ... They hate it because far too much of it is Labour. They believe local government is stuffed full of progressives who do not believe in phonics. The role of local authorities in education is a very contested space, and the whole point of the academy programme is to get schools off councils. The idea that we would use local government to manage anything that we did not have to was complete anathema.' (Timmins p.9^{4.37})

Guidance over-centralised

4.25.12 The DfE was criticised by the National Audit Office for trying to control what was happening in 22,000 schools by issuing hundreds of individual guidance documents. Between mid-March and the end of May 2020, 148 new pieces of guidance or updates to existing material, were sent to schools. As in other areas such as care homes, much of the guidance was published at the end of a week or late in the evening, according to the NAO, putting schools under pressure, especially when guidance was for immediate implementation. In addition, when the guidance was updated, schools were not always clear what changes had been made.^{4.37}

Relations with local public health unclear

4.25.13 The Institute for Government document also reports a lack of communication between the DHSC, the DfE, and local Directors of Public Health. The 2012 health legislation had weakened the role of Public Health directors who had been given responsibility to ‘assure’ the system locally, rather than deliver it. Professor Maggie Rae, President of the Faculty of Public Health told Nicholas Timmins

‘The lack of clarity about who is responsible has been a significant feature since the beginning of the pandemic. “Assure” is a very difficult word with which to be clear about roles and responsibilities. The local DPH will always have a view. But what we have had is a lack of clarity about whose view takes prominence and who is actually the decision maker.’ (Timmins p144^{4.37})

4.25.14 Timmins quotes one DPH who said school heads in her area, along with the regional health protection team wanted to reinstate mask-wearing in their schools. They were told they would have to apply but reported that they could not even establish who was the decision-maker, whether it was the DfE or the Joint Biosecurity Centre. In the end they thought it the right thing to do locally and did it. (p14^{4.37}). The DPH also commented ‘the DfE feels a particularly insular and siloed department, with a lack of connect, at a very senior level, between itself, DHSC and the public health policy response.’

Children and transmission of coronavirus in schools

4.25.15 Initially as the pandemic struck, the effect of coronavirus infection in relation to children was unclear. Press conferences played down the risk of the virus to children and young people with Government and top scientists tending to say that children were less likely to contract the virus and to pass it on. However, this approach meant that the Government did not stay ahead of what was happening in schools as they returned in September 2020.

4.25.16 Studies cited by indie_SAGE^{4.40} showed as early as May 2020 that between 1% and 5% of diagnosed COVID-19 cases were children, but that many were undiagnosed because up to a third of infected children never developed any symptoms. The indications were that children got less sick than adults and had a much milder version of the disease but there were cases of a COVID-19 related Kawasaki-type immunological disease that may require critical care. At this stage, according to indie_SAGE, UK data suggested that children are as likely as adults to become infected and carry the virus but may be less likely than adults to transmit it because, for instance, adults are contagious for longer than children.

4.25.17 Later scientific data seems to indicate that ‘transmission of SARS-CoV-2 can occur in schools and that clusters have been reported in all types of school settings (preschool, primary and secondary school). Transmission of SARS-CoV-2 in schools appears to be affected how widespread the virus is in the broader community.’^{4.41} The same study, from the European Centre for Disease Prevention and Control, confirms that most children do not develop symptoms when infected

with the virus, or they develop a very mild form of the disease. However, research has shown that children can become infected, and can spread the virus to other children and adults while they are infectious.

4.25.18 While the Delta variant and other identified SARS-CoV-2 variants of concern appear to be more transmissible in both children and adults than previous variants, children do not appear to be more likely to be infected with or transmit the Delta variant. The report concludes, however, by stating the importance of public health hygiene and organisational measures to mitigate the spread of the virus.

Key points in the timeline of school lockdowns and re-openings

4.25.19 It is necessary to recount some of the detail of the school lockdowns and openings to give a view of how the Government dealt with the virus in schools. The Government's slogan was always 'keep schools open and support the education of disadvantaged pupils'. It continued to utter this against a backdrop of chaotic decision making from March 2020 – June 2021, and it has continued in various forms to the time of writing.

4.25.20 While everyone agreed that school lockdowns were the last resort, schools were effectively closed for the majority of pupils between 25 March–September 2020 with disastrous consequences for pupils, particularly the least advantaged. The impact of crowding many children into one (often unventilated) place could lead schools to become 'institutional amplifiers', if asymptomatic children went unnoticed until an adult becomes symptomatic.

4.25.21 This was brought into sharp focus when the rapid circulation of the Delta variant spread to Kent schools and

South-East London in December 2020. This failed to raise the alarm for the Government until it was too late. In fact the DfE threatened Local Authorities in Southeast London with legal action for proposing to close their schools on safety grounds for a week before Christmas in December 2020.

Timeline

March 2020: no pandemic plan for school closures, first lockdown

4.25.22 Along with lockdown delay in general until mid-March 2020, the DfE was working, according to Timmins, with an influenza pandemic plan, dating from 2011, which stated that schools should stay open. There was no plan for school closures.

4.25.23 Courtney told the Inquiry that the NEU had called for closure of schools in March 2020, before the government took the step of doing so:

'We wish they had done that, because we now all realise and I think everyone now realises, that if the Government had gone to lockdown sooner, the peak would have been much lower, we would have got out of the restrictions on the other side much sooner. And then if they'd set test track and trace we might have stayed out of it.'

He added:

'Contrary to what many had thought, schools and colleges have never been closed and staff had continued working either on site or at home, for the whole time. When working in school staff had to work in crowded, often poorly ventilated, workplaces where social distancing had been nigh on impossible and with very limited mask wearing.' (Courtney)

4.25.24 The role of teachers and headteachers during lockdowns has often been ignored. They worked extremely hard to provide both online and offline access to the curriculum for their pupils, as well as in many cases, delivering books and meals. Teachers and schools were often creative and compassionate in their responses to the needs of their children in lockdown, as this example shows, from a school in Barrow-in-Furness, Cumbria:

'The school has a high level of pupils on Free School Meals with 47% overall although there is considerable variation within classes, with some classes having as many as 63% of pupils on FSM ... During Lockdown, we realised many children would be missing out on their daily reading book so we shared a bedtime story each evening on Facebook with teachers and teaching assistants in turn reading a chosen book ... We appreciated that not all children had access to devices so we gave out 60 iPads to families to facilitate this. The school has been kept open throughout Lockdown for key workers and vulnerable children. Free School Meals are delivered on a daily basis to families using our minibuses and this has helped maintain the contact with families.'^{4.42}

June 2020: opening of schools for some pupils

4.25.25 Instead of measured policy, governed by public health, schools and professional representatives, Government responses to the opening of schools, often voiced by Boris Johnson, followed a knee-jerk pattern that became familiar to millions of children, parents and school staff.

4.25.26 In May and June 2020 the Government was responsible for mixed messaging and a loss of confidence over

a return to school which took places for some classes in June. In May Boris Johnson had stated his 'hope for all primary school children to return to school before the summer for a month if feasible'. Education unions, including head teachers, had argued that while older primary pupils could be expected to understand social distancing, the younger ones could not. Although it had appeared at one stage that an agreement had been reached, this plan was overturned with Years R, 1 and 6 in primary school and Years 10 and 12 in secondary schools returning in June.

4.25.27 Osama Rahman, the DfE chief scientific adviser, told the Commons Science and Technology Select Committee that it was 'a cabinet decision', not the DfE's (Timmins p15^{4.37}):

'Just ahead of the final announcement, those being consulted believed they had an agreement that Years 5 and 6 would go back, but not the younger pupils. As that went into No.10, however, 'it was all blown out of the water', according to Geoff Barton, ASCL general secretary, the head teachers' union. 'I had sight of what Boris was going to say on Saturday morning, the day before he said it. We had strong reservations. We said that Reception and Year 1 were the least likely to understand social distancing. We kept making the point that Years 5 and 6 would be better.' In the end, according to both No.10 and DfE sources, the decision was taken without Williamson present.'

4.25.28 In May 2020, Gavin Williamson had accused unions of 'scaremongering' about the return to school. However Rahman, the DfE chief scientific adviser, told the Parliamentary Science and Technology Committee in May that evidence about the transmission rate among children was 'mixed', and that

there was a 'low degree of confidence in evidence they might transmit it less.'^{4.43} Further, Rahman admitted that the DfE had done 'no modelling' on the impact of transmission rates of starting to reopen schools after the May half term break. When asked by Education committee chair Robert Halfen about the scientific evidence Rahman had replied:

'The department has not done any modelling ... One of the SAGE groups has done various bits of modelling for different scenarios on what years you can bring back. My understanding is those will be published in due course.'

4.25.29 Secondary schools in England reopened for year groups 10 (aged 14–15) and 12 (aged 16–17) from 15 June although much of the teaching continued to be online. Courtney told the Inquiry that in May, prior to the suggested opening of schools in June, the NEU had put forward five tests for the safe reopening of schools:

'We want to begin to reopen schools and colleges as soon as we can. But this needs to be safe for society, for children and their families and the staff who work in them.'

4.25.30 The five tests, said Courtney, would need to be met by reliable, peer-reviewed science and transparent decision-making. The full text can be read online.^{4.44} In summary, the tests argued for lower COVID-19 numbers before schools opened, a national plan for social distancing, comprehensive testing, whole school protocols when SARS-CoV-2 cases occur, protection for vulnerable staff. In addition the NEU put forward a broader 10 point recovery plan^{4.45} for schools including priorities for disadvantaged children, provision of Free School Meals over the summer, opening up of local spaces to

expand schools, encouraging teachers to return to the profession, fair assessments in GCSE and A levels, increased mental health support for children and young people and more. Courtney told the Inquiry that the NEU had had 'a bit of engagement with Gavin Williamson about that, but they really didn't take it seriously.' Failure to take on many of the practical issues recommended by the NEU and other unions and by organisations such as indie_SAGE, led to a what Courtney described as a 'disastrous return for schools' in September 2020.

September 2020: return to school

4.25.31 Courtney told the Inquiry that schools had been 'badly let down in September'. When schools opened, and all the children went back, there had been a need for a mass testing, but this was still not yet available.

4.25.32 Cases continued to mount particularly in secondary schools. Along with SAGE the NEU had called for a 'circuit breaker' added on to the half term holiday in October 2020. Courtney told the Inquiry:

'We called for a circuit break around the half-term holiday. We know that cases fall when schools are closed, quite obviously. We could see already from September to October from case numbers in secondary school children, most definitely, to some extent in primary school children, cases were going up faster than the rest of society. We were therefore saying, have a circuit break, close the schools for a fortnight, have one of the weeks as online learning, but close the schools for a fortnight, so that cases get down to a proper level where test track trace can work. We know that SAGE were calling for that but the government ignored it.' (Courtney)

4.25.33 Courtney explained that the NEU had also been calling for a rota operation in secondary schools where children would be taught every lesson, but one week they would be taught in school, as had taken place in some other countries, and one week at home. But he said, the Government were not interested. Very significantly, Courtney said according to SAGE that that would have the same effect on suppressing the virus as closing the whole of hospitality.

4.25.34 In November 2020, the NEU called for schools to move into lockdown along with the general population, but this did not take place. Cases continued to rise both in schools and in the community.

December 2020: Alpha/Kent Variant

4.25.35 By 13 December 2020, there was exponential growth in the Alpha or so-called Kent variant of the virus in schools in London and the Southeast. London Mayor Sadiq Khan called for all schools to move into lockdown. However when the London Borough of Greenwich instructed schools in their areas to move to online learning, Secretary of State for Education Gavin Williamson threatened legal action if they did not stay open for face-to-face teaching; Greenwich Council was forced for financial reasons (i.e. they could not justify the expenditure of public money) to reverse their decision. At the same time Johnson's plans for the Christmas holiday period, mixing had to be drastically reduced to two days. Experts agree that it is highly likely that the failure to initiate a circuit breaker in October, and shut down schools a week early in December, accelerated the spread of the Delta variant.

January 2021: schools open for one day, then lock down

4.25.36 The period at the beginning of the Spring Term in January 2021 continued the dysfunctional chain of events, as the Alpha variant continued to spread. These events brought not only confusion, but dangers when many primary schools felt forced to open for just one day on 4 January 2021. The chain of events can be summarised as follows:

- End of December 2020: teaching unions recommend keeping schools closed
- 30 December 2020: Education Secretary Gavin Williamson announces that secondary schools are to remain closed until 18 January to give time for mass testing to be implemented and that primary schools in 50 local authorities will remain closed until 18 January, while those in the remaining 102 local authorities are to open
- 31 December: details are published showing that primary schools in 9 London boroughs where virus levels are higher than most, are told to stay open, while primary schools in many areas where there are lower levels of infection are allowed to remain closed:

'Nobody in the London system had been involved in those decisions and no one could explain why some boroughs were to have their schools open and some were not. Nobody understood that.'

A London borough chief executive said:

'I have never experienced a government decision that has made me so personally deeply angry. It was just incomprehensible.'^{4.37}

- 2 January: two head teachers' unions threaten legal action against Williamson giving him 48 hours to supply the scientific information showing it is safe to keep schools open
- 3 January: the NEU tells its members that it is not safe to return to school until at least mid-January calling on teachers to write to their head teachers using Health and Safety legislation
- 3 January: the day before the start of term, Prime Minister Johnson announces that primary schools will open as usual the next day.
- 4 January: the Governments of Wales, Scotland and England introduce more general population measures to deal with the mounting infections
- 4 January: most primary schools in 102 local authorities obey instructions on children go back to school but just for one day
- 4 January: Gavin Williamson reverses his announcement, now declaring that all primaries in London would remain closed until 18 January
- 4 January evening: Prime Minister Johnson announces the most severe national lockdown since March 2020, including all schools:

'Parents whose children were in school today may reasonably ask why we did not take this decision sooner ... The answer is simply that we have been doing everything in our power to keep schools open, because we know how important each day in education is to children's life chances. While schools were safe for children ... they may nonetheless act as vectors for transmission.'^{4.66}

4.25.37 We can only speculate on the damaging effects of the Government's gross failure to consult, to use available evidence, the failure of governance, of messaging, which led to millions of children, their parents and school staff returning to school for one day, in which Prime Minister Johnson and Education Secretary Williamson played such a devastating role.

4.25.38 Courtney told the Inquiry:

'We look back on the union's role with some pride, perhaps, but with some fear about what would have happened if we weren't in the right place at the right time. Because the Prime Minister on 3 January, said that schools were safe and that all schools would open the next day. We had a meeting that day of 40,000 of our members online, on Zoom. We know that 400,000 people watched at least some of that meeting on Facebook as well, and from that meeting, thousands of our members sent letters to their head teacher saying that they thought it was unsafe to open schools, citing section 44 of employment legislation as a protection on that. And the Prime Minister changed his mind overnight.'

On (the evening of) Monday 4 January he told the population of the country that schools were 'vectors of transmission.' Now, I don't know how much our action was influential in him making that volte face. But we know that some schools did open on that Monday 4 January, and that the virus spread because of that, and some people will have died because of the virus spread. Chances are, it would not have been our members, and it wouldn't have been the children. It would have been the grandparents or the parents of the children.' (Courtney)

March 2021: return to school

4.25.39 All primary schools in England reopened on 8 March whilst secondary school openings were staggered. NEU and other education unions wrote on 13 May 2021 to all employers and all head teachers/principals encouraging them to keep the current face coverings arrangements in place beyond May 17 with a further review at stage four of the lockdown roadmap in advance of 21 June. This appeal was ignored:

'Mask wearing by students in secondary classrooms was only introduced in March 2021 and was removed as of 17 May 2021. Many of our members were understandably shocked that in May 2021 the Government was prepared, yet again, and at a time when the Delta variant was becoming well established, to ignore the advice of the SAGE experts and relax the face covering requirements in place for schools and colleges.'
(Courtney)

4.25.40 From 17 May 2021 there has been no recommendation that face coverings should be worn in secondary classrooms. This goes against practice in most countries of the world:

'Although students are at much reduced risk from COVID-19, compared to older people, we also know that they can suffer from long covid. This is in itself a valid reason for ensuring that schools are as covid-safe as possible, in addition to the arguments around disruption to education and protection of local communities.' (Courtney)

4.25.41 Many head teachers welcomed the backing of the education unions in making sensible suggestions to protect the mental as well as physical health of staff and students and keeping disruption

to a minimum. The DfE, despite repeated requests, refused to provide data on the spread of the Delta variant across schools. Eventually data was provided but only in relation to outbreaks, not cases. Figures from one area, Bolton, show that in May 2021, 73% of pupils in primary schools were in attendance, only 54.9% in secondary and 66.3% in special schools

Underfunding and class size

4.25.42 As in other areas of the public sector, the funding of education affected schools' ability to respond to the pandemic. Education had experienced severe cuts to funding during the decade of Conservative Government from 2010. Courtney told the Inquiry that research by the Institute of Fiscal Studies had confirmed that spending per pupil in England had fallen by 9% in real terms between 2009–10 and 2019–20. This represented the largest cut in over 40 years.^{4.47}

4.25.43 The same report outlines that the failure to maintain funding resulted in a large rise in the number of schools in deficit: primary schools running a deficit had risen to over 10%, and secondary schools from 18% to 27%. The Government finally granted a funding increase to schools of around £8.6bn a year by 2022–23, but, reported by Courtney, this is only two thirds of the £12.6bn deemed necessary by the NEU to restore per pupil funding to 2015–16 levels and pay for increased costs.

4.25.44 The poor financial position of schools was highly relevant as the pandemic took hold, given the state of the fabric of many school buildings, lack of funds to employ extra staff, and lack of means to improve ventilation to minimise risk from coronavirus transmission. Further funding problems occurred when schools had to pay for staff cover due to

COVID-19. Over the Autumn Term 2020, 8.2% of teachers were absent between mid-October and December, up from the normal 2%.

4.25.45 Large class sizes have made social distancing much more difficult in the pandemic. Courtney considered class sizes to be part of the reason for the large amount of disruption to education and for the high rates of infection amongst England's school pupils. Information provided by the NEU shows the impact of Government failure to ensure that teacher numbers increase in line with pupil numbers. Secondary class sizes increased in 2020 for the fifth year in a row. The average secondary class size was 22 – the highest since 1980. The average class size in all primary schools was 27 in 2020. The number of pupils in classes of 31 or more has risen in both the primary and secondary phase.

4.25.46 Last year 13.1% of primary pupils were in classes over 30 and 13.7% of secondary pupils. Last year 993,412 pupils were taught in classes of 31 or more. Cuts to schools serving more deprived pupils have affected class sizes as well. The practice of providing smaller class sizes for schools serving more deprived communities have now, according to Courtney's written evidence effectively been ended.

4.25.47 Comparisons with Europe show that the average primary class size in European schools is 20 whereas in England it is 27. At Key Stage 3, the class size in Europe averages at 21 compared with Britain's average of 24.

School safety and spread of Delta variant

4.25.48 With the rapid circulation of the Delta variant, school safety policies, including distancing, hygiene measures, testing and isolation, masking, ventilation, and other factors are critically important. The NEU points out that Government failed to consider investment when it could in additional classrooms, classroom ventilation or to sanction systematic rota teaching in order to mitigate infection rates by reducing class sizes. In contrast, it was possible, for example, to see ventilation provision in individual New York classrooms online:

'So much more could have been done, and much earlier, to prevent the spread of infection. We believe having schools fully open with limited control measures played a significant role in the second wave and resulted in substantial disruption.' (Courtney)

4.25.49 Johnson did not publicly accept that schools were vectors for transmission until January 2021. The NEU believes that 'pupil bubbles' have in many cases been much too large – whole year groups in secondary schools for example. Schools and colleges are crowded environments and social distancing is at best very challenging and at worst completely impossible, particularly in relation to younger children and those with special educational needs and disabilities. The restricted size of school classrooms and lack of additional spaces had made social distancing difficult.

Post Inquiry

September 2021: safety in schools letter

4.25.50 A letter from researchers, parents and educators ‘England’s Schools must be made safe: an open letter to the education secretary’, September 3, 2021^{4.48} makes key points on safety issues to Education Secretary Gavin Williamson on the return to school in September 2021. While recognising the importance of schools staying open, the letter notes that the WHO states that schools must be made safe by adopting measures to minimise transmission of the SARS-CoV-2 virus. The authors express concerns about the lack of mitigations for children and educational staff, and the subsequent risk to children from COVID-19 as schools reopened in England in September 2021.

4.25.51 The letter states that children have suffered significant harms from COVID-19 in terms of 2300 hospitalisations in two months up to September 2021 and of an estimate of 34,000 children living with long covid in the UK, with 22 000 reporting significant impacts on their day to day activities, 7000 of whom have had symptoms for more than a year. Up to one-in-seven of those infected are expected to have persisting symptoms at 12-15 weeks.^{4.49} Long covid can be associated with multi-system disease in some children, including persistent cognitive symptoms.

4.25.52 The letter also pointed out that children were returning to school against a background of community infection levels 26 times higher than at the same time in 2020, and with the much more transmissible Delta variant accounting for almost all infections.

4.25.53 SAGE had warned that schools returning would likely lead to significant increases in cases in school age groups. This would coincide with increased pressure on the NHS over winter due to other respiratory viruses, and potentially alongside waning SARS-CoV-2 immunity among the most vulnerable. This puts everyone at risk and exacerbates the additional burden on people from disadvantaged areas, as well as those predisposed to more severe disease from BAME communities. The letter also calls for vaccination of school-aged children and full public health mitigation measure.

Laptops, online learning, and inequalities

4.25.54 The Government pledged to supply over a million laptops on 19 April 2020 in an attempt to bridge digital equalities; supply was described by Courtney as ‘alarmingly slow’. Given the global demand for laptops there were problems with the procurement, and according to Timmins,^{4.37} the central DfE contract with Computacenter was not placed until 19 April, a month after schools were locked down. The first 50,000 arrived on 11 May, but data on the progress of the laptop scheme was not released until mid-June. The first laptops were rolled out over the summer term 2020 – several months after children began learning from home.

4.25.55 The issue demonstrated how lack of funding had affected education support for disadvantaged pupils, in particular how schools had to pick up the pieces from a failed and under-resourced policy. The slow and haphazard roll out of laptops to disadvantaged pupils was a further illustration of Government failure to support the needs of schools and their pupils which adversely affected continuity of education.

4.25.56 Government figures indicate the target of 1.3 million laptops was reached on 11 May 2021 along with 76,245 routers, but this process was very slow and created an enormous amount of stress and anxiety for families trying to learn from home without the proper equipment, and for staff trying to support them. Many schools could not afford to wait for the Government scheme so lent out school laptops or purchased new ones for their pupils, from their already over-stretched budgets.

4.2.57 The NEU is now calling for the establishment of a new, dedicated technology budget for all schools to combat the digital divide. Schools are best placed to know what their school community needs to help them access learning. The digital divide was a problem long before the pandemic and will continue to increase inequality if not properly addressed.

Pupil 'catch-up' betrayal

4.25.58 On the final day of the Inquiry on 16 June 2021, Kevin Courtney spoke about the resignation of Kevan Collins, the Government's 'catch-up' tsar whose job it had been to put forward a programme for schools. Collins' proposals were wide ranging, schools-focused, and rested on his years of experience both as Director of the National Literacy Strategy under the Blair Government, as Director of Education in Tower Hamlets and with the Education Endowment Foundation, a body which looks at what is effective in schooling. However, instead of the £15 billion programme he recommended to the Government, only £1.5 billion was awarded, prompting him to resign with immediate effect.

4.25.59 Courtney contrasted the £1.5 billion Government offer, a tenth of what Collins had asked for, with some other countries' education catch up programmes. In the US, the equivalent settlement is £21 billion and in the Netherlands £18 billion:

'Kevan Collins had asked for £15 billion and they've only offered 1.5 billion. There's no way we're going to have a levelling up agenda that is going to cope with all of the extra lost education in those Northern red wall seats, there is no way that we will catch up.' (Courtney)

Vouchers and Free School Meals

4.25.60 The issue of provision of Free School Meals (FSM) to 1.78 million children reveals a great deal about the nature of this Government's thinking. At every turn they had to be forced to take steps to provide food for children in families facing long-term financial hardship and hunger. When school children moved to online learning in April 2020, there was no Government plan to ensure that eligible children would receive food. Initially, many schools tried to provide for pupils directly. After the bad publicity incurred by the sight on TV of teachers and others delivering food, they had bought from school budgets or from their own pockets, the DfE was forced to act.

4.25.61 The DfE contracted EdenRed, a French company that specialises in prepaid corporate employee benefits, meal vouchers, loyalty programmes and other services, to resolve the issue through the provision of food vouchers which were intended to be redeemed at a range of supermarkets. Severe delays were immediately experienced by eligible families. As Courtney told the Inquiry there were many reports of staff and head teachers spending hours on the phone

to the company to resolve issues. The helpline was charged at a premium rate and this only changed to a freephone number following media attention:

'The system was very labour intensive for schools, which were expected to co-ordinate the delivery of vouchers to parents via email or post every week. There were widespread reports of the vouchers themselves not working when families tried to spend them in supermarkets, causing untold distress, anxiety and stigmatisation.' (Courtney)

4.25.62 Supermarkets initially signed up for the voucher scheme included inappropriate, overly expensive ones, which limited how much food families could purchase – for example Waitrose and Marks and Spencer:

'So ineffective was the EdenRed provision, especially in the early days of the pandemic, that many schools felt they had no choice but to abandon the scheme and create individual food parcels for families in need.' (Courtney)

4.25.63 A further issue emerged when it was made clear at the start of the pandemic that FSM provision was for 'term time only' and therefore would not be extended to children over the 2020 Easter holiday, despite growing unemployment and increased reports of families being pushed into poverty. It was the footballer and campaigner Marcus Rashford's public letter to the Prime Minister, with his growing #ENDCHILDFOODPOVERTY campaign that secured a U-turn from the Government and saw FSM provision extended over the Easter holidays, May half-term and the summer break.

4.25.64 The Government voted not to extend FSM provision over the October 2020 half-term and over the Christmas

period for 2020/21. Instead, during the October 2020 half-term thousands of local restaurants, community hubs and caterers stepped up to provide food for children in their local areas instead:

'From the Christmas holiday 2020 to the present, the Government is still not providing FSM over the holidays. They claim that they are, but this is not the case – they are disguising this in the Covid Winter Hardship Grant which was established to provide money to Local Authorities to provide money to those they felt needed it, expressly to purchase food and fuel. This is not the same as ensuring every child eligible for FSM gets provision, although some families in this category may have been identified as requiring assistance by their local authority ... The Government has extended its Holiday Activities and Food scheme to now include all local authorities across England. This scheme provides funding for local authorities to establish 'holiday clubs,' including the provision of FSM, to local children deemed in need ... This a good idea but problematic, as it forces children to participate in a club before being 'allowed' access to FSM, and there are issues with travel costs and stigmatisation.'

Exam crisis

'... As an example of the Government's failure to have regard to the mental health of students and staff, the exams fiasco of last summer stands out. The Government caused significant stress and anxiety in the summer of 2020 by choosing to award grades via an algorithm.' (Courtney)

4.25.65 Courtney explained how the exam system had been adjusted during 2020 to meet the pandemic crisis:

'Grades in any normal year are awarded relatively – students get a grade based on where they rank in their performance in the exam compared to their peers. This has many perverse side-effects in itself and is unfair for many students. When exams were cancelled in 2020, Government's first thought was how to preserve the principles behind this rank order, and not necessarily how to fairly reward students with grades that reflect what they know and can do.'

4.25.66 The decision was therefore taken that grades would be awarded by comparing students and schools to each other and previous cohorts, rather than trusting and relying on teacher professional judgement of a student's capabilities:

'This, understandably, led to huge levels of anguish, stress and upset for thousands of students. There were many examples of students who would have been awarded an A by their teachers being given a C by the algorithm – and even some results as extreme as downgrading a C to a U. This meant the loss of university places for many and for an even wider group, a feeling that the grades they had been awarded were completely unfair and in no way a reflection of the hard work they had put in.' (Courtney)

4.25.67 Afterwards, the Government blamed a 'mutant algorithm' but in fact:

'The algorithm was designed to do what Government asked it to do: prioritise keeping a rank order of students, baking a proportion of 'fails' into the system and distributing grades to students based

on the previous results at the school attended, over giving them grades on the merits of their own work.' (Courtney)

4.25.68 A series of chaotic U-turns culminated in Government reverting to the grades that teachers had originally suggested for their students. However, this was not done until after the algorithm-based results had been issued on A-Level results days, causing even more unnecessary upset. Zahra Ali (whose poem is quoted earlier) who was beginning her A level studies and hoping to be a doctor, described in her witness statement how personal loss, the cancellation of exams, and loss of school friendships, combined to precipitate a mental crisis.

'When COVID-19 struck in March 2020, it was one of the most important years of my education, my GCSEs. With the world whisked away into a lockdown, exams were cancelled. I should have been pleased. No exams, but as a student who worked hard all those years it was hard to let it all go. All those years, gone. What made that time worse was the everlasting silence from the Minister of Education, adding fuel to the anxiety of students across Britain. Why were they taking so long? Didn't they already have contingency plans in place? ... When the Government finally announced what was going to happen with our GCSEs and the A level predictions there was an uproar from students. Our fate, our future was going decided by an algorithm ... Each individual, unique student was going to be categorised, ranked, and given their grades based on their school's previous performance and where they lived. It completely disregarded a child's individuality and ability to rise above societies expectations. We were just numbers on a system.'

4.25.69 It is difficult to summarise the very many instances where the Government could have done better in terms of supporting children, young people, and schools during the pandemic. As we stated at the beginning, listening to and taking advice from those in the professions and their representatives at all levels, as well as the advice of scientists, including their own SAGE advisers, would have made a significant of difference, not only to schools, but also to the course of the pandemic for families and the communities where they are situated.



5. IMPACT ON FRONTLINE STAFF AND KEY WORKERS

Inquiry Session 5

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

5.0 INTRODUCTION

5.0.1 In lockdown and beyond, large numbers of workers – often low-paid, frequently in insecure employment on zero-hour contracts and with a high proportion from BAME communities – served the public alongside NHS and care staff. It appeared to catch the Government unawares (despite Operation Cygnus in 2016/17, conducted during Jeremy Hunt's tenure as Secretary of State for Health) that high-quality PPE was essential not only for NHS staff – but also for the over one million care staff, transport workers, taxi drivers, supermarket and food store staff, delivery drivers, school and nursery staff, etc.

5.0.2 By the start of the Inquiry, nearly 900 NHS and care staff had died and many bus and train transport workers had also succumbed to COVID-19. Schools, shops and delivery staff had suffered too; all are part of the community, with individuals both becoming infected and passing on infection. Unable to work from home, and often living in homes with high occupancy and low space, many faced increased risk without access to support necessary for self-isolation.

5.0.3 Cases related to possible exposure to the virus at work were not sufficiently reported or investigated so that valuable lessons could be learned and findings applied. Psychological trauma was clearly leading to long-term mental health problems and around 10% of those infected were found to be suffering long term symptoms ('long Covid'). These will require considerable investment in health service infrastructure to provide assessment and ongoing treatment.

5.1 PROTECTING WORKERS FROM RISK OF INFECTION?

'I had little doubt at the onset of the pandemic that thousands of workers were not being adequately protected from serious risk to their health.' (Agius)

5.1.1 It is clear that neglect of health and safety at work by Government and employers resulted in the needless deaths of many workers as well as care home residents, with a disproportionate effect on those from BAME communities. After the initial lockdown, the public came to appreciate the work of many employees to be of key importance in keeping society functioning, with a new insight into how jobs and roles interconnected. High income/status occupations such as stockbroker were now compared unfavourably with the social value provided by, among others, cleaners, public transport staff, and distribution and shop workers in addition to those in the health and care service.

5.1.2 We heard, however, that those working in social care remained invisible, forgotten and undervalued. Of around 1.5 million working in the care sector, 840,000 general care workers were looking after 420,000 vulnerable people in care homes. Government's poor support for this sector was reflected in deaths of 11,186 care home residents up to 2 June 2020, and 131 social care workers up to 20 April 2020, with more deaths predicted.^{5.1} Data from the Office of National Statistics showed a twofold higher risk of death from COVID-19 for social care staff compared with the general population, with five times the chance of having a positive test result for the SARS-CoV-2 virus.

5.1.3 Vulnerability in the social care sector is likely to be connected to 50% cuts in local authority funding over the past 15 years adding to existing financial pressures. Other factors were the precipitate discharge of elderly hospital patients into care homes without testing, and subsequent spread of virus to other residents and care home staff. The national shortage of PPE meant the care sector lost out to the NHS. The pandemic highlighted that social care was 'broken' through lack of funding and resources.

5.1.4 Early in the pandemic NHS England recognised the disproportionate mortality and morbidity in BAME people. NHS Employers published guidance on 30 April 2020 for NHS organisations to take appropriate measures to mitigate the risk of COVID-19, including taking age, gender, underlying health conditions and ethnicity into account. However,

'Viral exposure and inadequate protection at work as the principal determinants of risk were not given adequate recognition.' (Agius)

5.1.5 Neither the 'Risk reduction framework' for NHS staff (used in conjunction with NHS employers guidance) nor PHE advice took sufficient account of relevant past research which had generated precautionary guidance on how to reduce risk of viral exposure. Pre-pandemic work from the HSE had demonstrated that the FFP3 type of facemask was much better than fluid resistant surgical masks (FRSM) in protecting against inhalation of airborne virus:

'There is a common misperception amongst workers and employers that surgical masks will protect against aerosols ... Live viruses could be detected in the air behind all surgical

masks tested. By contrast, properly fitted respirators could provide at least a 100-fold reduction.'^{5.2}

This led to the recommendations that these be used for workers exposed to risk from aerosolised virus.

5.2 PRECAUTIONARY APPROACH TO GUARD AGAINST COVID-19 INFECTION ABANDONED

5.2.1 During the pandemic, HSE abandoned this precautionary approach, and accepted less stringent requirements for PPE thereby exposing workers to greater risk of infection. While the reasons for this are not fully clear, it seems probable to have been related to the inadequate, rundown and neglected state of the national PPE stockpile.^{5.3} Pre-pandemic, not only had emergency stockpiles of PPE been allowed to dwindle, but also training for key workers in how to deal with a pandemic had been put on hold. In addition, early attempts to source PPE were weak and opportunities for collaborative procurement missed.^{5.4} As far back as 2008, HSE had warned that in anticipation of a pandemic, stockpiling of facemasks ('respirators') would be essential:

'The widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance.'^{5.2}

5.3 UNDERESTIMATION OF AIRBORNE SPREAD OF VIRUS

'A huge concern in relation to preventing spread of COVID-19 at work has been the persistent underestimation of the risk of airborne spread and hence the

inadequacy of precautionary protection, in spite of past lessons.’ (Agius)

5.3.1 The risk of airborne spread of virus was consistently played down despite mounting evidence, and with disastrous consequences. Lessons that had been learned during other viral epidemics and outbreaks (SARS-CoV and MERS-CoV - also betacoronaviruses like SARS-CoV-2) were not applied in the current pandemic. During the spread of SARS (SARS-CoV) in Hong Kong in 2002/03 it was learned that health and care workers had to be provided with FFP masks as minimum respiratory protective equipment.^{5.5}

5.3.2 This should have made it essential for use of FFP3 type facemasks for health and social care workers likely to be coming into contact with COVID-19 infected patients. As awareness developed of people without symptoms being able to spread the virus, such masks should also have been used in other occupations involving close contact with the public.

5.4 RATIONALISING THE RATIONING OF PPE

5.4.1 Consistently understating the role of airborne transmission was used to justify recommending less effective facemasks. We heard that the misplaced insistence that airborne transmission of virus came only from specific ‘Aerosol Generating Procedures’ (such as intubation of a patient immediately prior to mechanical ventilation) and seems likely to have been influenced by a need to justify rationing of equipment.

5.4.2 For example, PHE guidance did not advocate wearing the higher grade FFP3 masks for workers involved with routine face-to-face care of infected patients, despite the fact that breathing, coughing,

and talking generate aerosols carrying the virus. Although aerosol generation was much debated, PHE advice ignored the earlier precautionary guidance from HSE and was contrary to the principle that

‘All workers encountering such exposure must have a sufficient workplace assessment and appropriate risk reduction such as through better ventilation and filtering face piece respirators.’^{5.6} (Agius)

5.4.3 The PHE guidance on PPE was weaker than that from the European Centre for Disease Prevention and Control which, in February 2020, stated that the minimal composition of a set of PPE for the management of suspected or confirmed cases of COVID-19 should include an FFP2 or FFP3 respirator, with FRSM only to be used ‘in case of shortage’.

5.4.4 PHE guidance in respect of PPE was similar to that of the WHO, with the proviso that WHO advice was designed for lower and middle income countries with constrained resources.^{5.7} However, in December 2020 the WHO updated guidance to say that health workers caring for COVID-19 patients should use FFP2/3 masks providing they were widely available and cost was not an issue.^{5.7}

5.4.5 Despite overwhelming evidence supporting airborne transmission, the DHSC failed to upgrade recommendations during the second wave of infection even though there was now more than enough PPE stockpiled. Regrettably, the HSE failed to step up, show independence of political influence, and firmly enforce occupational hygiene measures for infection control, including regular staff testing, segregation, and improved ventilation. It should also have argued for application of precautionary principles given the mass of accumulated evidence for aerosol

transmission of coronavirus, advocating the use of FFP2/3 masks in particular.

5.5 HEALTH AND CARE WORKERS WERE AT INCREASED RISK OF INFECTION

5.5.1 Failures of risk assessment and provision of appropriate PPE led to many unnecessary deaths. There is clear evidence that health and care workers are at increased risk of contracting COVID-19. Compared to nonessential workers, health and care workers have a seven-fold increase in risk of severe COVID-19 (testing positive in hospital or death). Frontline, or patient facing health and care workers have a three-fold increase in risk of testing positive for COVID-19 compared to the general population. Compared to non-patient facing health and care workers they have a three-fold risk, and their household members have a two-fold risk of hospital admission with COVID-19. COVID-19 risk is also specialty dependent with Accident and Emergency departments, medical specialties including general, acute, and geriatric medicine, and infectious diseases all being at increased risk compared to intensive care health and care workers, who in some studies had a lower risk than other health and care workers.^{5,7}

5.5.2 The striking finding of lower risk of COVID-19 among intensive care staff (the most exposed to allegedly high risk 'Aerosol Generating Procedures') may be due to higher grade of PPE, and better training and facilities for changing PPE than other staff. Opportunities were missed to protect the primary care workforce, with PPE shortages persisting for months. BMA surveys in April 2020 found over one-third of GPs did not have eye protection, while in May, 69% of GPs had sourced their own PPE or relied on

donations, and in June ongoing problems with supply of masks to GPs were reported.^{5,7}

5.6 LONG-TERM EFFECTS OF INFECTION AND DEALING WITH THE PANDEMIC WORKLOAD

5.6.1 COVID-19-induced serious multi-organ damage causing lasting ill health and work pressure producing psychological distress are among the profound long-term effects of the pandemic. A precautionary approach to infection control from the start, and provision of support and mentoring for staff could have saved many lives and greatly reduced the burden of disease. An estimated 10% of people infected with COVID-19 may have significant post-acute or chronic symptoms persisting beyond 12 weeks. Moreover frontline work during pandemic has had significant psychological consequences with exhaustion, depression, PTSD and 'burnout' adding to sickness absence and long-term ill health.

5.7 INADEQUATE RISK ASSESSMENT

'Workers are legally entitled to be consulted about the risks to their health at work and the risk assessments and control measures which are consequently envisaged. This is particularly important to give a voice to, and empower workers. In many workplaces such consultation with workers was conspicuous by its absence.'^{5,6} (Agius)

5.7.1 Workers' concerns about risk and safety at work were often unheeded by managers, putting the onus on workers' safety representatives to do their own assessments and argue for protective measures to be implemented.

Poor understanding and lack of engagement by management contributed to unnecessary deaths and sickness. In fact, all employers have a legal responsibility to make a 'suitable and sufficient' risk assessment in respect of all employees.

5.7.2 The level of detail in the risk assessment must be proportionate to the level of risk and appropriate to the nature of the work. Risks in the pandemic were clearly high and the nature of frontline work so critical that detailed assessments should have been carried out. The common occurrence of an employer simply stating they were 'following PHE guidance' did not constitute a risk assessment. In any case, as set out above, PHE guidance provided inadequate protection relative both to pre-pandemic guidance and later professional consensus.^{5.8}

5.7.3 Frontline staff continued to have risk assessments and protective measures that were inadequate. The pressures on occupational health services during the pandemic were unprecedented and the evidence from trade unions would have been of value as regards the extent to which their members perceived themselves to be adequately protected.

5.8 THE CASE OF LONDON TRANSPORT STAFF

'... the view of union members was that the management were going to try and run this on "a wing and a prayer", where we do the praying, and they do the winging.' (Mirza)

5.8.1 Transport staff with unavoidable close contact with the public were tragically unprotected at the start of the pandemic. With regard to transport workers, the Inquiry heard that London

Underground simply announced it would follow Government and PHE advice, prompting union members to rapidly establish networks for information-sharing among themselves in order to promote worker and passenger safety.

5.8.2 London bus drivers were initially left to their own devices regarding implementation of safety measure and suffered from being a more fragmented workforce. Attempts to implement social distancing by cordoning off the front two bus seats led to threats of disciplinary action by managers; over 50 drivers died.

5.8.3 Government messaging was often confused, contradictory and unreliable. Risk assessments were primarily paper exercises that did not reflect the seriousness of the situation and were not proportionate to the risks involved. The union had had to push for a robust and consistent cleaning regimen; members fought for masks, hand gel and gloves (basic fundamentals that should have been on hand from the start), threatening to refuse to work on grounds of safety and invoking relevant legislation. Drivers also had to push for information about testing and access to test kits.

5.8.4 Low pay and insufficient financial support (including the low level of statutory sick pay) continually hindered people's capacity to isolate. As a consequence, overcrowding on London Underground trains and platforms frequently featured in national news coverage. A cursory glance of the images suggest many of those travelling were poor and from BAME communities, many no doubt working in privatised industries characterised by zero-hour contracts and weak or non-existent trade union or workplace representation.

5.8.5 Staff struggled with anxiety over developing infection, having seen friends and colleagues dying and adding to the national statistics. This was coupled with fears that the pandemic was being used as a pretext to drive down terms and conditions of work. Increasing numbers of work place outbreaks by January 2021 pointed both to inadequate risk assessment and implementation of safety measures by managers.

5.9 REPORTING CASES OF COVID-19 IN WORKERS: MISSED OPPORTUNITIES TO LEARN LESSONS

5.9.1 Reporting infection in the workforce should lead to investigation, lesson learning and application of knowledge gained to improve safety. Tragically, this was often not the case. Employers have a legal obligation to report cases of COVID-19 in workers for whom a 'reasonable judgement' can be made 'on the balance of probability' that they contracted the disease from work.

5.9.2 The legal provision for this arises from the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The report is made to the enforcing authority, usually the HSE, which should investigate in order to explore what lessons can be learned. Coroners may also investigate work-related deaths but compared with the HSE have very limited experience of inquiry into occupational disease caused by biological agents.

5.9.3 It is a matter of grave concern that Mr Hancock, the Secretary of State for Health and Social Care, when questioned at a House of Commons Select Committee sitting, apparently considered employers to be the appropriate investigators of the

deaths of NHS staff, appearing to discount the key role of the HSE.

5.9.4 From 10 April 2020 to 13 March 2021, 31,380 occupational disease notifications of COVID-19 in workers were reported to the HSE, including 367 death notifications. Out of these, 9,947 cases (including 139 deaths) were in 'human health activities', with similar numbers in social care. However, it is recognised that there is widespread under-reporting by employers^{5.9} and that HSE guidance for reporting work-related covid-19 may result in many thousands of cases being missed.^{5.10}

'HSE has investigated only a small fraction of the Covid RIDDOR reports. In my opinion this, on top of the already limited HSE reporting guidance, constitutes a very serious failing in investigating Covid contracted from work, and has missed opportunities to learn lessons and save lives.' (Agius)

5.9.5 The ONS statistical bulletins have shown that SMR for male security guards and related occupations were nearly four times higher than those for all men of working age, while for taxi cab, bus, and coach drivers the SMR were well over double.^{5.9}

5.9.6 This is consistent with the conclusion that jobs with frequent and close public exposure (besides health and social care) carry a higher risk of COVID-19. Such jobs did not fall within the remit of HSE reporting and were not therefore subject to investigation. Furthermore, HSE also considered that PHE guidance constituted 'effective control measures' and intimated that COVID-19 cases among employees did not need to be reported if such guidance had been followed.

5.9.7 PHE has collected data on hundreds of workplace outbreaks. However it is not clear whether PHE has pursued these to the extent necessary to learn lessons about specific measures to prevent further outbreaks, for example through work practice, engineering controls (notably ventilation) or standard of respiratory protective equipment.

5.9.8 The Secretary of State for Health had steered the HSE away from the need to investigate deaths from COVID-19 among health and care workers when presumed to have been contracted at work. During the pandemic the HSE did not assert the relevance of their own prior research findings and their precautionary guidance for worker protection against biological agents, but simply endorsed 'PHE guidance'.

5.9.9 The response by HSE in investigating occupational COVID-19 has been lacking, with only a minuscule proportion of reported cases being investigated. It should also be noted that the additional funding allocated to the HSE to meet the pandemic challenge bore no relationship to the scale of the task at hand.

5.10 VACCINATION TO PROTECT WORKERS

5.10.1 Delay in vaccinating health and care staff and other high risk occupational groups has contributed to infections and sickness absence. One month after vaccinations with the Pfizer/BioNTech vaccine commenced, NHSE wrote to Trusts and clinical commissioning groups requiring immediate vaccination of frontline staff, including those working in primary care, to 'Protect the NHS'. However, health and care workers' second vaccine doses

were delayed up to 12 weeks after the first dose.

5.10.2 While there was good evidence for the Oxford/AstraZeneca vaccine, in contrast, the Pfizer/BioNTech vaccine dose delay occurred despite the Medicines and Healthcare products Regulatory Agency approval, and WHO and Centers for Disease Control and Prevention advice, to use the original shorter dosing schedule.

5.10.3 Other high-risk groups (e.g. public transport drivers and teachers) were not given priority as a more comprehensive evidence-based account of occupational risk would have indicated they should have been. Had front-line healthcare workers been prioritized when immunization roll out commenced at the beginning of December 2020, this may have better maintained the functioning of the NHS in the face of soaring admissions and staff sickness or isolation.

5.11 EFFECTS ON HOSPITAL STAFF

'We cannot look after people to the standard we trained to – that is a devastating fact. The pandemic only exacerbated an already existing problem, we were on our knees long before COVID hit.' (Brewerton)

5.11.1 Stress at work has had a major impact on the mental health and wellbeing of staff with limited recognition and provision of support. The Inquiry heard from a nursing sister who had previously worked in an Accident and Emergency Department where difficulties from short staffing and lack of investment had created enormous pressures on staff.

5.11.2 The moral injury of feeling unable to give patients the care they deserved caused stress that had personally

resulted in a period of time off work. The potential for work to impact negatively on the mental health of staff was often unrecognised, and support services, when available were very variable.

5.11.3 Routine exposure to infected patients and unavailability of testing for staff added to stress. Despite some staff developing chronic symptoms ('long covid') and having to give up work, there seemed to be few that were reported under RIDDOR, with managers happily making the assumption that infection was always community acquired and not contracted at work.

5.11.4 This may have contributed to the Industrial Injuries Advisory Council decision that COVID-19 should not come under the Industrial Injuries Disablement Benefit Scheme.^{5.11}

5.11.5 Worries about the inadequacy of PPE were compounded by the advent of more transmissible newer variants but with no change to existing guidelines:

'Where it became a case of real moral hazard was when we totally ran out of resources. And yet you had patients who you knew, within ordinary times, if we'd had the resources or places to send them, the odds were that they would survive. So you were now having patients who rather than going to the Intensive Therapy Unit were going to High Dependency Unit, rather than going to High Dependency Unit were going to wards ...' (Ejimofo)

5.11.6 The initial positive approach by staff in a busy emergency department to managing the demands raised by the pandemic was tempered by having to cope with a huge increase in demand. This was seen as a direct consequence of government strategy side-lining primary

care with patients being told to go to hospital and not to their GP.

5.11.7 Staff faced additional pressure from having to cover sickness absence, and were worried about the adequacy of available PPE and the validity of national guidance, such that they sourced their own supplies.

5.11.8 Additional concern related to the fact that a high proportion of the workforce were from BAME communities, who had been identified as being more vulnerable to Covid-19.

5.11.9 Trying to prevent spread of infection among patients and staff in the department was challenging because of its physical layout and constraints on space. Increasing evidence of airborne viral spread added to anxiety, knowing that in a crowded environment with mixing of patients cross-infection was extremely likely. By the second wave of infection staff were simply exhausted as well as demoralised having predicted government strategy was likely to lead to a resurgence of hospital admissions.

5.11.10 Deaths among colleagues, and more widely among health and care workers and key workers heightened a sense of grievance that appropriate risk assessments were not being performed. Senior staff were having to work long hours to provide supervision, particularly for staff reassigned to unfamiliar roles. Problems were superimposed on those already created by chronic underfunding (such as pre pandemic short staffing) and also brought the lack of preparation for a pandemic into focus.

5.11.11 The Nightingale hospitals were a disappointment because frontline staff had not been consulted and would have highlighted the fact that valuable and

intensive care staff would have to be taken away from hospitals where they were required and were already in short supply.

5.11.12 Finally, when resources were running out, difficult decisions had to be made about prioritising patients, knowing that some who in normal circumstance had the potential to recover, would now die.

5.11.13 In terms of support for staff from employers and professional and regulatory bodies, a need for a robust and independent way of feeding back or reporting when staff feel they are being constrained from being able to carry out their duties by factors beyond their control was emphasised:

'The COVID-19 pandemic has highlighted a system that is broken, through lack of funding and resources. In order to avoid the same tragedy in another pandemic, lessons must not only be learned, but must also be acted on.' (Agius)

5.12 EFFECTS OF THE PANDEMIC ON WELLBEING OF FRONTLINE WORKERS

'It's been a roller coaster – my immediate team are absolutely amazing. But I lack confidence in my Trust; and feel hugely let down by the Government – cannon fodder absolutely nails it.' (quoted by Sumner)

5.12.1 The pandemic has had huge negative consequences for staff wellbeing across a wide range of sectors, worsening as time has gone on. The Inquiry heard from two psychologists about their research into the response of health workers in both the United Kingdom (UK) and the Republic of Ireland (ROI) to the handling of the pandemic by government. The project started in March 2020 to track the wellbeing of frontline workers

across different sectors using survey and interview data. It included health and care workers, social workers, education, civil defence, emergency services, supermarkets, and supply chain logistics staff.

5.12.2 The strategy for the pandemic adopted by the government of the ROI involved a suppression and elimination approach, moving quickly to impose restrictions. In contrast, the UK delayed 'lockdown', allowing huge sporting events like the Cheltenham Festival and Champions League football game to go ahead, even as numbers of infections were rising.

5.12.3 The study explored whether or not these different strategy approaches were reflected in different effects on wellbeing in frontline workers. Participants were asked how they felt about their government's response, whether they considered it to be timely, effective, or appropriate. For each of those metrics, those in the UK rated lower, in terms of their perception of the Government's actions.

5.12.4 There were statistically significant differences between the ROI and the UK in terms of worker wellbeing including resilience and burnout, with UK workers suffering more adverse outcomes particularly in the initial period from March to May 2020. The gap then decreased over time, with frontline workers in the ROI showing a decrease in wellbeing associated with change in government strategy, and those in the UK remaining at a low level

5.12.5 Workers described the UK Government advice as chaotic, and the overall response indefensible. There was particular criticism of unclear and ambiguous messaging; schools and

universities being open at certain stages; the failure to lockdown soon enough before Christmas 2020 (which effectively undid all their good work); rule-breaking was not dealt with consistently (especially the very notable rule-breaking by some prominent figures that took place). Social solidarity, compliance, 'incredible' generosity to those in need and appreciation for health and care workers were undermined by Government demonstrating that in practice, rules only applied to some.

5.12.6 This was 'devastating' for frontline workers, many of whom expressed a great sense of pride in their work and tried to stay positive even though feeling really overwhelmed – not having been provided with adequate PPE, testing or support. Health and care workers began to think about leaving their posts, particularly when early popular support (e.g. the 'clap for carers') was not followed up by compensation or support.

5.12.7 Wellbeing continued to deteriorate, with indicators of burnout and even PTSD in some, including in those with resilient coping styles. Little help was available for staff feeling under stress from having to deal with a mixture of very strong emotions.

5.12.8 A consistent finding from frontline workers was that they wanted timely and decisive action from the Government. Insofar as making sure their own voices were heard, many of the research participants said their focus was entirely on trying to get from one day to the next as well as keeping family life going at home.

5.12.9 Burnout involving physical and mental exhaustion, feelings of inadequacy and futility, was found to have increased at six months with a further rise by 12 months. A worrying trend, given the

likelihood of continuing high workload demands for a long period, was that recognisable levels of PTSD were beginning to emerge. Overall, the research showed that after 12 months, participants were starting to feel hopeless and losing the drive to keep working:

'And so much of this vital work is about that personal drive, because it's hard work, all of it is hard work. It's hard work, and it's dangerous. And for people to leave their door every day to go into that hard and dangerous work, they need to know that it's worth it, and that it means something...' (Kinsella)



6. INEQUALITIES AND DISCRIMINATION

Inquiry Session 6

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

6.0 INTRODUCTION

6.0.1 The COVID-19 pandemic has shone a light on pre-existing discrimination as well as creating further inequalities for already marginalised members of society. The coronavirus outbreak has magnified existing inequalities, but has disproportionately affected BAME communities, and this has been clear from early on in the pandemic. Whilst this was shocking, it was not surprising. The reasons for this are complex, but the over-representation of BAME groups in health and social care, and working in front-line positions which mean that they are unable to work from home, as well as being at a higher risk of disease severity. While this higher risk of disease severity may not have been predictable, different health outcomes and the reasons for them have a complex basis and include factors relating to poverty and relative wealth, housing and households, job type, and the impact of health inequalities. All these have contributed to this disproportionate, devastating outcome.

6.0.2 Certainly BAME staff working in the NHS ran a greater risk of being exposed to infection. BAME NHS staff were less likely to complain about working conditions, which compounded the issues discussed in detail elsewhere in this report, with the effect that risk assessments, for example, were not undertaken and PPE was not provided. The reasons were varied but pre-existed the pandemic, which has exacerbated such inequalities.

6.0.3 There have been significant issues with messaging and reaching individuals who do not speak English as their first language, in order to get important messaging to them about the pandemic. Similarly communication was not properly considered in relation to healthcare, in

populations who regularly changed their mobile numbers, so they were on occasion discharged from a service inappropriately, creating further disparities. There was a pre-existing mistrust of government policy in some communities, which has led to lower compliance with regulations, suspicion of policy, and vaccine hesitancy. The hostile environment for undocumented migrants has created some appalling outcomes, in various ways, but particularly in that some people have been too scared to go to hospital for treatment for fear of being deported or unable to pay for treatment (despite COVID-19 hospital treatment being free).

6.0.4 The pandemic has had a differential effect on women, in multifarious ways. They were much more likely to be furloughed, to lose their jobs by the nature of them, to undertake unpaid work given the closure of social care services, and to be the primary carer for children who were not at school.

6.0.5 There was a failure by policymakers to consider the unequal impact on women, which was particularly evident in terms of the effect on women's income and finances, for example the failure to take into account periods of maternity leave within the last three accounting years for self-employed grant calculation. Problems with statutory sick pay during the pandemic led to people having no choice but to have to go to work whilst ill, or face not being able to feed their families. From a public health as well as a compassionate perspective, this is an appalling choice to have to make which was entirely as a result of failed planning and policymaking.

6.0.6 During Session 6 of the nine live-streamed sessions the Inquiry considered and heard the impact of the virus on BAME people, the impact on women at home and

in the workplace, the effect on incomes, and the issues faced by undocumented and migrant people in accessing treatment. Whilst this chapter will predominantly focus on the elements of discrimination suffered by BAME populations and the effect of the pandemic on women it will draw upon other sessions where appropriate. The issues and discrimination faced by the elderly and disabled are dealt with elsewhere in this report.

6.1 HEALTH EQUITY

6.1.1 Right at the outset of the People's Covid Inquiry, Professor Sir Michael Marmot discussed his report on health equity in England,^{6.1} in an essay written 10 years after the Marmot Report, but pre-dating the COVID-19 pandemic, which stated that the effects of austerity have widened health inequalities in Britain, particularly among women in deprived communities and the north, and life expectancy has fallen. In comparison with life expectancy increasing by about one year every five and a half years among women in the period from 1981 to 2010, between the period of 2011 to 2018 this slowed to one year every 28 years among women, and every 15 years among men.^{6.1} The same report, in its conclusion, comments that there are no routine figures provided for life expectancy based on race or ethnicity. The figures that were available 'point to half of minority ethnic groups – mostly black, Asian and mixed – having significantly lower disability-free life expectancy than white British men and women'. Put simply, prior to the COVID-19 pandemic, there were pre-existing health inequalities the effects of which have been highlighted and augmented by the pandemic.

6.2 IMPACT ON BAME GROUPS

6.2.1 Recognising that 'this pandemic starts and ends within communities', the indie_SAGE report of 12 May 2020^{6.2} expressed concern about the effects of COVID-19 on BAME, marginalised and low-income groups. By then it was 'clear that COVID-19 has disproportionately affected ... BAME communities ...' and 'the over-representation of BAME communities as low-paid care workers in health and social care settings which makes them vulnerable to COVID-19-related infection and deaths'^(6.2) was noted. Further BAME groups were 'associated with higher risk of disease severity'.^{6.2}

6.3 INEQUALITIES PRIOR TO THE PANDEMIC

6.3.1 Professor Kamlesh Khunti is Professor of Primary Care, Diabetes and Vascular Medicine at the University of Leicester and a member of the government advisory body SAGE. He is Chair of SAGE Ethnicity Subgroup and a member of Indie_SAGE. In his oral evidence to the panel, Professor Khunti talked about structural discrimination as an underlying issue. Pre-pandemic, societal systems were already inequitable, such as housing, education, employment, earnings, benefits and credit. Structural discrimination puts people at a disadvantage, and this applies more so to BAME communities. In addition, BAME people may be exposed to more COVID-19 by virtue of their housing, or occupation. BAME people could be more vulnerable to COVID-19 because of their environment, air qualities or because of co-morbidities; for example BAME groups are more likely to have heart disease or high blood pressure.

These factors, combined with a greater risk of having poor access to care, and quality of care, create significant health inequalities.

6.4 INEQUALITIES AS A RESULT OF THE PANDEMIC

6.4.1 Professor Khunti told the Inquiry that overall 14% of the UK population is of non-white ethnicity. By the beginning of April 2020, data from ICNARC^{6.3} showed that 30% of those admitted to Intensive Care Units were of non-white ethnicity. The reasons why are complex. Professor Khunti said that he didn't think we could have seen this coming; 'we were definitely caught off guard.'

6.4.2 In written evidence submitted to the Inquiry, Professor Khunti described ethnicity as a social construct^{6.4} and set out a framework for how differences in health outcomes due to the pandemic could arise, through six pathways:^{6.4}

1. exposure;
2. vulnerability to infection/disease;
3. disease consequences;
4. social consequences;
5. effectiveness of control measures;
6. adverse consequences of control measures.

These different mechanisms place BAME groups at increased risk of critical care, the need for ventilatory support and death.

6.4.3 Differential consequences in relation to COVID-19 could arise as a result of working conditions and the level of impairment through stopping work. If a BAME person became ill, the control measures could have differential effectiveness of control methods due to language, messaging issues, resources, vaccine hesitancy, different working conditions, access to protection, PPE and not following advice because of stigmatisation.

6.5 HEALTH OF BAME POPULATIONS

6.5.1 The amount of deprivation contributes to the increased risk for BAME populations from COVID-19, and whilst mounting evidence suggests that people from BAME groups in the UK (predominantly South Asian and black African or Caribbean populations) and elsewhere are disproportionately affected by COVID-19 with a higher risk of infection, hospitalization and mortality, the reasons for the ethnic disparities were unclear.^{6.5}

6.5.2 There is also an increased risk, in particular for south Asian women living in multigenerational households, as found by a study provided in Professor Khunti's written evidence.^{6.6} Elderly adults living with younger people are at increased risk of COVID-19 mortality, and this is a contributing factor to the excess risk experienced by older South Asian women compared to White women.

6.5.3 A further study^{6.7} which considered obesity, ethnicity and risk of critical care, ventilation and morbidity for patients with COVID-19 concluded that being obese elevated a risk of receiving in-hospital treatment in all ethnic groups, but this risk was strongest in Black ethnicities.

6.6 WORKING CONDITIONS

6.6.1 Unjum Mirza talked about the way in which the phrase 'key worker' has created a shift in appreciation for the key roles in society, but that Government policy has not reflected this shift (report section 5.8). A high proportion of front-line staff are BAME people who throughout the pandemic served the public: staff and transport workers, taxi drivers, supermarket and food store staff, delivery drivers, and school and nursery workers,

as well as those in the NHS and care homes. The nature of this work means that it is impossible to work from home. All of these jobs made them more liable to come into contact with the virus, and to succumb to infection. Often in high occupancy and low space accommodation, they have been unable to self-isolate and consequently face increased risk, without financial support to facilitate self-isolation.

6.7 DOCTORS AND OTHER FRONTLINE HEALTHCARE STAFF

6.7.1 Dr Latifa Patel is Deputy Chair of the Representative Body of the BMA and a member of the BAME forum. The BMA has completed numerous surveys into the specific needs and disparities of minority ethnic doctors that set them out from their white counterparts. Prior to going into the pandemic these groups of doctors had been more at risk of bullying, discrimination and harassment, and were also the quietest and least likely to raise these issues, and their concerns to be acted upon. This created a multiplying effect. Mask shortages were between 36%-43% and there were shortages of scrubs, aprons and visors. BAME members of staff were least likely to raise concerns from experience prior to the pandemic, knowing full well that they were not going to be heard.

6.7.2 The mortality and morbidity data for health and social care staff during the pandemic showed that a disproportionate number of people from BAME groups were dying, and a disproportionate number of them are more unwell than their white counterparts. In a recent survey, only 50% of doctors were saying that they had been risk-assessed at work. The greatest proportion was within the minority ethnic group populations with about 10-15%

difference between minority ethnic doctors and their white counterparts in terms of how well they have been risk assessed.

6.7.3 Dr Chidi Ejimofo, an A & E Consultant, gave evidence in Session 5 of the Inquiry and told the panel^[1] about the impact of working in Accident & Emergency and not having enough staff, as many people fell ill, as well as of the 'underlying fear' of a large number of staff, including himself, from the BAME group. In terms of support for staff from employers and professional and regulatory bodies, Dr Ejimofo told the panel that there needs to be a robust and independent way of feeding back or reporting, when staff feel they are being constrained from being able to carry out their duties, secondary to things that are out of their control.

6.7.4 Dr Patel said that these issues had been raised by the BMA with the government who had not responded in the way the BMA would have liked, at a level which would have made staff 'feel safe and protected'. Staff need to feel safe and valued, which is particularly important in light of a record number of NHS staff reporting burnout, who are suffering from mental and emotional concerns, and who are considering leaving the NHS.

6.8 ACCESS TO HEALTHCARE

6.8.1 Once the lockdown of 23 March 2020 was implemented, access to primary care moved almost completely online. As General Practitioners were no longer routinely seeing their own patients in person, the impact on BAME communities was profound. There are particular difficulties with delivering medical advice online, and this disproportionately affected BAME groups.

6.8.2 As Dr Latifa Patel told the panel, virtual consultations

'... didn't cater to minority ethnic groups and low income families particularly well. In fact, they almost discriminated against them. You needed a really good Wi-Fi connection, you needed a good understanding of English, which we know not everybody does have, you needed a good microphone, you needed a high pixel camera.' (Patel)

Coupled with the technical aspects of online healthcare is the lack of patient confidentiality or privacy which could be impossible to achieve from a multi-occupancy home. This forced these patients to make calls from cars, bathrooms or toilets in an attempt to achieve privacy.

6.8.3 Lower income families tend to use pay-as-you-go mobile phones and change their numbers more frequently, which meant that as doctors were unable to contact them some patients were discharged prematurely.

6.8.4 The NHS 111 telephone service, which replaced primary care services for people with symptoms of COVID-19, was ill-equipped to triage BAME patients. For example, Oluwalogbon (Lobby) Akinola, of COVID-19 Bereaved Families for Justice, and who gave evidence early in the Inquiry, lost his father to Covid. He died aged 60, with no underlying health conditions, having never seen a doctor about his illness. The telephone consultation on NHS111 included a question about whether his lips were blue which was inappropriate for black Covid patients.

6.9 COMMUNICATION AND MESSAGING

6.9.1 As well as difficulties with online healthcare services, other communication and messaging was not adapted to reach BAME groups. Professor Khunti said in evidence that 'Ethnic minorities do need tailored messaging, it needs to be personalised, it needs to be accessible, needs to be culturally adapted'. The daily news conferences on television 'were in English and weren't accessible to most of the minority population, especially the deprived population who has been hardest hit'.

6.9.2 Dr Latifa Patel informed the panel that 'Communication throughout this pandemic from the Government has been wholly unacceptable' and 'made those disparities even ... greater for families from minority ethnic groups'.

6.10 UNDOCUMENTED MIGRANTS

6.10.1 Whilst in general there have been worse outcomes in terms of access to treatment in other countries, such as in the USA where Latino and black communities were less able to afford care, there is evidence that some people in this country have not accessed care due to their immigration status.

6.10.2 Alia Yule is the Access to Healthcare Migrant Organiser at Migrants Organise, a West London charity. She explained that there are a variety of ways in which people can be or become undocumented, and that this population is estimated at between 800,000 to 1.2m people in the UK. The Government's 'hostile environment' for undocumented migrants creates a wide variety of policies that affect a whole range of sectors and services needed for people

to live a normal, dignified life. The hostile environment means that undocumented people were denied those services. The hostile environment makes life very difficult for people who don't have the right immigration papers, including not just those who don't have legal status, but those who are unable to prove that they do have legal status, such as those from the Windrush scandal.

6.10.3 Alia Yule told the panel that the policy is

'... really about scapegoating a group of people ... making migrants the blame for the erosion of our public services and the defunding of our public services by saying, "it's those people who come here who steal our hospital bed, who steal our school places, who steal our jobs"; by sort of blaming the most marginalised and making it then extremely difficult for those people to speak out about what is happening to them.' (Yule)

In terms of access to healthcare, the hostile environment in the NHS means that migrants can be charged up to 150% of the cost of care. The rules are very complex. Payment is required up-front for 'non-urgent' treatment. Data from the NHS can be shared with the Home Office, which means that if they cannot pay they won't be treated. Many hospitals use debt collection agencies to try to recover these debts from migrants.

6.10.4 The way that this has impacted on access to healthcare, particularly during the COVID-19 pandemic is that even though treatment for COVID-19 is free, this was not publicised well nor made clear so migrant communities have been afraid to come forward for treatment. The rules were not clear on whether treatment provided at the same time as COVID-19 treatment was chargeable:

'... it's not really possible to have a health system in which you have some parts that are chargeable, and some parts that are not, and be able to communicate that to people clearly. And particularly when at the same time you have this system of sharing patient data with the Home Office sitting behind it. So, meaning that even when testing and treatment is free for people, there is still this fear of coming forward, lest you might make yourself subject to immigration enforcement as a result.' (Yule)

6.10.5 The inquiry heard several examples of the effect of the hostile environment. A Filipino man who had lived and worked in the UK with his wife for 10 years died at home from suspected COVID-19, having been so fearful of being detained and deported due to his immigration status that he did not present to the NHS. A Lebanese man who had been in the UK for two years and recently managed to get out of a detention centre developed COVID-19 symptoms. He was so fearful that a debt for treatment would jeopardise regularisation of his visa that he sadly died. A third example was a Black British man being treated in hospital for COVID-19 who had kidney failure and was in an induced coma. His family were sent a threatening letter requiring him to provide evidence of eligibility for free NHS care within seven days, failing which he would be charged for treatment, despite him having lived in the country for over a decade and having gained British citizenship two years previously, and despite the Government saying that no one should be status-checked for COVID-19 related treatment.

6.10.6 Several hundred people had been kept in a military barracks despite the Government's announcement that this would stop. The conditions were unsanitary, there was no way to achieve

social distancing or isolation and COVID-19 spread, with difficulty accessing GP services when they were ill.

6.10.7 Foreign national NHS workers who pay the immigration health surcharge are in essence subjected to a double-tax: the immigration health surcharge is £624 per person per year, which must be paid up front with every visa application and for every family member, and then workers also pay for healthcare through their taxes as well.

6.11 MISTRUST IN POLICIES AND VACCINE HESITANCY

6.11.1 There is increased vaccine hesitancy amongst BAME groups. Dr Latifa Patel explained that in order to understand vaccine hesitancy it is important to consider the position prior to the outset of the pandemic. Concerns and disparities already existed, and there was an inherent lack of trust in some Government policies, for example Brexit, immigration policies, the Windrush generation. In addition, Black and Asian patients are often more at risk within the NHS, so feel less trusting of it. As Ellen Clifford said in Session 4 (report section 4.20), whilst disabled people wanted to be vaccinated, there were problems with access and also distrust in the Government in the way that disabled people had been treated since 2010. She told the panel during that session that where she lived in South East London, distrust in government messages was more widespread amongst sections of the community, which had led to low compliance with mask wearing.

6.12 IMPACT ON WOMEN

6.12.1 The Panel of the People's Covid Inquiry heard from Dr Mary Ann Stephenson, director of the UK Women's Budget Group (WBG), which analyses economic policy for its gender impact and proposes alternative policies to create more gender equality. Dr Mary Ann Stephenson gave evidence about the effect of the COVID-19 pandemic on women.

6.12.2 In January 2021 the WBG published a report on the impact of COVID-19 on women, called 'Where women stand at the start of 2021'.^{6.8} Whilst men are statistically more likely to die from COVID-19, women have been hit harder by the social and economic impact of the pandemic.

Women and work

6.12.3 There were pre-existing inequalities which have been highlighted as a result of the COVID-19 pandemic. Women are more likely to be poor; more likely to work in insecure employment whether through insecure or zero-hour contracts, and more likely to work in sectors which had to close as a result of the pandemic, as well as in health and social care. The sectors that women are more likely to work in have been most badly hit by the pandemic, and the resulting closures. This meant that women have been more likely to be made redundant. There has been extensive research on the gendered impact of Ebola and other pandemics, but when these concerns were raised by an expert in the field at the beginning of 2020, the response was 'London is not Liberia, we won't have the same problems.'

6.12.4 As women are more likely to be poor, they are also more likely to be affected by the end of the £20 uplift in Universal Credit (which was withdrawn in September 2021) and pushed into poverty. People who lost their jobs as a result of the pandemic had the loss of earnings mitigated somewhat by the uplift. Dr Mary Ann Stephenson said: 'We are facing a cliff edge with the end of the furlough scheme, and the end of the £20 uplift in Universal Credit.'

6.12.5 Women were less likely to be furloughed than their male counterparts and furlough for childcare reasons, which was introduced later on in the pandemic, was not well publicised. Parents should have had the right to request furlough, or part-time furlough shared between parents should have been actively encouraged.

6.12.6 There had been significant problems with entitlement to statutory sick pay, which had disproportionately affected women, the consequence of which had reduced the ability for women to self-isolate where necessary. It had left many people with no choice but to carry on going to work, even when they were ill:

'The government needs to take action to actually introduce a Social Security system that acts as a genuine safety net ... we need a system that is there to protect us.' (Stephenson)

6.12.7 Women working in the NHS had been affected in a variety of ways. Dr Latifa Patel told the panel that a 'staggering' 77% of NHS staff are women. 'Yet from the offset in terms of how we were protected, our face masks, our gloves, our aprons, all of these were geared for men.'

6.12.8 NHS staff had lost on average about 15% in the real value of their pay over the last decade; local government workers had lost 23% and in the social care sector, or sectors which had been outsourced, the vast majority of workers were on minimum pay and conditions, and are predominantly women, and people from BAME backgrounds.

6.13 MATERNITY AND CHILDBIRTH

6.13.1 On a practical level women patients have been affected during the pandemic by the way maternity care was delivered. Midwife and other appointments were suddenly experienced without partners, people had babies in hospital without the support of family and friends, and some women even gave birth on their own. The BMA has been campaigning on issues relating to maternity, as well as equality for PPE.

6.13.2 Women who had recently taken maternity were disadvantaged in the calculation of the support given to the self-employed since maternity leave was not allowed for in the averages over the three years prior to the pandemic.

6.14 MENTAL HEALTH

6.14.1 Women's mental health had been affected by the pandemic, for all of the reasons above, but in particular the mental health of young women had been badly affected. This was as a result of the significant underfunding of the CAMHS which were 'threadbare' and needed proper investment to enable people to get the support they so desperately needed.

6.15 DOMESTIC VIOLENCE

'People were trapped at home with their abusers, which meant that there was nowhere else to go, there was no way of getting away from a situation ... that made things particularly bad.'
(Stephenson)

6.15.1 A review of women's organisations from the Women's Resource Centre showed a 79% increase in demand and over 50% showed an increase for women with complex needs, including violence, but there hadn't been the resources to meet the level of demand.

6.16 GENDER INEQUALITY

6.16.1 Echoing many other witnesses in the Inquiry, Dr Mary Ann Stephenson told the panel that COVID-19 hadn't created these problems, but rather that it had highlighted pre-existing issues: 'endemic structural racism in society, huge inequalities between rich and poor, inequalities between women and men'. Consequently she recommended that an expert in gender should be part of the advisory group SAGE.

6.16.2 In order to implement policies which promote equality, this country could draw upon the policies of other nations. For example, many Scandinavian countries and South Africa have adopted impact assessments and gender budgeting. Scandinavian countries also have more equitable sharing of leave policies. Dr Stephenson told the panel that Joe Biden in the USA had recognised that this is a moment for change, and that it is possible.

6.16.3 Dr Mary Ann Stephenson also said that the Government's 'Build Back Better' proposals focus on investment in construction schemes, some of which

are important and needed, but unlikely to provide jobs for people who have lost work in retail, hospitality, or the beauty sector for example.

6.16.4 In addition, modelling of investment in social care shows that the same amount of money invested in care could create nearly three times as many jobs as money invested in construction, even if you paid care workers at a higher rate than currently.

7. PROFITEERING FROM THE PEOPLE'S HEALTH

Inquiry Session 7

PEOPLE'S
COVID
INQUIRY

Learn lessons, save lives.



7.0 INTRODUCTION

7.0.1 The UK should have started from a position of strength in facing the national emergency and the global pandemic. Its publicly provided National Health Service is world-renowned and its research and policy in public health has had a similar reputation. Possibly influenced by this, the Global Health Security (GHS) Index had assessed the UK and the USA as having the best plans in the world to respond to capability to prevent, detect, and respond to infectious disease threats.^{7.1} The reality could not have been further from the truth: UK death rates and impact on the UK economy were amongst the worst of the advanced economies and inequalities have been laid bare.

7.0.2 The Inquiry heard how a series of policy decisions had turned world-leading pandemic planning on paper into one of the world's starkest failures. The contrast between the need for the nation to pull together and to rely on its public resources on the one hand and, on the other, the policy decisions of Government is breath-taking. Witnesses in this and previous sessions testified to Government decisions to deliberately bypass the UK's public services and local authorities and to contract out Covid-related services to private companies, too many of which had neither a track record with the health service nor of cooperating with other sectors on a mass scale. Effectively, the Government was ignoring, and did not even consult, experts in public health and general practice with strong local connections, intensive care, infection control and NHS procurement and 700,000 volunteers.

7.0.3 It is ill-judged and irresponsible of the UK Government to have allowed its ideological loyalty to the private sector and

its mistrust of publicly funded services, pre- and during the pandemic, to have determined its policy decisions.

7.0.4 Witnesses at the Inquiry testified to the devastating impact of the policies on every major area of service planning and decision-making:

- The pre-pandemic running down of public health, the NHS and social care
- Procurement policies pre-pandemic which had fragmented a previously effective national network and, coupled with neglect of the outcome of pandemic planning exercises, led to unproductive emergency procurement of thousands of ventilators and the deeply flawed sourcing of PPE
- Decisions to outsource Covid services and capacity building, included the COVID-19 Clinical Assessment Service (part of NHS 111); laboratory capacity (Lighthouse labs); private hospital contract; diagnostic testing; testing and contact tracing; the failed early prototype contact tracing app; and even the food voucher system for school children
- Expenditure on private consultancies, for example, on 'test and trace' services and the development of 'vision, purpose and narrative' for the National Institute for Health Protection, newly created mid-pandemic – now renamed the UK Health Security Agency (UKHSA)

7.0.5 The one notable success – in vaccine development and procurement – was a partnership between the publicly funded university research teams and Pharma – notably the Oxford University collaboration with AstraZeneca plc – and delivered with dramatic success by the NHS.

7.0.6 Our Inquiry heard testimony that there were well-established service provision and supply routes readily available – from publicly provided services (GPs, local government, NHS and university labs), established public procurement routes (ventilator manufacturers supplying the NHS) and offers from businesses to divert their work into PPE production. These were bypassed and ignored, with serious consequences.

7.0.7 The impact of pre-pandemic outsourcing of procurement contracts distributed by NHS Supply Chain failed spectacularly. The massive expenditure on outsourcing and privatisation to create 'NHS Test and Trace' has been a notorious failure. The poor quality of private contracts during the pandemic inevitably may have contributed to a wholly inadequate response to coronavirus, placing staff in the NHS and care sectors and the general public in avoidable danger.

7.0.8 The National Audit Office (NAO) reported that public contract funding has been differentially awarded to Conservative Party donors and close contacts.^{7.2} Profits for shareholders have benefited spectacularly, particularly on the outsourcing of NHS Test and Trace.^{7.3} There have been successful legal challenges on behalf of the taxpayer in relation to Covid contracts – one important example being the successful challenge on the Palantir contract (see para 7.12).

The inquiry heard from staff, patients and family members who have been directly affected by decisions to outsource clinical and support services contracts.

7.1 PRIVATISATION AND OUTSOURCING

Pre-pandemic policy on the NHS and social care continued into the pandemic

7.1.1 In the years prior to the pandemic, the opening up of NHS services to contracts with the private sector had been the dominant government strategy. The Inquiry heard in Session 1 about the negative impact on health and social care of government policies broadly hostile to public expenditure funding publicly provided services, particularly since 2010. The combined impact of underfunding, marketisation and competitive contracting had left public services ill-prepared for the pandemic and for their role in protecting those at greatest risk. Now the policy escalated dramatically during Covid, with the usual tendering process and competition guidelines set aside under emergency coronavirus legislation. The major plank in Government pandemic policy has been, and remains, to build a parallel outsourced service, bypassing public resources.

Impact of a marketised health system on costs and efficiency

7.1.2 Counter to the assertion that competition would drive up efficiency and cost-effectiveness, the Inquiry heard in Session 1 that the opposite was the case:

'Before the market system ... about 6-7% of NHS spending was effectively on administration and management overheads. ... [In a] fully marketised system, the level of that spending is upwards of 20%. ... We're somewhere in the middle – not a fully marketised, fully privatised system. But ... we've

introduced a lot of the overheads and the complications that run along with them, but without bringing the funding in.' (Lister)

7.1.3 Social care and mental health have been particularly affected by privatisation. Lister explained that, with the Thatcher reforms, social care was effectively privatised from 1993. Private nursing homes largely took over responsibility for residential care. With the current state of care in the community, unless you have the most extreme level of need, you will not receive support from local authorities. Effectively, people who have medium or low levels of need and who could previously have been supported to live in their homes through funded resources, are now getting nothing until they actually reach crisis point. Over a million are not getting social care or support. 1.6 million are without the mental health support they need.^{7.4}

7.1.4 Models of mental health care have radically changed and to a large extent continue to move away from hospital-based care. Numbers of hospital beds have been slashed^{7.5} and today much of the NHS hospital mental health inpatient capacity has been replaced by private beds, at greater cost:

'Those NHS hospital beds were effectively ... replaced by increased dependence on private hospital beds, quite often a long distance away from where people actually needed the treatment. This is not part of an improvement in services. This was part of an actual decline and mental health remained under massive pressure long before the Covid epidemic has now piled massive increased pressure on all fronts in terms of mental health.' (Lister)

7.1.5 Professor of Global Health Medicine David McCoy, speaking on behalf of the Centre for Health and the Public Interest (CHPI) in Session 7, had studied worldwide evidence on how private care can destabilise health systems:

'If you get the public and the private interface wrong, you end up with a system like you have in the USA, where you have a health system that is both extremely expensive, not cost effective at a population level, and extremely inequitable. And the direction of travel that we have in the NHS is very much towards that kind of public/private model that we have in the United States.'

7.1.6 In his opinion it is possible for advocates of private involvement in health services to 'cherry-pick certain indicators and give the impression that there are improvements', but looking at health at a population-wide level, at equity and efficiency, covering all elements of health care, 'then yes, without question in my mind we are going down the route of a flawed health policy'.

7.1.7 McCoy said that there were many MPs and members of the Lords who held stakes in the private hospital sector, and that conflicts of interest should concern everybody. He considered current legislative proposals to be a cause for concern: they include the establishment of Integrated Care Systems, where the private sector may be invited into the decision-making process of how public funds will be used and distributed within the health system, together with a lack of adequate regulation. (Since the end of the inquiry, Owen Paterson MP has resigned after lobbying for Radox and other companies, in a paid role. Radox is one of the beneficiaries of the Test and Trace programme [see para 7.1.9]).

Policy choices and consequences

7.1.8 The Government has stated that contracting with private companies has been an essential component of its pandemic response. The Inquiry heard several examples of what became of these initiatives and what is known about the companies who got the contracts. This was not 'value for money'. Under the cover of the emergency, the Government has awarded [£18bn in coronavirus-related contracts](#) during the first six months of the pandemic, most with no competitive tendering processes.

7.1.9 The £22bn NHS Test and Trace budget had been expanded to £37bn by the second year and is larger than funding for the police and fire services combined, with multimillion pound contracts handed to private companies big and small. The failed NHS contact tracing app cost the taxpayer £11.8m. Radox Healthcare was paid £133m for test kits that were later withdrawn as faulty. They remain a major player in SARS-CoV-2 test processing. Key aspects of their practice have been severely criticised.^{7.6 7.7}

7.1.10 During the course of the Inquiry, beneficiaries of contracts worth £1.5 billion were identified by the NAO to be contacts of ministers and conservative MPs. (They included personal friends, neighbours, party supporters or donors.) The NAO was highly critical of this.^{7.8} (See also 'Governance failures' para 7.11.3) The Public Accounts Committee reported that they could find no evidence that the NHS Test and Trace investment had made any impact on the spread of the virus.^{7.9}

Use of consultancies

7.1.11 Part and parcel of the reliance on the private sector is the expense and profit-taking margins involved. Famously the outsourced NHS Test and Trace service was paying Deloitte £900,000 per day for its 1000 consultants at an average close to £1000, and for some as much as £6-7000, per day.^{7.10} Mid-pandemic, the Government chose to reorganise its public health administration, employing management consultants McKinsey at a cost of £563,000 for advising on the 'vision, purpose and narrative' of the National Institute for Health Protection (now renamed the UK Health Security Agency^{7.11}).

7.2 HOSPITAL CAPACITY AND CONTRACTING WITH PRIVATE HOSPITAL SECTOR

7.2.1 The impact of past policy of stripping back public sector capacity (in public health, NHS hospital capacity, primary, mental health and community services) led to a rushed and ill-thought-out decision to purchase private hospital capacity en bloc that in the end was grossly underused. Over the 10 years prior to the pandemic, the NHS acute hospital sector had been cut back to a dangerous level of reduced capacity. The UK has one third of the number of beds per head of population compared to Germany (Wrigley), the impact of historic policy:

'The NHS has over the past few decades seen a reduction in its bed capacity, to the point where England has one of the lowest beds-to-patient population ratios in Europe. And this has been partly a deliberate strategy to reduce that reliance on NHS hospital beds. I would say it's part of a strategy to create room

and opportunities for the private sector to develop in the hospital sector. So, we entered the pandemic with a lack of hospital capacity.' (David McCoy)

7.2.2 With the alarming situation unfolding in Italy in February and March 2020, the Government faced the shortfall in capacity in hospital beds and ITU ventilators and staff with some panic. However, rather than seeking ways urgently to build NHS capacity, it turned to the private hospital sector with a huge block contract in March 2020, renewed for four years in a £10 billion deal from April 2021. This left the NHS without the investment to build its capacity and long-term resilience it so badly needed.

7.2.3 The Inquiry heard that government policy choices during the pandemic were based on attitudes to public services that appeared to be ideological. After years of government denial that privatisation was core policy, the Secretary of State for Health and Social Care was confident to change this defensive stance and to publicly announce to Parliament mid-pandemic the policy of bringing in the private sector to 'partner' the NHS:

'The independent sector has played a critical role in helping us get through the crisis and will play a critical role in future ... That has put to bed any lingering, outdated arguments about a split between public and private in healthcare. We could not have got through the crisis without the combined teamwork of the public and private sectors.' (Matt Hancock, Commons 2 June 2020^{7.12})

7.2.4 McCoy gave evidence from the CHPI's research examining the contract between Government and the private hospital sector during the pandemic and the financial issues connected with it (published October 2021^{7.13}). The

March 2020 contract was set up by the Government with 26 companies in the private hospital sector to block book their entire capacity of 8000 beds. This was done ostensibly to help the NHS manage the COVID-19 epidemic, but in return, the NHS would cover all the operating costs of the private hospital companies. McCoy said that there could have been an argument to bring in capacity urgently, but the question was whether this was a good deal. The CHPI data suggests that it was not.

7.2.5 Private hospitals had been facing 'real jeopardy' with the COVID-19 pandemic, said Dr McCoy, and were seeing a decline in demand from privately funded patients: 'This deal really helped to keep those private hospitals afloat.'

7.2.6 In the initial period of the contract, March-August 2020, the private sector's 8000 beds would be made available to the NHS and a stated number of doctors, nurses and other clinical workers. It is not known exactly how much was paid, nor about the large amount of capacity that wasn't used to deal with the pandemic. The private sector capacity was underused, but the Government was paying for the entire capacity, at the full running cost of those private hospitals – all the operating costs, including rent, interest payments and staffing to the private hospital groups.

7.2.7 Capacity was probably used for diagnostics and non-elective procedures, not patients with COVID-19. The CHPI has data for 187 private hospitals out of 193 with overnight beds. They have estimated that on average there was one COVID-19 patient per day in the private hospital sector, and probably at peak there may have been at most something like 67 patients.

7.2.8 On 39% of the days from March 2020 to March 2021 no bed was occupied by a COVID-19 patient, and on 20% more days, only one bed was occupied by a COVID-19 patient. In total, the 187 private hospitals accounted for 0.08% of the national total of 3.6m COVID-19 bed-days. And for non-Covid work, by their estimate, less NHS-funded health care was provided in the private hospital sector than in 2019.

7.2.9 Estimates of the cost of those contracts – details are not in the public domain – are between £200m and £500m per month.^{7.14} Government estimates are that the contract cost £2 billion between March 2020 and March 2021. The CHPI thinks it is closer to double that amount.

7.2.10 From April 2020 onwards, private hospitals were allowed to continue to provide care to privately funded patients and the income from that privately funded healthcare was paid back to the government. Essentially this meant

'During this period of time, the private hospital sector was able to continue with providing private health care to privately financed patients at a time when the NHS was obviously being challenged by the COVID-19 pandemic itself.' (McCoy)

National Increasing Capacity Framework

7.2.11 As the initial contract neared the end, the Government created a four-year £10 billion funding programme – the National Increasing Capacity Framework – which aims to allocate approximately £2.5 billion a year to the private hospital sector, covering 90 approved suppliers (including smaller providers – optometrists, cosmetic surgeons and sole-specialist clinics) and costing about double the amount of NHS funded care provided in the private sector

in 2018, and 2019 – a big investment not in the NHS but in the private sector to deal with the growing waiting lists.

7.2.12 Not only did the private sector have all its running costs underwritten during the first pandemic year, but forward-looking, there is a guaranteed continuous stream of public funding going into the private hospital sector to meet unmet NHS demand for semi-urgent and elective care that has built up during the pandemic.

7.2.13 There is rising demand for private sector healthcare as those with the means to pay privately will do so to avoid growing NHS waiting lists, 5.7 million in October.^{7.15} In the main, it will be NHS staff working sessions in the private sector operating on NHS patients.

7.2.14 Prior to the pandemic, something like 18% of NHS funding was being directed towards the private sector^{7.16} (excluding GPs as independent contractors). Inevitably this will rise and the failure to invest in NHS capacity will have structural effects on the health system as a whole. It heightens problems around the creation of a two-tier system and for some segments of society, a decreasing commitment to the NHS as a public service based on the principle of universal access at its centre.

7.2.15 When asked whether the same people in Government were going to repeat the same mistakes, David McCoy questioned whether these Government decisions were mistakes or whether they were really part of commitment to a privatisation of the health system. And he warned:

'This will essentially erode some of the fundamental principles of the NHS, which is a publicly funded and publicly provided service across the board ... which will

result in inefficiencies in the delivery of health care at a population level.'

7.2.16 The CHPI's report recommends that the Department of Health and Social Care answer the following questions:

- Exactly how much was spent by the NHS on purchasing services from private hospitals during the first year of the pandemic, and what did the NHS receive in return?
- Why were the private hospitals allowed to continue performing non-urgent elective care when the NHS was under the greatest strain, and why was the amount of purchased capacity reduced before the widely predicted second wave of the pandemic?
- To what extent did the contract protect the interests of the private hospital companies rather than those of the NHS?

7.2.17 McCoy explained how the private sector has virtually no clinical staff and relies on NHS staff working private sessions. In order to maximise profit margins, the sector usually refuses to offer clinical training whilst reducing training opportunities for NHS staff to be involved in the elective NHS work transferred over to the private hospitals.

7.2.18 Dr Wrigley reinforced how there were negative consequences of the increasing use of private hospitals. Commenting on the Government contract with the private hospital sector, extended by four-years and £10 billion, this could have a devastating effect on training of doctors, nurses and health staff. All junior doctors receive their training from their peers and their seniors, all within the bounds of providing day-to-day care. Private hospitals have no willingness to take on

training because it might slow procedures down, not as many patients would be going through the theatres or outpatient clinics. The less complex patients, who could be useful for training for surgeons and others, are going through the private hospitals, and trainees would lose that vital time and experience that they need to learn how to do procedures.

7.3 PRIVATISATION OF PROCUREMENT PRE-PANDEMIC

7.3.1 The history behind the evident failings of the procurement supply chain from the start of the pandemic is outlined in the report co-authored by Inquiry witness John Lister and campaign group, We Own It.^{7.17} Procurement and supply were privatised well in advance of the pandemic.

7.3.2 Important background to the Inquiry evidence is the history of the NHS Logistics Authority, set up in 2000 as an NHS Special Health Authority. Providing 'considerable value to the NHS', it was 'market tested' for outsourcing to the private sector and was dissolved in March 2006. Its functions were transferred to NHS Business Services Authority in preparation for being contracted out (NHS Logistics Authority Annual Report 2005-06). NHS Logistics Authority was replaced by NHS Supply Chain in 2018 after years of pursuing a policy of outsourcing.^{7.18} The overall strategy was the 'just-in-time' approach dominant in commerce and industry, aimed at minimising costs. NHS Supply Chain is technically a part of the NHS, headed by the Secretary of State. But this is an umbrella for a complex web of contracts with private companies. Immediately upon its formation NHS Supply Chain outsourced two major contracts for IT and logistics, and then broke up and outsourced the whole

procurement system, by delegating eleven supply areas to various contractors. DHL was put in charge of finding wholesalers to supply ward-based consumables, including PPE kits. Unipart was given control over supply chain logistics, including the delivery of PPE. The rationale for this drive towards greater outsourcing and greater fragmentation was 'efficiency savings'.

7.3.3 'Just-in-time' procurement has been shown to be fundamentally unsuitable for public health planning. Pandemic exercise planning highlighted the high risk of running out of PPE and other essential equipment early in a pandemic (see report section 1.4 and paras 7.7.2 and 7.7.5).

7.3.4 Under the NHS pandemic influenza preparedness programme (PIPP), pharma distribution firm Movianto was responsible for maintaining a stockpile of PPE. However, within days of the pandemic spreading in the UK, it became evident that there were serious supply problems of vital PPE. Adequate life-saving supplies simply were not available for frontline NHS staff, let alone for other frontline work in care homes, community services, for school and transport staff. In financial trouble, Movianto, the European arm of US Owens & Minor, was sold in June 2020 to a French healthcare logistics firm EHDH.^{7.19}

7.4 OUTSOURCING OF THE NHS 111 COVID-19 CLINICAL ASSESSMENT SERVICE

7.4.1 The NHS 111 advice service was rapidly expanded by creating the COVID-19 Clinical Assessment Service (CCAS). The Government outsourced the recruitment of staff and running of the service to the private sector.^{7.20 7.21} In Sessions 1 and 2, a GP and two members of Bereaved Families for Justice have

spoken of the impact of making the outsourced COVID-19 triage, part of NHS 111 (see report sections 1.1 & 2.7). The majority of staff were non-clinical and poorly trained call handlers, the first point of contact for coronavirus enquiries, testing and contact tracing.

7.4.2 The Inquiry heard the impact of cursory training and life-critical decision-making algorithms in non-clinical or inexperienced hands:

'Really early on, one of the key patterns that was emerging was of people who clearly needed hospital treatment but were told to stay at home by the 111 service ... despite having really severe other symptoms that [you imagine] at any other time would have resulted in them going to hospital.' (Goodman)

7.4.3 Lobby Akinola gave poignant testimony about his father:

'My dad got ill at home, and ... over the course of the next two just over two weeks, he was at home kind of deteriorating. And during that period, he was calling the 111 help service and also spoke to his GP [on the phone] and to just get advice on what he should be doing and whether or not he needed to go to hospital. And he was advised to stay at home and ... when they thought he might have a lung infection ... they sent him some antibiotics but unfortunately, he then died shortly after receiving the antibiotics and passed away at home. My dad ... was at home throughout the entire period of time.'

7.4.4 One important question for a future public inquiry is whether outsourcing this critical triage service to private companies using largely untrained, non-clinical staff, and triage failing to apply NHS and professional clinical and safety standards,

contributed to the avoidable deaths of people like Akinola's father.

7.5 PRIVATISING PUBLIC HEALTH TESTING AND CONTACT TRACING

7.5.1 Previous Inquiry sessions heard of the horror of public health specialists and clinicians at the failure of the Government to mount any effective system for case finding, testing and tracing of contacts, and isolation with support (FTTIS).

7.5.2 Dr Wrigley told the Inquiry that the Public Health system had been 'eviscerated' following disinvestment and restructuring over the last 10 years. The 2012 Health and Social Care Act had promised that Public Health would have a ring-fenced budget, embedded in local government, but the budgets had 'just disappeared'. Though the enfeebled state of public health was of government making, it provided the cover and rationale to turn to the private sector for Test and Trace at the start of the pandemic.^{7.22}

7.5.3 The regular reports of tragic and calamitous failure of the process loomed as a spectre behind the grandiose daily claims of Secretary of State for Health Matt Hancock, and the Government, who tried to avoid criticisms of current failure by setting ever higher targets for future test capacity, future targets for numbers of people who would be traced and told to isolate.

7.5.6 The pandemic demanded an urgent development of testing, test equipment, processing and communication of results and essential part of the FTTIS public health approach. The inquiry heard that public services with clinical knowledge, and companies with expertise already working with the NHS and with significant capacity were available to step up

on testing and tracing. The UK's local public health, primary care, university and hospital services were waiting. Government support and investment could have been invested to transform them into the national integrated network that the pandemic demanded. Instead, the Government bypassed 44 existing NHS labs and employed private sector firms such as Deloitte, Serco and Sitel to set up the privately-run 'NHS Test and Trace' with poorly coordinated, often remote, parallel testing sites without, for far too long, automatic reporting of results to GPs or local public health. And to process the SARS-CoV-2 tests, they set up the Lighthouse laboratories through private sector and private-public partnership contracts (see report section 7.6).

7.5.7 The BMA has long-opposed deepening privatisation and outsourcing in the NHS. Now it had significant concerns about the substandard performance of the Test and Trace system. Contracts for £37 billion have been awarded to private companies to run the misleadingly named 'NHS Test and Trace' service over the two years, described by the Public Accounts Committee as 'unimaginable costs' with no evidence of good outcome.^{7.23 7.24}

'There is no clear evidence to judge NHS Test and Trace's overall effectiveness. It is unclear whether its specific contribution to reducing infection levels ... has justified its cost.'

The scale of the expenditure was justified by the Government as the way to avoid a second lockdown. The plan failed to avoid two further lockdowns and 100,000 further deaths.

7.5.8 Wrigley added to what Salisbury had said in session 2 (see report section 2.6): GPs had major concerns for patients trying to access Test and Trace: sometimes

they had to travel hundreds of miles to get a test, including driving on motorways when they were unwell – and test results were often delayed. And for many months there was no process to communicate test results to patients' GPs.

7.5.9 The privately contracted app development to aid contact tracing by alerting people when they had been in proximity to a person infected with coronavirus was also an expensive failure. Public confidence was lost when there were serious questions of data-confidentiality and effectiveness. The failure of the pilot on the Isle of Wight led to the app's demise. Meanwhile other countries developed more effective apps, with greater data protection accompanied by greater public confidence. The cost of the failed project was over £10m. A radically revised NHS app was finally launched in September 2020 at the aggregate cost of over £35m.^{7.26}

7.5.10 Dr Wrigley told the Inquiry that the companies involved in the 'NHS Test and Trace' service such as Serco and Sitel had no experience about how to run services. In one instance Serco had subcontracted to a company called Hays Travel where staff had had one day's training or less. This had caused huge concern for doctors. One Hays Travel staff member who worked on a COVID-19 phone line stated: 'We're not medically trained. I believe members of the public believed they were ringing medically trained people.'^{7.27}

7.5.11 Wrigley pointed to the sharp contrast where NHS GPs and their teams have been fantastic in delivering the coronavirus vaccine campaigns. The Government had to be given their due for ordering enough vaccines in good time, but

'We do [a national vaccine rollout] every year with flu campaigns. We know our

population, we know our patients, our patients trust us. So, we were absolutely in the best place to do that. It really does frustrate me when the Government or the Cabinet try and take credit for the vaccine campaign, when actually it's the NHS. It's all the staff in surgeries, hospitals and centres that have delivered vaccines, plus all the volunteers. And we must celebrate the achievements of the NHS in that.'

7.5.12 Wrigley told the inquiry that the BMA had published documents asking for a larger proportion of the national budget for Track and Trace to be allocated to local Public Health teams to allow integration between testing being delivered at scale and contact tracing led by Public Health doctors on the ground who know their area and know their patients, but these pleas had been ignored.

7.5.13 Postscript: The Public Accounts Committee of the House of Commons followed up their critical report of February 2021^{7.23} with a further report, finding that there had been some improvements, for example in the cooperation between the UK Health Security Agency and local authorities' public health teams, but that NHS Test and Trace Service is

'... one of the most expensive health programmes delivered in the pandemic, allocated with an eye watering £37bn over two years, although it underspent by £8.7 billion in its first year ... but its outcomes have been muddled ... professed aims ... overstated or not achieved. For the vast sums of money set aside for the programme, equal to nearly 20% of the 2020–21 NHS England budget, we need to see a proper long-term strategy and legacy as it moves into the new UK Health Security Agency.'^{7.25}

We return to this in our findings and recommendations (see report section 7.13)

7.6 PRIVATE PATHOLOGY LABORATORIES

7.6.1 As stated earlier (see report section 7.5), 'NHS Test and Trace' run privately by Serco, Sitel and others, placed testing and contact tracing outside of the NHS. Alongside this, the Government decided early in 2020 to bypass NHS, public health and university laboratory capacity. They set up the parallel network of private or private-public partnership mega-labs named 'Lighthouse laboratories'. Five Lighthouse laboratories were established in Milton Keynes, Alderley Park, Glasgow, Cambridge and Newport alongside a contract with Randox for Northern Ireland. Additional sites are planned for Charnwood, Newcastle, Brant's Bridge and Plymouth. Leamington and a site in Scotland were announced in November 2020. The Inquiry heard evidence critical of these decisions and their outcomes.

7.6.2 The critically needed nationally integrated process referred to above – to coordinate the finding and testing of patients, communicating results quickly to GPs and local public health teams and to enable the tracing of contacts – was never established. Private contracting of parts of the process dislocated what should have been a seamless chain. The inquiry heard from Dr Salisbury (see report section 2.6) that test results not reported to GPs routinely for several months – this basic requirement had not been in the contract:

'The Government has set up a growing network of Lighthouse Labs in partnership with a variety of suppliers including NHS Trusts, commercial suppliers, and not-for-profit

organisations, in order to process test samples from an entirely new network of testing sites.'^{7.28}

7.6.3 The laboratories will have investment for technology for automation, robotics and PCR testing and genomic sequencing for SARS-CoV-2, aiming to process up to 150,000 tests each day. There is every reason why such investment should be led by the NHS and public health as part of a national public health laboratory service, one that should be integrated with GP and other NHS services. The decision for these labs to be led in the main by private interests is further proof of ideologically driven policy.

7.6.4 A company linked to Lord Ashcroft, a major donor to and former chair of the Conservative Party, won a contract for £350m to provide laboratory staff for the COVID-19 testing operation.^{7.29}

The Leamington Lighthouse

7.6.5 Matt Western (session 9) is Labour MP for Warwick and Leamington and Labour's Shadow Universities Minister. The Leamington Lighthouse Covid Mega Lab, first announced in November 2020, is sited in his constituency and was still not up and running when Western gave evidence in June 2021.

7.6.6 Western had been campaigning for months for greater transparency from Government and tried to hold Ministers to account over this project. He had no prior engagement with the DHSC or his local authority regarding the project, despite being the local MP. He was sent a letter by Health Minister Lord Bethell on 17 November 2020 with 'advance notice' of the announcement made on 16 November 2020. The other lab was going to be based in Scotland. Work on the Scottish

lab had stopped while the UK government assessed 'the long-term demand' for it.

7.6.7 The Government initially said the project could create up to 2,000 jobs. More recently, they've said around 1,800. They initially said it would be opened in early 2021. This later changed to Spring 2021. By June there was still no opening date that the Government will provide to him. His constituents who had been recruited to work at the lab still had no start date. Individuals had left other jobs, after being told the lab would open in early January 2021. Now without income, they contacted him for advice. He challenged the Health Secretary in the House of Commons to 'tell us what is going on, and can he confirm when the place will open'. He refused to provide an answer. Western wrote to Lord Bethell several times, but no one could give him a start date or explain the delay. There had been no response to his most recent letter in March.

7.6.8 Western referenced the report by Pat McGee entitled 'Mega-laboratory in Leamington Spa: a Trojan Horse for a Private System'. McGee is a former State Registered Biomedical Scientist, previously employed by Coventry and Warwickshire Pathology Services. The report says that the Government awarded the mega-lab contract to the private company Medacs without it being advertised or put out to tender – in much the same way as has happened with numerous PPE contracts. At least three other private companies have been involved in recruitment of staff – Blue Arrow, Lorien and SRG Talent. Western tried and failed to get more details of the involvement of private companies from the Government, whose public claim is that the laboratory is publicly owned and will be operated by DHSC as part of the NHS Test and Trace laboratory network:

'There is a clear lack of transparency, [there is] waste and cronyism surrounding the Government's contracting process throughout this pandemic, which equally applies to this project.' (Western)

The key question is why the Government chose to set up a brand-new laboratory, rather than expand on existing NHS pathology services at University Hospitals Coventry and Warwickshire NHS Trust.

7.6.9 Earlier in 2021 there was an outbreak of COVID-19 amongst the staff currently contracted to work at the site to get it up and running. At least 25 employees tested positive. It is an embarrassment that the Government cannot even protect staff working on the site of a lab set up for large scale COVID-19 diagnostic testing. There are concerns regarding lack of regulation, accreditation and quality standards of the facility and its employees:

'[These] apply within NHS based laboratories. I have heard from scientists who fear the lack of regulation, poorly qualified staff and mismanagement at the facility could be reminiscent of the issues with the Milton Keynes laboratory.' (Western)

7.6.10 Western was concerned about the lack of transparency and has been unable to find out details including how much this was all costing the taxpayer:

'The Government had admitted to him that some staff and suppliers are subjected to non-disclosure agreements, confidentiality clauses or specific terms of employment in place, which only adds to the secrecy surrounding this project ... There have been too many failures and too much taxpayers' money squandered by this Government for us to allow

Ministers to avoid accountability in the way they are at the moment.'

7.6.11 Western summarised three main concerns regarding this project:

- A total lack of transparency
- Privatisation of NHS services, and
- Delay of the project

The concerns remain unanswered. The lab was declared open in July 2021 as the Rosalind Franklin Laboratory.^{7.30}

7.6.12 Postscript: On 15 October 2021 a scandal broke over the failure of the unaccredited Immensa Health Clinic to identify and explain why at least 43,000 cases of coronavirus infection may have received negative PCR results from that private laboratory service during September and October. Just 0.2% of tests for one area whose tests were sent to Immensa in Wolverhampton were positive against an expected rate of 8%. The UK Health Security Agency temporarily suspended the lab's operations. Immensa was founded in May 2020 and given a government contract worth £119m 3 months later for SARS-CoV-2 testing. It received a further contract worth £50m in July 2021. Its sister company in the UK, Dante Labs has been under investigation over its coronavirus-testing for travel tests.^{7.31 7.32}

7.7 FAILURES OF PPE SUPPLIES WERE DETERMINED PRE-PANDEMIC

7.7.1 Testimony in Sessions 1 and 7 explained pre-pandemic government policy of outsourcing NHS services and functions and how the Government continued this policy in responding to coronavirus. Time and again, the serious limitations of outsourcing had been

exposed. Critical NHS supply functions had been outsourced in the years prior to the pandemic by NHS Supply Chain, who had subcontracted out PPE procurement and stockpiling.

7.7.2 With pandemic infection at the top of the country's risk register, pandemic planning exercises had been carried out. One such operation was Exercise Cygnus in 2016. In Session 1 (see report section 1.4), Gabriel Scally explained Exercise Cygnus:

'It was a training exercise aimed at influenza. The scenario was an episode of pandemic influenza. It involved ... 950 people and resulted in a report which had a significant number of important recommendations in it.'

7.7.3 As became clear in *the Sunday Times* team's book, *Failures of State*,^{7.33} several key lessons and recommendations emerged. Urgent and drastic improvements were needed. Ring-fenced funding should be provided. There was a warning that 200,000 in the UK may die from pandemic influenza. Ventilator capacity was insufficient. Numbers of excess bodies would have to be managed. Quantity and specificity of PPE needed overhaul. Care homes would not cope with large numbers of elderly people discharged to them from hospitals to free up beds. There would be a serious economic impact. The warnings from pandemic training exercises were however mothballed and not made public.

7.7.4 Speculating as to why the Government ignored the recommendations, Scally said:

'I think it was because public health in general, the health of the people, became a lesser interest of the Government than it had previously been.'

7.7.5 This had serious consequences leading to the lack of ability to respond to the pandemic: contracts such as those given out by NHS Supply Chain had been exposed as failures. From the start, there was never an adequate supply of PPE. The Government argued that Cygnus was modelling influenza and the country was justifiably not prepared for the consequences of a novel coronavirus pandemic – PPE specifications and supplies, and the needs of hospitals and care homes. However, since the end of the Inquiry sessions, it has come to light that there was another pandemic dry run, also in 2016.

7.7.6 Exercise Alice has come to the Panel's attention more recently through the FOI requests of Dr Moosa Qureshi.^{7.34 7.35} Senior health officials modelling the impact of a coronavirus hitting the UK – just four years before the COVID-19 pandemic – concluded that there was a serious need for stockpiles of PPE, a computerised contact tracing system and screening for foreign travellers – predictions of the key areas of failure in the first year of the pandemic from February 2020.

7.8 FAILED SUPPLIES OF PPE COST LIVES

7.8.1 At the start of the pandemic, in February 2020 there were clinicians watching what was happening in China and in horror that nothing seemed to be happening in response in the UK. Lancet articles from Wuhan health professionals, the WHO's escalating advice and warnings and the situation in northern Italy were picked up on social and mainstream media.^{7.36 7.37} One thing was clear to staff: their lives were on the line and PPE was going to be the difference between life and death. National supply and distribution of

PPE and essential equipment in the right place at the right time were going to be key.

7.8.2 Nevertheless, the Army was having to bail out a failed distribution chain. Stockpiles of PPE delivered were found to be inadequate or out of date, leading to a desperate rush to find suppliers; distribution problems related to previous privatisation of NHS Logistics also caused difficulties in keeping up with demand. Established procurement routes used by the NHS were ignored. Government messaging was complacent:

'The country has a perfectly adequate supply of personal protective equipment) at the moment ... [supply pressures are] completely resolved.' (Dr Jenny Harries, Deputy Chief Medical Officer, 20 March 2020 at daily Downing St. press briefing^{7.38})

7.8.3 There is a very stark contrast between the assessment of the provision of vital PPE equipment by the Government and their advisers on the one hand and frontline staff on the other. With government guidance on PPE changing 40 times (Agius) there was a strong suspicion that policy on PPE was adjusted to meet failing levels of supplies rather than health and safety principles on managing risk of airborne transmission of a fatal virus (see report section 5.4).

7.8.4 The inquiry heard a very different reality from Michelle Dawson, consultant anaesthetist (Session 7). Dawson told the Inquiry of how, at the start of the pandemic, she had watched hospitals being built in Wuhan in a matter of days:

'This is going to spread around the world. This is going to impact every country.'

7.8.5 As the virus spread and patients were flowing into hospitals, the availability of PPE was in serious trouble:

'This was in the middle of March, when we had nothing ... At that time, we were working on Covid ICU with no PPE whatsoever, unless we went within six feet of a patient, because we had to conserve the stocks.' (Dawson)

Dawson felt dazed that nothing seemed to be happening (in the UK). A large group of medics around the world, were sharing information on Twitter about COVID-19 as it crossed continents. But in the UK she had seen 'absolute inaction'. The PPE supply situation was serious. A colleague in another hospital had told Dawson at the end of February/beginning of March that they had run out of PPE, apart from for ITU.

Opportunities rejected

7.8.6 Staff were going into ITU without PPE believing it was safe because patients were intubated and that coronavirus was within the tubing, spread by droplets. But in fact it was spread much more dangerously by aerosol. As the Inquiry heard from palliative care consultant Rachel Clarke (see report section 4.19), Dawson realised it was not only the NHS not being supplied with the PPE, but also hospices and care homes, which pre-pandemic had been getting PPE via the NHS Supply Chain. Because these organisations were not classed as hospitals, they were expected to go into a global fight for PPE on their own.

7.8.7 Dawson realised that the pandemic stock of PPE was greatly rundown. She knew it was not just the UK: 'the whole world needs the same stuff at the same time'; that there were a limited number of

manufacturers and virtually none in the UK. Dawson worked in procurement in the NHS in addition to her anaesthetist role, she knew about the processes and legalities.

7.8.8 She had started looking to see if she could open up supply chains through her contacts. She had managed to open up a supply chain directly via the Chinese Government for 50 million high quality close-fitting FFP3 masks, the type necessary for working with COVID-19 patients. Dawson and colleagues had contacted the Cabinet Office about the China supply by phone and email and followed it up a week later, but nothing had happened. So those masks had been sold to Germany. A further offer of 30 million masks a month was not acted on either. The PPE on offer had fulfilled all the quality criteria, had the correct product codes, but they were not followed up by the Government.

7.8.9 The fight to get PPE was very aggressive because everybody needed it:

'America was buying futures on PPE ... They weren't buying what was in the warehouses. They were buying what would be made [in the future]. And then there are the people who were willing to sell stuff that was fake. There were people willing to just profiteer really, and the prices rose and rose.' (Dawson)

7.8.10 However, the Government was not listening. Highly experienced and knowledgeable NHS staff who knew what they were talking about (including the BMA itself, see below) were ignored. Dawson said there was no consultation to her knowledge with anaesthetists and intensive care clinicians or Royal Colleges on Government procurement decisions. Instead, the Government continued to rely on outsourced contracts with unproven companies, including start-ups with no

track record whatever in PPE or working with the NHS. They handed out hundreds of contracts for supply of PPE worth tens or hundreds of £millions, awarded to companies with no previous experience, including a pest control business and a confectioners.^{7.39} Undoubtedly there was profiteering. The procurement process, via a secretive, ineffective and uncoordinated private route, has been criticised by the National Audit Office for questionable practice.

Forced into self-help

7.8.11 In March 2020, a group including doctors, businesspeople and others had got together to set up a charity (Heroes^{7.40}) and started raising money and sourcing masks from industry. Huge amounts of PPE were donated by companies; one businessman had couriered it out with his fleet of vans to wherever it was needed. A website was set up which allowed anybody anywhere in the UK to put out a plea for help if they were running out of PPE. Later on, there were similar situations with gowns, visors and other items of PPE. The charity not only organised PPE but also food drops and gifts to cheer up staff.

7.8.12 To add insult to injury, Dawson had been told that hospitals who had sourced PPE for themselves (out of necessity) outside official channels had recently been informed that they were not going to be refunded by Government, because they shouldn't have done it, possibly costing them tens of millions of pounds.

The British Medical Association was also ignored

7.8.13 David Wrigley testified that the BMA was also hugely concerned about the lack of PPE. The Inquiry had already heard

that the Government had pre-pandemic delegated large parts of the management of the procurement process to supply chains, a complex web of external companies. Procurement was based on the Government's just-in-time business model wholly unsuited to the pandemic emergency. This left the Government less able to respond in an agile way.

7.8.14 The BMA had been contacted daily by doctors about lack of supplies, with hospitals sometimes one day or less from running out and no idea where supplies were coming from. There was also concern about the poor quality of the PPE available.

7.8.15 There was no shortage of offers of reliable help: over 70 companies contacted the BMA about being able to supply good quality PPE. They had contacted the Government but hadn't received any response. This was as hospitals were on the verge of running out of PPE. Just as happened to Dr Dawson and colleagues, the offers passed to the Department of Health by the BMA received no response. NHS in-house expertise was completely bypassed.

7.8.16 The BMA had concerns over reports about procurement going outside the normal rules governing the NHS. This was not new. Previous BMA reports had highlighted contracts for goods and services being awarded to private firms with no relevant experience or expertise. Now the Government opened up high priority lanes that led to fast track offers of PPE contracts, based not on what you knew but who you knew to get these 'golden nugget' contracts.

7.8.17 It raised serious governance concerns. There had not been proper oversight of the procurement of those deals and no transparency. Governance needs to be much more robust.

Companies often hide behind commercial confidentiality as an excuse. Public notices with contract details are required to be published within 30 days and The Good Law Project has taken the Government to court to successfully challenge them on these issues. In February 2021 a High Court judge ruled that Matt Hancock had acted unlawfully in failing to publish contracts.

Comparing outcomes from outsourced contracts with the NHS-led vaccine campaign

7.8.18 Wrigley said that the concerns about private contracting in the NHS were not new. Many of the companies given NHS contracts have poor track records. For example, in 2012 Serco had admitted to presenting false data over 250 times about the performance of its out-of-hours service in Cornwall. 'At one point they had had one GP covering the whole of Cornwall, but they had tried to cover this up.'^{7.41} In 2018 Serco had been reported to have provided inadequate staff training at a breast cancer hotline, where patients were being assessed by call handlers with one hour's training.

7.8.19 In the pandemic, it was about life and death. Companies such as these were put in charge of providing vital services and equipment to protect the workers on the front line. Not having confidence in these companies made those working with patients 'really frightened about the equipment they were using'. The BMA is committed to a publicly funded and publicly provided NHS, with significant and sustained funding to strengthen the NHS and local Public Health capacity and expertise.

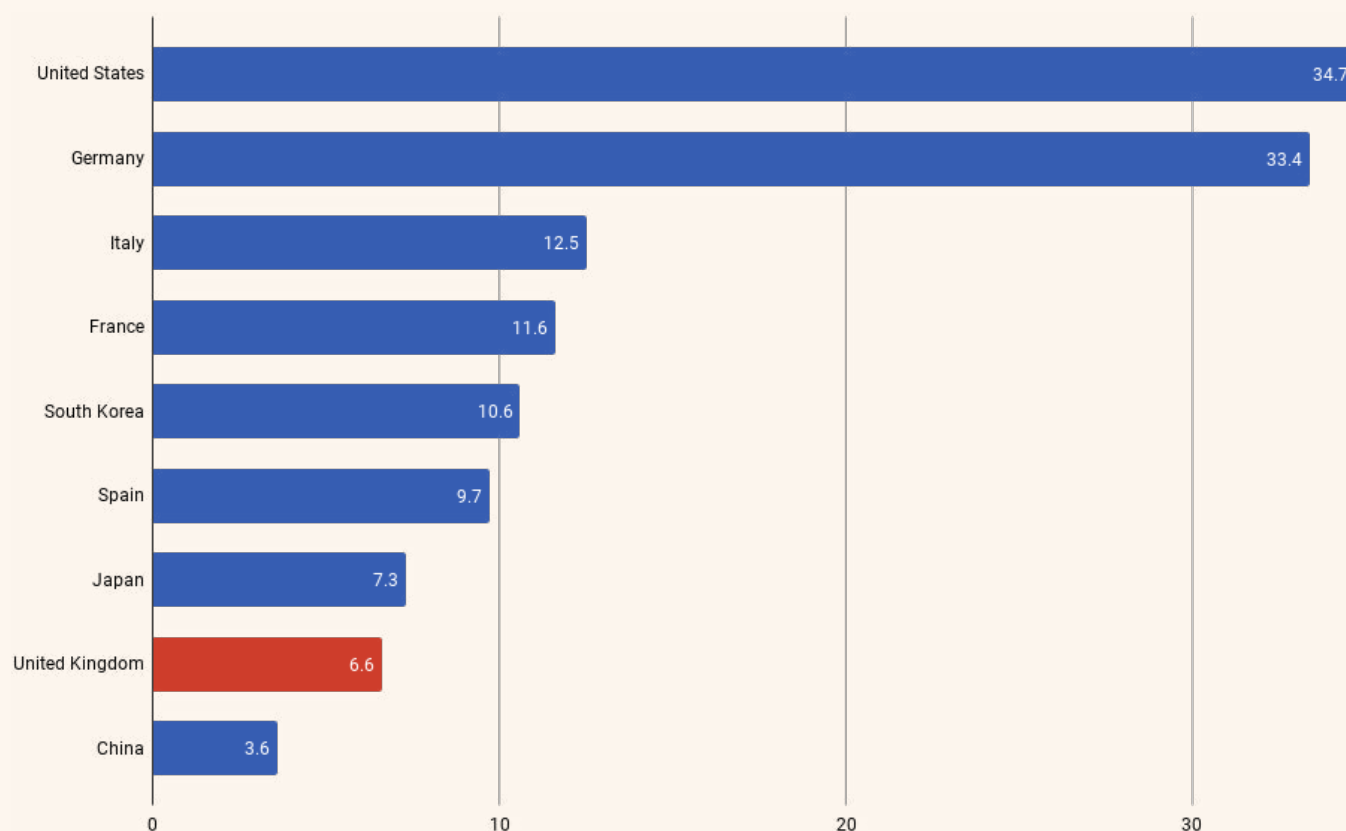
7.9 VENTILATORS

7.9.1 The pre-pandemic baseline of intensive care beds and ventilators saw the UK very low down the table in international comparison, half the number of Italy and one fifth of Germany. The failure to action the recommendations from past pandemic exercises had consequences including the very real threat of the UK running out of ventilators.

7.9.2 Dawson said that the EU had contacted the Government saying that they were going to do an EU contract for ITU ventilators and had invited the UK to join. The Government said no. When news of this broke in the press, they said that they had not received the email, which turned out to be untrue. The Government then made headline-grabbing announcements of how their deals with private sector contacts would save the NHS. Much publicity was given to communications between James Dyson and Boris Johnson – but, as the Inquiry heard, no Dyson ventilators were ever produced. And in an attempt to build up NHS capacity at the start of the pandemic, the government bought 30,000 ventilators for £569 million; less than 10% were used.^{7.42 7.43 7.44}

7.9.3 Michelle Dawson had been incredulous at this situation, including the contract that was offered by the Government to Dyson. She told the Inquiry that ventilators, like other sophisticated equipment, range from the very simple to the exceedingly complex. It was the exceedingly complex ones that ITUs needed. ITU ventilators have different computer programmes and are a 'massively complex piece of kit' which have taken years to develop. There were numerous different parts – consumables

Critical care beds per 100,000 population before pandemic



Source: WHO, American journal of respiratory and critical care medicine, Society of Critical Care. Were countries prepared for scale of outbreak? [reproduced by BBC 3 April 2020]

such as tubing and filters – which had to be compatible with the ventilator:

'To have all of the software written, the hardware correct, the compatibilities made, the consumables manufactured – it was going to take years. But we already had them. They'd already been designed. They'd already been through all of the quality assurance. There were multiple companies in the UK who already made fit-for-purpose ITU ventilators, and they approached the Government saying "we can make these, we just need funding, and then we can make these for you". And they were ignored.' (Dawson)

7.9.4 Dawson compared giving Dyson a contract to make ventilators from scratch to asking somebody who makes vacuum

cleaners to make a fighter jet or helicopter in a month. In the end Dyson did not supply the NHS with any ventilators.

7.9.5 Most telling of all, the limiting factor in any case wasn't ventilators – it was staff. Dawson felt that the failure to support the NHS and its staff facing the pandemic contributed to the damaged morale and exhaustion of staff witnessing those decisions and suffering from their impact:

'Every single day at work, there's an NHS worker in tears in the changing room. Terrible because we saw colleagues dying ... and we were terrified we would be the next one ... and you just have to keep going in there and keep working.' (Dawson)

7.10 PRIVATISATION OF DATA AND GOVERNANCE OF CONTRACTS

7.10.1 Rosa Curling, lawyer and co-founder of Foxglove Legal campaign organisation, gave evidence on data and pandemic contracts. The rewards for proper data use in the public interest are potentially lifesaving. Health data is incredibly useful and there is a wealth of extremely important and helpful information that could certainly make our NHS services stronger and safer – never more important than in a pandemic if used with integrity. The potential use for high level data in tracking the pandemic and responding quickly is self-evident.

Trust

7.10.1 The question to pose is whether we can make sure that that data remains a public asset for the public good with safe data-sharing compliant safeguards, rather than allowing unprecedented access to huge multinationals like Amazon, Google or Alphabet (Apple), with enormous corporate resources and power, and incentive to monetise and market patient data:

'The risks involved, going from minor embarrassment to a total corruption of trust in the medical profession, are really serious.' (Curling)

7.10.2 The issue of trust has recurred at every step of the pandemic and is central to data issues: centralised data is key to enhanced emergency planning. Yet, as with so many other government decisions, the combination of unprecedented centralisation of data, total lack of transparency of contracts and handing unmonitored control of use of data to major private companies indicates that the

lack of trust from the public has been well-founded.

NHS data: public safety and private exploitation

7.10.3 Curling told the Inquiry that Foxglove Legal was challenging the collation of NHS data called the COVID-19 Data Store. It was set up in March 2020, announced very quietly on an NHS blog and involved a series of different contracts and agreements with US tech giants Amazon, Microsoft, Google, plus Faculty and Palantir.

7.10.4 The Data Store would be a 'single source of truth about the pandemic' that was 'unprecedented' according to the Department. It was for the first-time collecting health and social care data from a variety of different sources, collated on a national level, and held in one single place. It was collecting health data in a way not seen before.

7.10.5 NHS data is unique – 'the largest set of machine-readable health data on the planet' – with an estimated value of about £10 billion a year if marketised by the tech corporations across the world who exist to 'aggregate and monetise data'. During the pandemic, normal rules about procurement and data protection were being set aside. Foxglove wanted to ensure that those emergency arrangements didn't become the norm without the consent of the public.

7.10.6 The Government revealed virtually no details about the data deals with the private companies nor about the types of data that were going to be stored in the Data Store. It was suggested in the press at the time that these tech companies were hoping to bed down in the NHS long-term. This raised several questions: on

public trust in that the companies would have access to 'all of our most sensitive, confidential medical information'; on what security was in place to protect it; on who would have access to it and on what terms; and whether the Covid Data Store would come to an end when the pandemic resolved.

Transfer of GP patient data to NHS Digital

7.10.7 Operating under the greater freedom afforded by the emergency coronavirus legislation, the Government and NHSE were making further bolder plans for data centralisation for the longer term. Rosa Curling told the Inquiry that the Secretary of State had issued a Direction for England that GP-held patient data should be transferred to NHS Digital on 1 July 2021. In addition, in keeping with the new White Paper (February 2021), some social care data would also be transferred resulting in 'a huge mass data set of health and social care data' to be held by NHS Digital. The data – a collation of over 50 million GP patient history and medical records – was to be transferred from GP records on 1 July straight up to NHS Digital, unless patients opted out.

7.10.8 The legal obligation is on the Secretary of State and NHS Digital to notify the public about such a proposal and to seek patients' individual consent. Curling reported that, when a similar attempt was made in 2014, every single patient was written to, and their consent was requested. This time, it did not happen. There was a website statement and a few tweets which basically asserted that, unless an individual were to opt out, there would be an assumption that they had consented. Foxglove was concerned about whether

that was lawful under data protection law and were preparing a challenge.

7.10.9 Days after Curling's evidence to the Inquiry and faced with growing public opposition and one million patients choosing to opt out, the Government suddenly announced on 8 June 2021 that this date had been moved to 1 September. Subsequently the deadline was deferred again with no end date. Though the timetable in this ministerial direction has been postponed, fundamental issues raised must be addressed. To restore public trust and to respect data governance, there needs to be a full and proper consultation process in which people are given full information about any changes.

7.10.10 There were further serious questions. What was NHS Digital going to do with that information? What limits do they have in relation to use of those data? Who can access the data? For what purposes can it be used? Is there a meaningful consent framework that permits patients to differentiate between academic and for-profit access?

7.10.11 The inquiry was reminded that health data is incredibly useful and there is a wealth of extremely important and helpful information that could certainly make NHS services stronger. However, public trust must be maintained, and data safeguards ensured.

7.10.12 The potential commercial value is indicated by Palantir agreeing to be paid just £1 for the first contract, establishing them in position. They then got £23 million for the next stage. Curling questioned the suitability of a company like Palantir, very well known in the US for its role in controversial intelligence and security work, and as a major Donald Trump donor. It has been criticised repeatedly by its own

staff over its role in the US Immigration and Customs Enforcement (ICE agency) in relation to family separations at the US-Mexico border. The question must be asked: is this the sort of partner in the long term, that the NHS wants to be signing deals with? Would their very involvement not undermine confidence in the health service amongst the very communities where the Government states it's trying to now shore up trust, for example, in relation to the vaccination programme?

7.11 GOVERNANCE

7.11.1 The Nolan Principles of Public Life are accepted as a standard for behaviour in public life. The seven principles – Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership – have no statutory basis but are published and promoted by the Commons Committee for Standards in Public Life.^{7.45}

Conflict of interest and cronyism

7.11.2 Several Inquiry sessions heard testimony questioning the governance of contract awarding during the pandemic. Government contracts to the private sector have been eye-watering. £18bn in coronavirus-related contracts during the first six months of the pandemic, most with no competitive tendering processes.^{7.46} £22bn for the first year of NHS Test and Trace expanded to £37bn by the second year – a total larger than funding for the police and fire services combined. Multimillion pound contracts handed to big private outsourcing firms. The failed NHS contact tracing app cost the taxpayer £11.8m. Randox Healthcare were paid £133m for test kits that were later withdrawn as faulty. There have been many highly public failures (see

7.6.12 above) and soaring profit margins for contracts. In many instances there are political connections to the Conservative Party.^{7.47}

7.11.3 A major risk inherent in the awarding of contracts for public services to private interests is the conflict of interest between maximising company profits and the delivery of quality services. The Nolan principles were breached when contracts totalling £1.5bn went to companies with connections to the Conservative Party without openness.^{7.48} In one of two highly critical reports, the National Audit Office concluded in November 2020:

'The high-priority lane [with government and political contacts] sat alongside a normal lane established to assess and process other offers of PPE support ... About one in ten suppliers processed through the high-priority lane obtained contracts ... less than one in a hundred suppliers ... came through the ordinary lane.'^{7.49}

Failures of governance in pursuing contracts

7.11.4 The Government's justification was the urgency of the situation and the legal cover of the emergency coronavirus legislation. However, the duty of public office was to make rational and informed decisions. There was an irrational failure of Government to respond to clinicians, the BMA and current PPE suppliers willing to supply PPE. Instead, decisions were pursued which wasted vast sums of public funds with serious consequences. The process for awarding many failed private contracts has been grossly negligent.

Failure of candour

7.11.5 At a time of national emergency, when public trust was at a premium, that trust was undermined by large numbers of high-value contracts being awarded without transparency for the public. Not only were contract details withheld, but the implications for public interest issues were kept from public view – such as whether contracts protected the public from the risk of data abuse or were transparent in their content, extent and duration.

7.11.6 Wrigley told the inquiry that the Good Law Project's legal efforts had forced disclosure of various contracts. A legal challenge to Matt Hancock on the secret contract given to Palantir has been successful but the DHSC has been slow to comply. Only now, post-Inquiry, the Information Commissioner has found the DHSC to be in breach of its obligations under the FOI Act and instructed the DHSC to reveal the details of 47 contracts awarded to companies in the VIP lane to the good Law Project within 35 days from 18 October 2021.^{7.50}

Legal challenges on governance

7.11.7 The Government has been held to account for its governance shortcomings in the media and by parliamentary bodies, but it has taken legal challenges to pressure the Government into revealing contract details or force their hand when found to have acted unlawfully.

7.11.8 There have been important successes some of which are referred to in this report:

- Then-Secretary of State for Health and Social Care, Matt Hancock was found in breach of the law on failing to disclose

contract awards within the statutory time frame through the Good Law Project's judicial review

- The DHSC must now place details of 47 VIP-lane contract awards in the public domain, following the Good Law Project's successful complaint to the information Commissioner
- The public disclosure of the Palantir contract through legal action of openDemocracy and Foxglove
- FOI requests by Foxglove Legal for copies of the contracts on the NHS Data Store and related Data Protection Impact Assessments (DPIAs) documents – only revealed after threatened legal action
- Public opt-outs and threat of legal action by Foxglove on the transfer of GP data
- Freedom of Information requests and associated legal actions led to the revealing of Exercise Cygnus and Exercise Alice, through the work of Dr Moosa Qureshi and Leigh Day Solicitors

7.12 CASE STUDY OF THE NHS DATA STORE AND PALANTIR CONTRACTS

7.12.1 Rosa Curling told the Inquiry that the Data Store could of course, partly be in the public and NHS interest, so they had made a series of FOI requests, asking for copies of the contracts and also DPIAs, documents which are like equality impact assessments. These are basically required of public bodies, to think about what impact, from the data rights point of view, the Data Store would have for individuals.

7.12.2 The deadline for the FOI requests had not been met, so Foxglove had given notice of the start of legal proceedings, with a deadline of May 2020. As a result,

the Government eventually published the contracts (with some information redacted) on 5 June 2020, the day before proceedings were due to begin. The DPIAs were published a few days later, but had been completed after the event, which is not what the law requires.

7.12.3 Foxglove took a second case about DPIA in relation to the awarding of two further Covid-related contracts with these companies; and a third contract, signed with Palantir for two years, going beyond the expected end of the COVID-19 pandemic. The brief was wider and required public scrutiny.

7.12.4 Curling explained that the DPIAs are not just mere legal formalities but key to good governance. The public has the right to be consulted about how their medical data is used and with whom it is shared. While there are potentially life-saving rewards for proper data use in the public interest, 'the risks involved, going from minor embarrassment to a total corruption of trust in the medical profession, are really serious'.

7.12.5 DPIAs are about ensuring accountability in a period where trust in some of our health institutions has been eroded. The public needs to be asked for their consent about whether they want their most sensitive, confidential information to be shared with private corporations or whether in fact, they want that data to be kept within public bodies, as a public asset for the public good. If this arrangement is going to be changed, then a democratic mandate is needed:


'You have to get proper consent for that to happen. Otherwise, you really are threatening, I think, the trust and patient confidentiality that is really at the bedrock of our National Health Service.'
(Curling)

7.12.6 There are many examples of flagrant conflicts of interest, lack of candour and openness. The NAO reported their findings on test and trace^{7.51} and concerns about the Government procurement process (see para 7.9.2). The public has every reason to question whether the current system for regulating conflicts of interest is fit for purpose. There have been calls for giving the Nolan principles and regulations on conflict of interest a statutory basis independent of Government.^{7.52}



8. GOVERNANCE OF THE PANDEMIC

Inquiry Session 8

**PEOPLE'S
COVID
INQUIRY** 
Learn lessons, save lives.

8.0 INTRODUCTION

8.0.1 This chapter draws primarily on testimony given by Dr Deepti Gurdasani, Cllr. Steve Cowan, and Ms Jean Adamson (Session 9), Prof. Jonathan Portes (Session 8) and Michael Bimmler, a barrister specialising in public and human rights. Additional points are incorporated from Prof. Gabriel Scally (Session 1), Sir David King (Session 2), Janet Harris (Session 3), Prof. Stephen Reicher (Session 8), Mr Kevin Courtney (Session 9) and Prof. Raymond Agius (Session 5).

8.0.2 In this chapter, our focus is on how the system as a whole operated in pursuit of strategic goals, and in particular how it was led from central government, how the governance of institutions involved contributed to success or failure, and how those occupying senior positions can be held to account for their actions and inactions.

8.0.3 We know a lot about the political ideas (and how they related to COVID-19) which were occupying the Prime Minister in early February 2020 through a speech he gave in the Painted Hall of the Royal Naval College at Greenwich:^{8.1}

'This country is leaving its chrysalis. We are re-emerging after decades of hibernation as a campaigner for global free trade. And frankly it is not a moment too soon because the argument for this fundamental liberty is now not being made ... Free trade is being choked and that is no fault of the people, that's no fault of individual consumers, I am afraid it is the politicians who are failing to lead ... and in that context, we are starting to hear some bizarre autarkic rhetoric, when barriers are going up, and when there is a risk that new diseases such as coronavirus will trigger a panic and

a desire for market segregation that go beyond what is medically rational to the point of doing real and unnecessary economic damage, then at that moment humanity needs some government somewhere that is willing at least to make the case powerfully for freedom of exchange, some country ready to take off its Clark Kent spectacles and leap into the phone booth and emerge with its cloak flowing as the supercharged champion, of the right of the populations of the earth to buy and sell freely among each other ... and here in Greenwich in the first week of February 2020, I can tell you in all humility that the UK is ready for that role.'

8.0.4 This ideological orientation combined with the character that fails to connect the big ideas to practical action, his tendency to work shorter hours and to take more holiday than prime ministers normally do, and the strong distractions of a chaotic personal life come together to make Prime Minister Johnson supremely ill-fitted to lead the governance of the COVID-19 crisis. The fact he failed to attend the first five COBRA meetings on the pandemic is well-known. The evidence for these assertions is well documented through published material.^{8.2} No 10 declined our invitation for the Prime Minister to give evidence to the Inquiry about this, so for a more detailed account taken from testimony under oath we must await the promised full judicial inquiry.

8.0.5 So we turned instead to looking at what evidence there was on the functioning of the various organisations and institutions close to the Prime Minister, to see whether they were able to compensate for the character flaws and balance the ideological predilections to cope with the circumstances. We are citizens of a modern democracy rather

than the subjects of a medieval monarch to whose inadequacies we must simply submit. While it is true that executive power has become more and more concentrated in the centre of central government, there are institutions with independent embedded values which make up the ecology of governance, which we draw on our evidence to explore.

8.0.6 Witnesses varied in how far they were willing to point the finger of blame at government. Some were very tough:

'It's been a strategy of - I would say - negligent manslaughter, but I think that is far too generous because it's not negligent. Essentially it has been a policy where they have been fully informed on the risks - mass deaths, the risk of suffering, but have gone ahead anyway ... The government's policy has focused on a herd immunity narrative, acceptable deaths ... We know now that there have been over 150,000 deaths and a million people suffering with long covid, which we do not understand ... and unforgivably, 30,000 of those are children.' (Gurdasani)

'The health of the people became a lesser interest of government [from 2010 onwards] than it had [previously] been ... There is a plethora of evidence that ... the public's health has declined and equalities decreased ... and that is because we have been unfortunate enough to have a government which has no real interest in the public's health.' (Scully)

8.0.7 Others may have been less outspoken, but there is common recognition from witnesses that our system and some of those who lead it have fundamentally failed us, as demonstrated by our high death rate and poor economic performance compared with many other

countries of equivalent wealth, population density and science base. Our report concludes that a highly centralised system of government such as ours has become may be able to provide good leadership in such a national emergency, but that since such leadership is unlikely to be available all of the time, we need to ensure that there are effective institutionalised supports and constraints to ensure that the pressures for good crisis decision-making are firmly in place. Below we set out in some detail the evidence that leads to this conclusion

8.1 HOW SYSTEMS OF GOVERNANCE CONTRIBUTED TO OUTCOMES

The centre of the centre – sofa government again

8.1.1 As Cllr. Steve Cowan observed, this country has a very centralised system of governance, and the elevation of Boris Johnson to the role of Prime Minister was accompanied by a further ratcheting up of centralisation, most spectacularly in the prorogation of Parliament where even the monarchy was enrolled in the programme (which was subsequently found to be unlawful by the Supreme Court).

8.1.2 How did this tight centre perform in the battle to beat the pandemic? We have no direct witnesses who were at its heart as the Prime Minister and the Secretary of State for Health and Social Care did not respond to our invitation to be witnesses, so we must make what judgements we do on the basis of the observations of other knowledgeable witnesses. We recognise that the analysis will be incomplete unless a full public inquiry is able to cross-examine the key players in those central institutions. The centralisation

of decision-making in a pandemic is not necessarily the wrong approach, but the less that leadership is distributed the more important it is that it be highly effective because of the greater impact of failure. If we look at the performance of the centre of the centre, there do seem to be a number of recurrent lessons.

8.1.3 The Prime Minister in Cabinet is meant to be the setting where the contested questions and policy priorities are resolved, but the issue of the balance to be afforded economic matters and the pandemic was not fully confronted and resolved in the early part of the pandemic.

8.1.4 It was clear from published statements of key players that the idea of herd immunity, whereby the economy continued as normal and the population fell victim to the infection with assumed immunity for those who recovered was the favoured option for weeks.^{8.3} Advisors to the Prime Minister seem to have deluded themselves into believing herd immunity was an acceptable way forward in order to accommodate the Prime Minister's policy preferences.

8.1.5 It seems unlikely that the full implications of this approach were tested in front of full Cabinet and that they gave their consent. Had it been put to Cabinet we would almost certainly have seen leaks which expressed reservations. In this case, the absence of evidence probably does constitute the evidence of absence. So we have some reason to believe that the institution at the very core of government, Cabinet, was sidelined and ineffective – a return to the 'sofa government' described in the Chilcot report on the Iraq war as disastrous for good decision-making.^{8.4}

8.1.6 It is also the case that Boris Johnson had taken the precaution of removing from

Cabinet the experienced MPs of standing who might have been expected to have an independent opinion after he succeeded Theresa May as Prime Minister, excluding most of them from the Conservative Party so that by the time of the pandemic they were not even in Parliament. The remainder were on the backbenches and doing useful work following the crisis through select committees, but even the second order ministers who were in the Cabinet would surely have been briefed about the consequences of a herd immunity strategy and also about the delay to essential action that was taking place while such a strategy was being considered, which became all too evident in the high death rate experienced in March, April and May 2020.

8.1.7 Professor Jonathan Portes has pointed out to us that almost all economists take the view that public health has to be restored and that the economy can take the hit of going into lockdown in order to stop the spread of the virus. Because of the success of the job replacement scheme – putting aside any reservations about the level of fraud – working from home and support for business, better off members of the public were building up savings that when spent after the all-clear was sounded would cause a big economic bounce back. The constant flirting with the idea of riding out the infection and building up herd immunity was not an economic but a political idea, straight from the Prime Minister.

8.1.8 The strong view of the public health profession, as expressed by many of our witnesses, is that infection must quickly be found and eliminated for an effective response.^{8.7} The periodic resurgence of a strategy of letting the economy run explains not only the late initial lockdown in the first wave, the financial incentives

to go out and mix in the summer of 2020, the late lockdown in the Autumn of 2020 despite the clear and published advice from SAGE on 21 September and the intention of having Christmas 2020 off from the pandemic, etc.

8.1.9 This led directly to a very large number of deaths, as noted by Dr Deepti Gurdasani (para 8.0.6). Had Cabinet endorsed a coherent strategy of suppression of the virus and using effective testing systems to find any outbreaks it seems very likely that we would have experienced far fewer deaths and incurred less economic damage (including the debt incurred to pay for furlough and other benefits for an extended period). A Cabinet that worked would have been a better guarantee of that than one man's whim.

8.2 POLICY ERRORS

8.2.1 Further errors arose out of the chaotic decision processes in the centre. Public health experts use the mantra 'find, test, trace, isolate and support' as the recipe for overcoming an epidemic, but one section of the community were not supported despite the fact that they were at high risk of becoming infected and infecting others. Although the centre had been willing to provide relatively generous support for many millions of people in the secure employment where furlough became a possibility, people whose employment was more precarious could not be supported through furlough because they worked in the gig economy, possibly on zero hours contracts and with no employment protection and sometimes not even access to statutory sick pay.

8.2.2 Prof. Portes reported that not only was the level of statutory sick pay below any comparable country in the OECD (see

report section 4.8), but it was massively below at just over £90 a week. The knock-on consequences of the failure to pay an adequate amount were that the test and trace system underperformed because people were not prepared to name their contacts, that in any case people did not pick up the phone when Test and Trace called, and that large numbers of people with transmissible infection carried on working and therefore spread the virus. What kind of strategic centre fails to consider such an obvious option? Probably one that is overwhelmed, populated by people who tell the boss what he wants to hear, and where key voices are drowned out.

8.2.3 There is then the larger question of the test and trace system itself and the choice to set something up *de novo*, with most operations run through outsourced contracts and leadership from a person with no relevant experience of the field (see report sections 2.3, 3.3 and 7.5). There was in fact plenty of capacity available already - not in the one and only laboratory of Public Health England, but in a variety of settings such as major hospitals and universities and existing private sector labs. Some effort would have been necessary to bring about a surge in capacity but that would have been done building on a sound foundation rather than on thin air, as with what happened. How can a system which has at its disposal some of the finest minds around not have come to a better decision about how to take this forward? The answer is probably panicked 'sofa government' rather than considered and well-supported decision-making.

Contempt for standard operating procedures or protocols

8.2.4 Managing something as big and complex as government is not like managing the corner shop or the local pub. Large organisations develop procedures to help give due weight to factors which it is best to consider in different types of activities. One such is procurement procedure, which had developed protocols over time to achieve the best value for money for the system. These standard procedures will have been developed when urgency was less of a factor than during the pandemic, but the evidence published by the National Audit Office shows a failure to understand the significance of such things and their apparent replacement with the principle that it is not what you know but who you know, as the NAO's discovery of fast-tracked bids to provide service from friends of ministers, who were 10 times more likely to be awarded government contracts than bids that came through in the normal way (see report section 7.3).^{8.5}

8.2.5 The evidence shows that the contracts awarded to friends had a high failure rate. This is not surprising if key parts of the process such as whether the potential contractor had a track record of delivering similar services, seems to have been over-ridden. This retreat into a courtier culture should have been addressed by departmental permanent secretaries, who are personally responsible to the Public Accounts Committee of parliament for the propriety and value for money of the spending in their department. The Permanent Secretary of the Department of Health and Social Care has questions to answer about this.^{8.6} We discuss below the implications of Permanent Secretaries not having control

over departmental expenditure. Not only was there some evidence of corruption but there was plenty of evidence of poor outcomes from the procurement process.

Hitting the jackpot

8.2.6 In the light of this litany of incompetence and malfeasance, it is hard to explain why the commissioning of the vaccines was so different. Dominic Cummings in his evidence to the Health and Social Care/Science Select Committee inquiry^{8.7} suggests that he and the Chief Scientific Adviser, Sir Patrick Vallance, took control of the process. Sir Patrick had until very recently been a senior executive at GlaxoSmithKline and was himself a clinical pharmacologist, very relevant experience for the task.

8.2.7 Someone with strategic experience in the pharmaceutical industry was found to lead the work and seems to have had an enclave protected from the chaos in which to gather resources and create the necessary relationships. The recently published story of the development of the Oxford/AstraZeneca vaccine certainly suggests that crucial risk capital to finance the development of the vaccine was available at an unusually generous level.^{8.8} The official public inquiry may tell us more and see how far positive lessons might be learned for the functioning of government but the contrasting examples of Test and Trace and vaccine development and procurement are stories which shout out about the importance of relevant specialist knowledge and the need for decision-making which uses it.

8.2.8 The primary message that comes out of this section is that the leadership of our response to a pandemic is the most stretching and challenging role, even for someone who has the character to

undertake it. When the electorate chooses someone as Prime Minister who clearly does not have that ability, that way lies disaster – as demonstrated in the death toll for the UK. Lucky the country led by politicians who understood the issues, worked hard and with determination to follow the right strategy in a timely manner and were able to build their political resources to allow them to continue. A key feature of our constitution is that the Prime Minister in Cabinet is at the apex of decision-making, a collective system which allows for the frailties of the human beings who occupy the post of Prime Minister. For the second time in two decades, that system has failed and we urgently need to ensure that it works in the future.

The national public health function was not up to the job

8.2.9 For over a century, public health physicians have been at the core of the UK's response to epidemics and national emergencies, indeed the art and science of public health was invented in the UK slums of the nineteenth century. It had become a well-established career with a capacity for training and experience at a number of levels so that there was a talent pipeline of public health leaders able to come to the fore to provide leadership when needed. This changed from 2010 onwards. As Prof. Gabriel Scally (see report section 1.4) said:

'The capacity for emergency planning and resilience at regional and local level had been systematically stripped out since 2010, leaving central government incapable of dealing with what was a very predictable, and predicted, national emergency.' (Scally)

8.2.10 The Health and Social Care Act of 2012 changed the NHS, including

Public Health, into a system for commissioning and contracting rather than a comprehensive service for ensuring the public's health, and with that change the system's capacity for strategic public health leadership was eviscerated completely at regional level, and downgraded with reduced funding at local level as it was passed over to local government.

8.2.11 At national level, PHE was set up; however, the national authority previously exercised by the regional directors of Public Health, who depended for their effectiveness on their capacity to speak with professional independence, was not replicated in PHE. It was set up as a part of the DHSC, having no separate governance or statutory powers and responsibilities.

8.2.12 The chief executive of PHE since its origin and until 2020 was Duncan Selbie, whose background was as an NHS Trust manager and chief executive of one of the now defunct Strategic Health Authorities. He had no professional qualifications and no work experience in public health. His background fitted him for the role of leading a public health improvement service, doing useful work on a number of priorities, but did not fit him for being a professionally authoritative voice on epidemic control. Developing and running a programme for health improvement is not the same thing at all as having the personal credibility to come to the fore in a pandemic. This would depend on knowledge of the field of public health, experience of earlier epidemics, and the personal leadership style and capacity to confront obstacles to success

8.2.13 Those professional public health specialists who occupied senior positions in PHE were, in effect, civil servants, and

unprepared for the senior leadership roles they were suddenly faced with. Deputy chief medical officer Dr Jenny Harries, until 2019 a relatively obscure public health doctor in PHE's regional office structure, showed her inexperience by failing to remain separate enough from ministers and the Prime Minister. She was used in a televised 'fireside chat' with the Prime Minister and, encouraged by him, gave false reassurance to the public.^{8.9}

8.2.14 Whereas in the past, public health officials spoke on their own account as experts and were careful to guard that independence so that the public would see them as truth-tellers whose opinion could be trusted, what we see in this example and others is someone with a public health leadership role who regards it as her job, like any other civil servant, to serve the government of the day.^{8.10}

8.2.15 No 10 Press conferences held with senior PHE staff on the podium alongside ministers or the Prime Minister led to them providing justification for government policy rather than saying what a top public health professional would say, as several of our witnesses have pointed out. Dr Jenny Harries (now the head of PHE's successor body, the UKHSA), for example, justified the abandonment of testing in March 2020 despite the advice of the WHO:

'I remember watching with some disbelief when the deputy CMO, Dr Jenny Harries, when asked by the BBC reporter why we had not followed the advice of the WHO. She said that advice is for developing countries. Frankly, that is absurd. It is a very dangerous way to respond.' (King)

8.2.16 Dr Harries' co-deputy CMO, Prof. Jonathan Van-Tam may have managed to keep more of a distance. In the final question of the Downing Street press

conference held on 30 May 2020, following a question from the Observer's Toby Helm which pointed out that more than a million people had signed a petition calling for the sacking of Dominic Cummings and asking whether people in authority should give a lead and obey the rules, Jonathan van Tam answered slowly and deliberately:

'... in my opinion, the rules are clear and they have always been clear. In my opinion, they are for the benefit of all, and in my opinion, they apply to all.' (Van-Tam)

It is notable that he did not appear again in the No 10 press conferences for a very long time.^{8.11}

8.2.17 The destruction of independent public health capacity may have had its most significant impact in the absence of this discipline as an independent voice on the SAGE. Now that the minutes of the early SAGE meetings have been published we know that senior staff of PHE were present at those meetings, and in the minutes were described as part of the group of scientific advisers. Actually, as civil servants, they were unable to express independent scientific advice, but this meant there was no independent public health advice, leading to an over-reliance on the other disciplines such as epidemiology – important though that was.

8.2.18 The under-provision of proper public health advice was a major problem in the early days. It is not surprising that many of the people who agreed to serve on Indie_SAGE (the parallel voluntary body chaired by Sir David King) were the very people who constituted the independent strategic capacity which was so clearly needed by government. Had more of those people been present on SAGE in the early stages of the pandemic, it seems unlikely that WHO advice would have been ignored,

testing dismantled, and international travel permitted.

Chief Medical Officer and Chief Scientific Advisor

8.2.19 Was Professor Chris Whitty, the Chief Medical Officer, not a strong enough advocate of the case for public health? It is worth noting the following comments made by Professor Scally:

'Only one of the four national Chief Medical Officers was a fully trained and experienced Public Health physician.' (Scally; see report section 1.4)

And this was not Professor Chris Whitty. Prof. Scally expanded on this point later in the press.^{8.12} Whitty is an eminent scientist and a person with many relevant qualities, but in the early stages of the pandemic clearly lacked the practical wisdom that is at the core of the field of public health. A senior public health leader always makes sure that they protect their right to give their independent professional opinion, because so much depends on people trusting their advice and therefore following it.

8.2.20 As the former chief scientific adviser, Sir David King, said, referring to the Phillips Report into government handling of the BSE crisis (of which Phillips was very critical),

'The scientific community was never allowed to communicate with the public directly. Openness, honesty, and transparency with the public as well as with government ministers is vital.' (King; see report section 2.1)

8.2.21 The Chief Medical Officer was fairly new in post but had occupied the role of departmental chief scientific officer in the Department for International Development

and then the DHSC. He was therefore well-versed in the Whitehall routine of seeing experts as 'on tap but not on top'. Of course the elected government of the day has the final say, but the public has a right to know that the decision was in spite of advice rather than, as was claimed in the 'following the science' refrain, because of it.

8.2.22 It is fair to say that a rather more robust stance developed as we moved into the Autumn of 2021, as evidenced in the published advice of the September 21 meeting of SAGE shows:^{8.13}

'A package of interventions will need to be adopted to reverse the exponential rise in cases. Single interventions by themselves are unlikely to be able to bring R below 1. The shortlist of ... interventions that should be considered for immediate introduction includes:

- a. A circuit breaker to reduce incidence to low levels*
- b. Advice to work from home for all who can*
- c. Banning all contact within the home for members of other households*
- d. Closure of all bars, restaurants, cafes... etc*
- e. All university and college teaching online*

The more rapidly interventions are put in place ... the faster the reduction in incidence and prevalence ... the greater the reduction in Covid-related deaths.'

Despite the unequivocal nature of this advice, it was not followed for a further five weeks.^{8.18}

8.2.23 The Chief Scientific Officer, Sir Patrick Vallance, was newer to Whitehall

and more used to being listened to with respect by those at the top of a major pharmaceutical company whose top leaders knew their future as a company depended on good scientific advice being followed. Both the Chief Medical Officer and the Chief Scientific Adviser should be guaranteed their independent status in the future. Governments may choose not to follow their advice, but they will then face the court of public opinion if they override it and disaster follows. The only way to retain their independence rather than conforming to Whitehall 'groupthink'^{8.14} is for them to have the right and the duty to speak for themselves to the public.

The role of top civil servants

8.2.24 In our un-codified constitution, the convention is that policy advice to ministers is confidential and not to be made public. The main reason for this convention is to protect the anonymity of civil servants so that they will feel able to offer tough advice to ministers – 'speaking truth unto power'^{8.15} without their future career under a government of a different persuasion being compromised, thus giving our system of governance the benefit of continuity of expertise and knowledge.

8.2.25 Governments are accountable to the public through Parliament for the decisions they take and civil servants are accountable to ministers – so goes the argument, rather than directly to the public. Civil servants, according to this convention, can be ordered by ministers to do most things, although not to break the law, and they should resign if they feel they cannot follow the order.

8.2.26 Continuity of expertise and knowledge should have been important advantages for the UK in responding to

this pandemic as during the previous 15 years we had experienced the foot and mouth epidemic in 2006, where many of the same principles of epidemic control applied and also a very extensive Foresight project in 2006 where a huge amount of work went into setting out what would need to be done if the most pressing risk on the UK national risk register came about, a novel virus which had crossed the animal/human barrier and created a pandemic:

'This was the single biggest Foresight programme that I ran. We met for just over two years on that programme.'
(King)

There had also been the more recent Exercise Cygnus in 2016 and, as we have recently been told Exercise Alice, which unlike Cygnus with its focus on influenza, worked on what needed to happen if we were struck by a coronavirus pandemic.

8.2.27 Nonetheless we were clearly not prepared. This was not only, as Prof. Portes said, because the wrong balance had been struck since 2010 between sustaining the public institutions that we need in an emergency and the policy of austerity but also because something clearly was wrong in how the heart of government functioned. Some of this failure is explained by the misfortune of being led by a prime minister who is widely reported by many of those who have known him throughout his career as not fit to govern. From time to time, the electorate will bring someone to the office of Prime Minister who does not have the ability to fulfil the role of crisis leader. So what does our constitution offer in those circumstances? A tough and experienced civil service capable of ensuring that ministers fully consider all the issues in making their decisions.

8.2.28 The Whitehall model of confidentiality and continuity depended for its strength on the mutual interdependence of civil servants and ministers, but over the last several decades that relationship has been undermined by the presence of an ever-growing army of political advisers, appointed by ministers and working directly to them, bypassing top civil servants. The question the pandemic raises is whether the relationship between ministers and civil servants has been so undermined by the use of special advisers that it can no longer put tough questions to ministers and expect to be heard? It is certainly the case several very senior civil servants, including the Cabinet Secretary and head of the civil service, were removed from their posts before or during the early months of the pandemic, thus reducing top level capacity to provide challenge to the strategic direction being taken.

8.2.29 The Cabinet Secretary Sir Mark Sedwill, appointed to that role in 2018, resigned in June 2020 at the age of 55. Such early resignations rarely happen from the post of Cabinet Secretary and it is therefore possible to surmise that this was the work of Dominic Cummings, who had made no secret of his desire to bring about fundamental change in Whitehall. He clearly saw a raging pandemic as no hindrance to getting on with his agenda. The chosen successor, Sir Simon Case, was one of the youngest ever to hold the post and his most demanding role previously had been as Private Secretary to Prince William. The appointment must have raised eyebrows amongst the select group of past cabinet secretaries. A weakened civil service could still do administrative tasks well, as discussed below, but the core function of the top of the civil service to 'speak truth unto power' seems to have been eroded too far to be safe.

Use of scientists

8.2.30 We need to consider the role of scientific advice and advisers and whether or not they were well used. There are two different codes of legitimacy involved in interactions between the science community and government. The actions of government are legitimate because they are the elected government of the day, chosen by the people. Scientists get their legitimacy from their research, opening their ideas to challenge through peer-review and the judgement they bring to their conclusions. How could such different codes of operating co-exist?

8.2.31 What seems to have happened in the early days of the pandemic with the SAGE is that they were regarded as subservient to the will of the government of the day. Minutes were not published until some months had elapsed, the group consisted at first of a mixture of scientists and government advisers. Prof Stephen Reicher drew attention to the fact that 'behavioural fatigue' was a dominant strand in SAGE's early deliberations and instrumental in the delayed lockdown, but the idea has no basis in behavioural science (see report section 4.7). We believe this is a reference to the government advisers who attended SAGE but were not behavioural scientists:

'It was believed in Government that the British people would not be able to stick with restrictions and so restrictions should be delayed. When this idea first came out it was ascribed to behavioural scientists. It did not come from behavioural scientists. It actually came from non-behavioural scientists making assumptions and therefore giving very bad advice.' (Reicher)

8.2.32 Scientists were required to abide by the notion that policy advice to ministers should be confidential, even though they were not civil servants, needing to be shielded against public awareness of the position they advocated. They continued to be active scientists with no future career in Government in prospect. Sir David King, former chief scientific officer, referred to the Phillips Commission into the Government's handling of BSE, which recommended full transparency for scientific advice (see 8.2.20). Sir David himself insisted on it when he was Chief Scientific Adviser during the foot and mouth epidemic. Dame Deidre Hine's report into swine flu recommended the same principle.^{8.16}

8.2.33 The smothering of the independent science voice was most graphically seen in the presence of the most senior scientific advisers standing either side of the Prime Minister at the regular Downing Street press conferences, with the Prime Minister conducting the process and sometimes refusing them the opportunity to give a full answer. This was personally demeaning for them, but more importantly reduced respect for their independent opinions, both in government and amongst the public.

8.2.34 However, after the disastrous first few weeks of the epidemic when the scientists acted at least in public with docility, we began to see that they would use publication of their research to force a reconsideration about the strategy of herd immunity. When the public became aware of the disastrous death toll that would follow, even the Prime Minister was forced to take notice.^{8.17} So although tens of thousands of lives were lost because of the initial lack of transparency and because there was poor public health leadership, ultimately SAGE came good, at

least during the first wave. In subsequent waves, the Prime Minister was even less amenable to rational argument and the death toll soared. It is very clear that full transparency and therefore independence of scientific advice would have changed the dynamics of how the Government was led during the pandemic and we have no hesitation in recommending it.

Arm's length regulators who failed to regulate

8.2.35 National bodies outside of central government deserve some investigation. They are typically set up at arm's length from government and although ministers will set their overall mission and agree the level of resources, the bodies are at arm's length to give them the independence to serve their mission as they think best. We have testimony from two witnesses on how two such bodies failed to live up to their mission during the pandemic.

8.2.36 Jean Adamson, a member of COVID-19 Bereaved Families for Justice and herself an expert in the field of social care, gave evidence on how the Care Quality Commission fulfilled its role (see report section 4.9). An academic expert, Prof. Raymond Agius, gave evidence about the poor response of the Health and Safety Executive in defending workers against unsafe working conditions (see report section 5.4).

The Care Quality Commission

8.2.37 The core mission of the CQC was to regulate the health and social care sector on behalf of its users, who were by definition vulnerable people not able to act themselves in their own best interests. The CQC's website makes great play of the fundamental standards of

care that it upholds. Among the dozen or so standards listed are: 'person-centred care, safety, safeguarding from abuse, complaints systems and the duty of candour'^{8.18} – all of which they claimed to uphold.

8.2.38 Our witness, Jean Adamson, presented a challenge to them. Her beloved father died of COVID-19 in a care home in April 2020, and she was a professional expert in assisting care homes to achieve the standards set out for them by the CQC. She joined COVID-19 Bereaved Families for Justice shortly after her father died and through engaging with others began to realise the enormity of what had happened to thousands of people in care homes. She became a seeker after truth having difficulty getting the most basic information about what had happened to her father:

'We need to understand why our loved ones died in a place where we expected them to be safe ... After my father passed, I made a formal complaint to the care home ... They did not give me answers to my questions about hospital discharges, about the number of cases in the home and they did not give me an un-redacted copy of my father's notes.' (Adamson)

8.2.39 Her experience of her father's care home was evidently that it did not live up to the standards set for it by the CQC. Most of her evidence, however, was reserved for the subject of the CQC:

'We feel very let down by the Care Quality Commission, as the health and social care regulator for England ... I felt they would be supportive of bereaved families but what actually happened is that they refused to disclose the number of Covid-related deaths in individual care

homes ... an important measure of the quality of a care home.'

8.2.40 Her interpretation of this behaviour on the part of the CQC is that they have sought to protect the commercial interests of the care sector rather than be open and honest and transparent to families. She said that in her discussions with senior staff of the CQC it was obvious that they were petrified that if information came out and that led to people moving their relatives away from poorly performing homes this would lead to a loss of care home beds as such homes would collapse:

'I feel that the CQC's position has become untenable ... It is no longer arm's length but has become political' (Adamson)

8.2.41 Although it had the governance to be an arm's length body and the formal mission, it actually functioned as though it was part of the DHSC. A few days before Ms Adamson gave her evidence to this inquiry the CQC advised that it would be publishing the care home by care home information on COVID-19 related deaths on 21 July 2021. This was done, although it should be noted that figures were not published for the time before 10 April 2020 on the grounds that figures were too unreliable before that date. The question remains – why did it take so long to publish this material and for the CQC to remember whose interests it exists to promote and protect?^{8.19}

Health and Safety Executive

8.2.42 Chapter 5 of this report, drawing heavily on the evidence of Prof. Raymond Agius, sets out in detail how the body set up to protect the safety of people at work, the HSE, failed to do so during the pandemic (see report section 5.4). The

evidence shows that it deferred to PHE in what was clearly on their part an attempt to rationalise the inadequate supply of PPE, endorsing PHE statements. It failed to bring into consideration its own expert knowledge on aerosol transmission of viruses and failed to speak up for the use of higher grade masks for health care workers who were not working in ICU but potentially in contact with infected patients even after these masks belatedly became more widely available. The evidence of its failure on this protective measure is that health care workers in ICU, in close contact with highly infected patients undergoing respiratory treatment were in fact less likely to catch COVID-19 than other health care workers deemed less at risk and therefore less well protected.

8.2.43 Equally significant was the lack of HSE's voice in protecting other parts of the workforce outside the NHS. The origins of HSE as a protective regulator, working especially in non-unionised settings where the workers could not organise to protect themselves, seems well and truly in the past. The high incidence of COVID-19 in workers running essential services, the failure to demand that premises are properly ventilated and that protective equipment was provided, all contributed to a betrayal of the fundamental mission of the HSE. As with the CQC, they allowed themselves to be drawn into the programme being defined by Ministers in the core of Government rather than fulfilling their statutory duty. This tells its own story about the overwhelming power of the core of the executive in our system of governance. Even organisations set up by Parliament to be at arm's length from that power seem to be drawn into it.

Accountability of ministers and public servants with statutory responsibilities

8.2.44 Is there a remedy in law so that ministers and other public servants can be called to account? Michael Bimmler, a barrister specialising in public and human rights law discussed the legal aspects of the Government's response to the pandemic. Bimmler explained the 'no harm' principle which exists in international law, which says that states have a duty to take all appropriate measures to prevent and reduce what is called significant trans-boundary harm. This applies to natural disasters, during which states have to take appropriate steps to prevent harms. The greater the risk of the harm at hand, the more efforts are required from the state. With regard to the pandemic, all states were subject to this duty, so they had a duty to stop further spread of the pandemic, or at least to take such steps as they could to stop the further spread, and to prevent or reduce further outbreaks.

8.2.45 International Health Regulations (IHR), dating from 2005, and adopted by more than 190 states in the World Health Assembly place a number of mandatory obligations on states. These include, for example, a duty to develop and maintain the capacity to respond promptly and effectively to public health risks including pandemics, and a duty to base that response on scientific principles and evidence. These international laws raised a number of questions as to whether the UK's response actually complied with IHRs, including adequate pandemic planning, and a capacity to respond promptly and efficiently. Bimmler noted the availability of PPE and ventilators, discharge of patients

into care homes without testing, protection of patients in hospitals and care homes, and reaction to the second wave.

8.2.46 He also discussed the European Convention on Human Rights (ECHR), in particular the right to life, the right not to be subjected to inhumane treatment, and the right to respect for private and family life. He explained that the government has to take proactive steps to promote these rights by putting appropriate safeguards in place, and that they are systemic duties owed to the public at large, in particular to exposed people. This would include frontline workers in the NHS, and the vulnerable such as the elderly and those with pre-existing medical conditions:

'It is quite clear from the case law that acts and omissions in areas such as health care policy, health care provision, health care regulation, are covered by this article to the right to life.'

8.2.47 He pointed out the 'duty to investigate' when a state's breach of those duties under the ECHR had cost someone's life. This could range from a coroner's inquest to a public inquiry if national level policy decisions were involved. He also reinforced the evidence of Professor Raymond Agius in chapter 5 by noting the duty of employers to ensure the health and safety of their employees at work by providing a safe workplace with necessary training and equipment (such as PPE), and that a breach of those regulations could be a criminal offence.

8.2.48 On enforcement, he pointed out that it was difficult to challenge breaches of international law, but that claims against breaches of ECHR could be brought in UK domestic courts

Central government departments

8.2.49 There has been much criticism of central government for its role in leading the response to the pandemic (see above 8.2.9 to 8.2.43). However, several witnesses have reminded us that in some respects central government performed well. Where strategic agreement about a response had been reached within the centre of the centre, there were cadres of hard-working and well managed staff able to deliver new services at speed. Prof. Portes draws our attention to the major successes achieved by HMRC, working closely with the Treasury, to develop and implement the furlough scheme and support for business.

8.2.50 Another example he gave was the DWP's expansion of Universal Credit to much larger numbers of claimants, their removal of the obstacles to receiving benefit which are part of the normal run of things. The £20 top-up could not have been in the gift of the DWP without backing from the Treasury, but perhaps is a tacit acknowledgement from them that the cuts to benefits during austerity had left basic benefit levels too low for survival when times were harder.

8.2.51 Another example quoted in our evidence is the Department of Housing, Communities and Local Government. They get a commendation from Steve Cowan, Leader of Hammersmith and Fulham Council, for their willingness to share information with local government and to work in partnership, and for extending the funding of local government so that it could do the job required in a pandemic.

8.2.52 There were other more fraught examples of the work of central government departments brought to our notice by witnesses. Kevin Courtney

naturally had a lot to say about the role of the DfE in the pandemic (see report section 4.25).

8.2.53 All of this evidence is reinforced in a recently published report written by former journalist Nick Timmins for the Institute for Government,^{8.20} which demonstrates a systemic weakness in the education sector that cannot be fully explained by a weak Secretary of State. The DfE found itself having to run the nation's schools in a time of crisis with a wholly inadequate capacity to work effectively at the regional and local level, and – according to Timmins – a pathological hatred of local government which made working in partnership with them a little difficult.^{8.20}

8.2.54 Our witness Prof. Jonathan Portes was right to draw attention to the difference in pandemic performance between those parts of central government at some distance from the chaotic centre, who did a commendable job in providing extended services which were vital to the survival of very many people. Not all of central government was shambolic

8.3 LOCAL AND REGIONAL RESILIENCE

8.3.1 While the overall architecture of public health was unfit for purpose in the pandemic, we are fortunate that very many public health specialists took it upon themselves to make a contribution. We have already noted the contribution many of them gave to indie_SAGE and further to enhancing public understanding of the pandemic through their writings. Many of these people were also witnesses at this Inquiry.

8.3.2 At the local level, there are many examples of voluntary and community action led by public health specialists on a

voluntary basis. Our witness Janet Harris said of her work in Sheffield that it grew as a result of noticing the failings in the test and trace system and because of her earlier substantial experience in mobilising the community to combat infectious diseases. Janet Harris is a semi-retired public health specialist. When coronavirus hit she and friends began to realise that test and trace was not working well and recruited and trained a group of local volunteer support workers to provide assistance for people who had been told to isolate. With the assistance of doctors in one of the city's hospitals, they also did contact tracing for coronavirus patients in hospital, which no official agency was doing (see report section 3.7).

8.3.3 No government at the national level can hope to deal with a pandemic without local and regional actors playing a significant part. It is in the nature of infection that it has to be stopped house by house and street by street, and that this can only be done by people with local knowledge and local credibility. We have already heard that the public health function at the regional level had been 'eviscerated', and during the decade before the pandemic, local authority funding had been stripped away leaving it less capable of responding to an emergency (see report section 1.4). Public health went into local government after the 2012 Health and Social Care Act and also lost funding once its ring-fenced protection was removed. Additionally, over the decade local government lost control of its micro-level service providers, the schools, as the government herded them into academies, outside local authority control.

8.3.4 Despite this disabling history, we are fortunate that at least some strong local leadership capacity remains.

A case in point is our witness Cllr. Steve Cowan, leader of Hammersmith and Fulham Council. He pointed out what a centralised country this is, and that local government 'tends to wait for instructions from central government and then follow them'"

8.3.5 He went on to say that in February 2020 he had noticed that many other liberal democracies, mentioning South Korea, Germany and California were adopting restrictive policies and that the UK government appeared to be an outlier:

'It looked like the government's focus was not on the Covid pandemic. Their heads seemed to be in a different space from where I thought they ought to be ... a lot of them were off ski-ing.' (Cowan)

8.3.6 In the February half term holidays, he came to the view that since there had been no word on the pandemic from the Prime Minister, that probably meant he was not thinking about this issue, which also in turn meant others may not be. He instructed the chief executive to put Hammersmith and Fulham onto a civic emergency footing, and to work out with staff what the council would need to do to protect the population. Hammersmith and Fulham was one of the first councils to declare a civic emergency on 13 March, stopping all public meetings and closing the parks in the light of parks being very crowded because of unseasonable fine weather.

8.37 At the regional level, they worked with other London councils and agreed a letter to the Prime Minister demanding a lockdown. This was signed by all London council leaders, including Conservatives, and was received by No 10 the day before lockdown was announced. After the lockdown announcement on 23 March:

'Quite good relationships were established between the Department of Communities and Local Government, with regular meetings and the Secretary of State Robert Jenrick saying 'spend what you need. We will reimburse you.' (Cowan)

There was not in fact full reimbursement.

8.3.8 Of particular note is the borough's work with its care homes:

'There are four large homes, all private sector. Council officers had realised that untested people were being discharged from hospital into these homes in the first week of April. Already there had been 25 deaths from this group of patients.' (Cowan)

The lead member for health and social care and the director of Public Health arranged for the homes to have free PPE (from Charing Cross Hospital), training for staff in infection control, with testing carried out locally by Imperial College. This gave the lie to the claim by Matt Hancock to the Select Committee on Health and Social Care that it was impossible to test patients who were being discharged from hospital to care homes.

8.3.9 The council had the statutory power to close the homes if they were failing to protect residents, but needed the care they provided for local people, so they worked positively with them - ingenuity, collaboration and soft power were the order of the day:

'It really was something where the public sector ethos at ground level really worked and we all rose to the challenge - local government, NHS, care homes, teachers.' (Cowan)

8.3.10 Nine months after the first lockdown, on Sunday 13 December 2020, London council leaders were called to a Microsoft Teams meeting with the public health director for London, Prof. Kevin Fenton.

'He told us that unless there was a full lockdown during the next eight days, there would be a second wave which would dwarf the first and lead to far more deaths.' (Cowan)

8.3.11 For the second time in this evidence, Cllr. Cowan told us that at the London-wide (regional level) there was cross-party agreement to send a demand to government for a London-wide lockdown from people from all parties. Unfortunately, this time they were unsuccessful in forcing a lockdown within that time frame, resulting in far more deaths than there need have been.

'I think the Prime Minister was more focused on being the man who gave you Christmas rather than focused on the science of stopping the second wave.'

8.3.12 The Hammersmith and Fulham story shows what can be done in places with effective leadership to mobilise the resources needed to protect people. And yet apart from local government's sponsor department, The Department of Communities, Housing and Local Government (which has just experienced a name change removing the words 'local government' from its title) the disdain of Whitehall for town hall is very clear, not least in the quotation above revealing attitudes in the Department for Education (8.2.53).

8.3.13 It is clear to us that in any future public health emergency, central government needs to work in partnership with local government and local public services, sharing information and resources. This probably applies to public policy in general, but certainly in the circumstances we examined it is a ludicrous conceit to act as though all wisdom belongs in the No 10 bunker.



**POSTSCRIPT:
EVENTS SINCE
THE END OF THE
PEOPLE'S COVID
INQUIRY**

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

9.0 INTRODUCTION

No judicial inquiry yet in sight

9.01 At the time of this report going to press (end of November, 2021) there is still no news on the appointment of a chair for the promised judicial inquiry into the management of the pandemic or an indication of when this might begin its deliberations. This reflects an ongoing reluctance in the Government to be scrutinised and held to account. It does, however, make the contemporaneous account of the pandemic highlighted in the People's Covid Inquiry report and its findings and recommendations even more important given this absence of action by those in positions of power.

9.02 Although the scope of the People's Covid Inquiry was limited by availability of resources and its voluntary basis, the investigation was wide ranging and an excellent example of a 'citizens' tribunal' – part legal proceedings, part theatre, part publicly speaking 'truth to power' – aimed at raising issues to more visible levels than governments or the media are prepared to do on their own.^{9.1}

Ongoing death toll

9.03 The pandemic continues in the UK with lethal consequence. At the time of writing (15 November 2021) the average daily deaths have been over 120 per day for four-weeks and rose to 169 at the end of October.^{9.2} The pandemic has continued worldwide. Known deaths from COVID-19 have surpassed five million, out of 253 million confirmed cases.^{9.3} Internationally, the UK has fared badly for the 6th richest economy with 214 deaths per 100,000 along with the USA (233 deaths per 100,000). Countries of

various geographies and economic wealth have fared better, some remarkably so (Portugal 178, Germany 118, Ireland 113, Canada 78, Vietnam 24, Australia 7, China and New Zealand less than one death per 100,000).^{9.4} There has been no sign that the Government wants to learn lessons from this tragedy and the significance of the ongoing death toll in the UK is played down in official circles.

9.04 Coronavirus cases and deaths are rising again in Europe. In the UK 69% of the population is fully vaccinated; in Portugal it is 87%, and Ireland 76%. Much of the world has not received anything like the quantities of vaccine needed to protect billions of people. In the UK the pandemic is very much alive, and it remains true that the basic public health measures such as mask-wearing in public places and improving ventilation are required alongside the vaccination programme.

9.05 The fact that a judicial inquiry is still urgently needed cannot be doubted (as we called for on 7 July 2021 in our urgent findings [see Appendix]) given the current challenges posed by the ongoing pandemic and the huge pressures being faced by the NHS.

9.1 'ONE OF THE UK'S WORST EVER PUBLIC HEALTH FAILURES'

9.11 The management of the pandemic has been explored by parliamentary representatives in a report published on 12 October 2021, from the House of Commons Health and Social Care, and Science and Technology Committees.^{9.5} The outstanding take-home message from this report is summed up in the conclusion that this was 'one of the UK's worst ever public health failures'. This is a hugely powerful statement, particularly given

that one of the committee chairs (Jeremy Hunt) was a former Secretary of State for Health with responsibility for the NHS from 2012-2018. However, the report is framed in a way that avoids attributing blame to politicians for the consequences of their actions including the dire state of the NHS at the start of the pandemic – and in this sense must be considered a whitewash.

9.1.2 Despite this, the report contains scathing criticisms^{9.6} of Government management: the initial response was delayed, care homes were abandoned, the 'world-beating' test and trace system had marginal impact. The report describes^{9.7} how comparisons with flu and a fatalistic view of the inevitable spread of infection impeded reaction to the pandemic. While clearly condemnatory of the delay in the first lockdown for reasons including lack of testing capacity and doubts about public compliance, the explanation is presented uncritically in terms of the nebulous concepts of 'groupthink' and 'British exceptionalism'.

9.1.3 The higher death toll is attributed to delay in initial lockdown and lack of targeted financial support for individuals seen as having been a huge barrier to people isolating. While little negative attention is focused in the select committee's report on the delay in triggering the second lockdown, senior scientists now feel this was an even more serious error, leading to tens of thousands of unnecessary deaths.

9.14 Rather than incriminating 'groupthink', the main problems^{9.8} were seeing the public as a problem, failing to value public health at a local level, and seeing the private sector as the best way to run a test-and-trace system.

Bereaved families excluded

9.15 The select committees report is also notable for the absence of the voices of those who lost loved ones to COVID-19. A representative of the Covid-19 Bereaved Families for Justice^{9.8} group commented:

'The report ... is laughable and more interested in political arguments about whether you can bring laptops to Cobra meetings than it is in the experiences of those who tragically lost parents, partners or children to Covid-19. This is an attempt to ignore and gaslight bereaved families, who will see it as a slap in the face.'

9.16 Not only were they not invited to give evidence to the committees, when they were finally seen by the Prime Minister 398 days^{9.9} after he first agreed to meet, the date of the promised judicial inquiry into pandemic management had still not been specified.

9.17 Hunt outraged bereaved relatives in a radio interview by describing the account given in the select committees report as portraying 'a game of two halves', using a jarring football metaphor to imply that whatever sins resulted in over 150,000 deaths, these were absolved by the vaccine rollout programme.

9.18 Astonishingly, he also claimed to know nothing of Exercise Alice,^{9.10} a pandemic modelling exercise only recently made public. This was commissioned in 2016 where the pathogen in the spotlight was not influenza, but rather the coronavirus that causes Middle East Respiratory Syndrome (MERS-CoV). Senior health officials who war-gamed the impact of this coronavirus hitting the UK, warned four years before the onset of the current pandemic of the need for stockpiles of PPE, a computerised contact

tracing system, and screening for foreign travellers.

9.19 The select committees report lends enormous weight and urgency to the call for a full judicial inquiry. The recurring excuse that this would divert attention and resources from fighting the pandemic has worn very thin, given both the evident need to learn and apply lessons to manage the current surge in infection, and the time being found for both a major reorganisation of public health structures and the NHS as a whole.^{9.11}

9.2 OUTSOURCED 'NHS' TEST AND TRACE AND PATHOLOGY SERVICES

9.2.1 The failure to build a strong public health test and trace system was reviewed by the Public Accounts Committee in its update report 27 October 2021^{9.12} on the outsourced NHS Test and Trace (see para 7.5), summarised as:

'One of the most expensive health programmes delivered in the pandemic ... allocated £37bn over two years ... outcomes muddle ... aims overstated or not achieved.'

9.2.2 The Leamington Lighthouse mega-lab referred to in section 7.6 of this report finally opened in July 2021, as the Government continued its rollout of private or private-public partnership outsourcing of NHS pathology capacity. In the same policy direction, Sajid Javid announced £5.9 billion spending on 199 community diagnostics hubs, with many companies already approved for these contracts.

9.2.3 In October 2021, the concerns expressed through the Inquiry about the lack of governance in the awarding of contracts outsourcing important health responsibilities became all too real.

Immensa Health Clinic was founded in May 2020 by Andrea Riposati. In August 2020 Immensa was awarded a £119m PCR testing contract without tender and a further £50m contract in July 2021. The UK Health Security Agency announced that Immensa Lab had wrongly given negative SARS-CoV-2 test results to over 43,000 people who in fact were infected. Their contract was temporarily suspended though they continued to process private travel-related tests.^{9.13} The laboratory had never been accredited. This contributed to the spread of coronavirus by unsuspecting people and may have led to illness and possibly deaths.

Virus transmission crisis

9.24 The Government's SAGE has warned of the need for a possible winter lockdown if measures are not taken now to tackle rising infections. The Chief Scientific Adviser to the government advised to 'go hard and go early' with coronavirus restrictions if cases surge (as they are doing), but the Government continued to paint an optimistic picture, wishing to give the impression that there is no cause for concern. In contrast, local public health chiefs in England are beginning to break away from government guidance^{9.14} and at least a dozen have called on their population to go back to mask wearing and working from home. Cases among younger (unvaccinated) school pupils aged 5-12 and 13-17 have doubled from September to end October 2021 with infection rates of almost 6%.^{9.15} Figures suggest that this rise among children has driven a surge in cases across all age-groups in the community, but particularly in households with children (adults aged 35 – 54). While deaths are low amongst children, there are concerns about the growing number of cases of children with long covid.

9.3 WORST EMERGENCY EVER FOR THE NHS AND SOCIAL CARE

9.3.1 The NHS, mental health and social care services have been left devastated after 21 months of the pandemic, faced by frontline staff already struggling with 100,000 vacancies, insufficient beds and ITU capacity, at least 7000 GPs short, close to 1000 health and care staff dying from COVID-19, social care settings in disarray with staff vacancies rising from 6% to 10%, and care homes unable to take new referrals due to staff shortages.

9.3.2 The NHS is under severe pressure (acknowledged by its Chief Executive Amanda Pritchard) and expecting worse to come as winter, influenza and Respiratory Syncytial Virus return. Necessary infection control measures during the pandemic have seen another 9,000 beds taken out of commission, making it even more difficult for the health service to catch up with the backlog of work. This cannot be fully compensated for by expensive contracts put in place to use some of the 8,000 private hospital beds (see report section 7.2), which fund the private sector and fail to build the extra capacity the NHS needs.

9.3.3 In the 30 years before the pandemic, numbers of NHS hospital beds have more than halved giving the UK one of the lowest numbers of beds for its population in Europe. Half the acute hospitals in England are averaging 95% bed occupancy (85% being regarded as the acceptable safe maximum), with around 5% taken by COVID-19 patients (around 8,000 patients at any one time).

9.3.4 The proportion of patients attending A&E departments and being seen within four hours has fallen to 64% (with a national target of 95%). Recently, every ambulance service in the country^{9.16} was

on the highest state of alert due to such pressures. Build-up in hospitals has backflowed causing intense pressure in A&Es and worse than ever delays in ambulance handovers to A&E, leading to deaths of patients in the back of ambulances trapped in delayed handover queues. This has exacerbated the availability of ambulance crews for new calls, and delayed responses to 999 calls have resulted in deaths before paramedic teams arrive.

9.3.5 Figures show^{9.17} further increases in numbers of patients waiting for treatment, standing now at nearly six million while NHS staffing shortages are leading to cancelled operations. Thousands more patients are not yet coming forward as predicted, for example with cancers. The wider health consequences of the NHS having to divert its entire focus to coronavirus are only slowly becoming clear.

9.3.6 General practitioners have dealt with 196.8 million appointments so far this year – up 12% on 2019 – but have been vilified as lazy^{9.18} in some of the national press. This campaign has generated verbal and physical abuse of staff and been supported by Sajid Javid, the Secretary of State for Health. GPs are now considering industrial action while other health trade unions are already balloting members over strike action^{9.19} in relation to a below-inflation pay offer.

Care support and mental health services deficits

9.3.7 300,000 adults are waiting for care support,^{9.20} 55,000 for assessment, and over a million people are not getting the care and support they need.^{9.21, 9.22} Care staff vacancies have risen from 6% to 10%. In addition, care homes^{9.23} are now

refusing to take patients from hospital to free up beds because of their own staffing shortages. These have been needlessly exacerbated by the Government's policy of 'no jab – no job'.^{9.24} The Care Quality Commission has warned of a 'tsunami'^{9.25} of people without the care they need this winter unless staff shortages are tackled. The tsunami of unmet need includes 1.6 million people who are without the mental health support they need and mental health care is in deep crisis.^{9.26}

9.3.8 The chief executive of the NHS Confederation (a membership body for organisations that commission and provide NHS services) made a heartfelt appeal to the Government^{9.27} saying:

'You have got to recognise that we need a national mobilisation. You've got to recognise there is a health and care crisis coming over the next three or four months and accept it, acknowledge it and encourage the public to do everything they can to help.'

9.3.9 The head of the British Medical Association representing doctors has said the Government is being 'wilfully negligent'^{9.28} in not reintroducing mandatory mask wearing indoors and encouraging work from home.

9.3.10 Meanwhile, having returned from a holiday break in Spain (October 2021), the Prime Minister insisted the only effective way of combating the pandemic was to press ahead with the booster vaccination programme, that everything was under control and there was nothing to worry about. The leader of the House of Commons, Jacob Rees-Mogg^{9.29} then wrongly assured people that you could not catch the virus from friends.

9.3.11 Despite all the above, Sajid Javid stated in a recent press conference^{9.30} on coronavirus (the first for five weeks):

'We don't believe that the pressures that are currently faced by the NHS are unsustainable.'

He argued that the NHS is in fact coping, while predicting daily coronavirus cases might rise to 100,000. Nowhere are there consistent public health messages to be heard about reducing infection other than through vaccination, and little attention has been given to improving ventilation in buildings, for example with only 8% of schools reporting having received promised carbon dioxide monitors.

9.4 INCOMPETENCE, INDIFFERENCE OR DEMOCIDE?

9.4.1 The present pandemic management policy in Westminster is indifferent to the loss of life, the long-term complications of COVID-19 in survivors, and the impact on NHS staff and other frontline workers. The question is raised as to whether this amounts to democide ('the killing of members of a country's civilian population, as a result of its government's policy, including by direct action, indifference, and neglect'), 'social murder',^{9.31} gross negligence manslaughter, or misconduct in a public office?

9.4.2 Campaigners who have raised such possibilities have watched with interest as French police searched the homes and offices of officials including the former prime minister as part of an investigation^{9.32} into that government's handling of the coronavirus crisis. Current and former ministers of the French Government have been targeted by at least 90 formal legal complaints from civic groups and members of the public over their response to the

health emergency. In addition, a Brazilian congressional panel has recommended that President Jair Bolsonaro be charged with 'crimes against humanity',^{9.33} asserting that he intentionally let the coronavirus rip through the country and kill over 600,000 people in a failed bid to achieve herd immunity and revive Latin America's largest economy.

9.5 GOVERNMENT DIRECTION IS APPARENT IN THE HEALTH AND CARE BILL

9.5.1 Mid-pandemic, the Government produced a White Paper proposing a major national reorganisation of the NHS in England. This was followed by the Health and Care Bill, currently going through Parliament^{9.34}. The legislative plans are consistent with the decisions taken and policy direction during the pandemic. The decision makers have had much extra freedom during the pandemic, with less scrutiny over contract distribution. The Health and Care Bill will centralise extraordinary powers in the hands of the Secretary of State for Health and Social Care, will deregulate a great deal of contracts awarded in the NHS, and facilitate the current policy direction of embedding private interests in the NHS. It contains proposals that will diminish the powers of local authorities and the ability of local populations to have access to NHS plans and proposals and a chance to challenge. The Bill does not end the policy of procurement through private contracting that has been awash with conflicts of interest. There are therefore genuine concerns that the new Health Bill will facilitate that culture rather than repair it.

9.5.2 Events such as Immensa in October and Owen Paterson in November (although

not directly related to the pandemic, one of his paid jobs was with the private laboratory company Randox^{9.35}, a major pathology contractor in the Government's outsourced parallel pathology system – he has since resigned as MP) have reinforced the concern that there is a serious loss, if not a total breakdown, of governance and integrity in public life – sleaze is in the headlines. This is in itself a threat to the public's health.

9.5.3 The lessons to be learned from the pandemic have not been learned by Government and ministers. We hope that the findings and recommendations in this report will prompt further discussion and challenge. It was a further shock to hear in November that Johnson has paid Deloitte £900,000 to prepare evidence for the inquiry in the spring, an inquiry which will, amongst other issues, look into Deloitte's handling of the Test and Trace failed services.^{9.36} If and when the judge-led public inquiry calls for evidence, we will make our report and supporting documents available for scrutiny.



APPENDICES, REFERENCES AND FURTHER INFORMATION

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

APPENDIX 1: TERMS OF REFERENCE FOR THE PEOPLE'S COVID INQUIRY

The People's Inquiry is tasked to look at the urgent lessons to be learned from this coronavirus pandemic. At the time of writing (January 2021), the total of excess deaths from COVID-19 since the start of the pandemic has exceeded 100,000. The shocking scale of this tragic loss of life was avoidable. We need to know why. The Government has failed to learn from mistakes and has not agreed to a public inquiry. Mistakes are being repeated and more avoidable deaths are lost.

The Inquiry will examine the events of the pandemic and identify the lessons to learn, both positive and negative. It will look at the context for the NHS and social care at the outset from January 2020. Both successes and the failures will be explored, so that the important lessons can be learned and the consequences avoided in future.

The NHS when fully funded, well-staffed and equipped has been the pride of Britain. The NHS and public health as previously conceived should have been in the best position to support the safety and health of the population.

The Inquiry will look at:

- a) the extent to which the NHS, including public health, based on its founding principles would have been enabled to respond differently.
- b) Issues on health inequalities, community and GP services, mental health and social care will also be examined, including the extent to which vulnerable sectors of society have been protected or let down.
- c) The impact of the pandemic, policies and decisions at government level and their implementation.

The evidence will provide the basis for conclusions and recommendations on the provision of health and social care in England, including the future funding and organisation of the National Health Service and the need for a national service for care, support and independent living.

January 2021

APPENDIX 2: PEOPLE'S COVID INQUIRY WITNESSES GIVING ORAL TESTIMONY

The YouTube links go to the start of each individual's testimony.

Jean Adamson, Covid-19 Bereaved Families for Justice

https://youtu.be/_MmH8ABPAIw?t=6665

Raymond Agius, Professor Emeritus of Occupational and Environmental Medicine, University of Manchester

https://youtu.be/bRtKxm_5lno?t=2954

Oluwalogbon 'Lobby' Akinnola, Covid-19 Bereaved Families for Justice

<https://youtu.be/ReR5LtgyPxx?t=3209>

Rachel Ambrose, NHS nurse in CAMHS (Child and Adolescent Mental Health Service), convenor Nurses of Colour, Nurses United

<https://youtu.be/cp4tqXWOS3I?t=4441>

Rehana Azam, National Secretary GMB Union

<https://youtu.be/g1z6PNCGL5I?t=504>

Michael Baker, Professor of Public Health, University of Otago, New Zealand

<https://youtu.be/g1z6PNCGL5I?t=4586>

Michael Bimmler, Barrister in public law

https://youtu.be/_MmH8ABPAIw?t=7995

Kirsty Brewerton, NHS Clinical Sister, and founder of Sitting Rooms of Culture

https://youtu.be/bRtKxm_5lno?t=4489

Rachel Clarke, Consultant in Palliative Medicine, Christopher House and NHS, author

<https://youtu.be/Tb0UNPPIGik?t=5885>

Ellen Clifford, National Steering Committee, Disabled People Against Cuts, author

<https://youtu.be/Tb0UNPPIGik?t=324>

Anthony Costello, Professor of Global Health and Sustainable Development, University College London; former Director at WHO, member of Independent SAGE

<https://youtu.be/g1z6PNCGL5I?t=2451>

Kevin Courtney, Joint General Secretary National Education Union

https://youtu.be/_MmH8ABPAIw?t=2161

Stephen Cowan, Leader of Hammersmith & Fulham Council

https://youtu.be/_MmH8ABPAIw?t=4560

Rosa Curling, Lawyer, co-founder of Foxglove, formerly of Leigh Day Solicitors

https://youtu.be/NrS6_GCXtDE?t=4050

Dr Michelle Dawson, NHS Consultant Anaesthetist, trustee Healthcare Workers' Foundation charity (previously 'Heroes')

https://youtu.be/NrS6_GCXtDE?t=5990

Dr Chidi Ejimofe, NHS consultant in Emergency Medicine

https://youtu.be/bRtKxm_5lno?t=5711

Jo Goodman, Co-founder Covid-19 Bereaved Families for Justice

<https://youtu.be/UVIPRxdRx7Y?t=434>

Deepti Gurdasani, Clin. epidemiologist & statistical geneticist, Snr Lecturer in Machine Learning, QMUL

https://youtu.be/_MmH8ABPAIw?t=586

Phil Hammond, NHS doctor, journalist, and comedy writer/performer

<https://youtu.be/35tdMRcznbU>

Janet Harris, Sheffield Community Contact Tracing Group

<https://youtu.be/g1z6PNCGL5I?t=5847>

Professor Sir David King, Chair of Independent SAGE

<https://youtu.be/ReR5LtgyPpk?t=620>

Kamlesh Khunti, Prof. of Primary Care Diabetes & Vascular Medicine, University of Leicester, member government advisory body SAGE; Chair of SAGE Ethnicity Sub-Group; member of Independent SAGE

<https://youtu.be/CE0-QfCOMXw?t=2300>

Elaine Kinsella, Chartered psychologist, lecturer in psychology, University of Limerick, Ireland (with co-researcher Rachel Sumner)

<https://youtu.be/cp4tqXWOS3I?t=2710>

Dr John Lister, academic, author and campaigning health journalist

<https://youtu.be/UVIPRxdRx7Y?t=5870>

Professor Sir Michael Marmot, Director, UCL Institute of Health Equity, Dept of Epidemiology and Public Health, UCL

<https://youtu.be/UVIPRxdRx7Y?t=1361>

David McCoy, Professor of Global Health Medicine, Institute of Population Health Sciences, QMUL; Centre for Health and the Public Interest

https://youtu.be/NrS6_GCXtDE?t=733

Martin McKee, Professor of European Public Health, member of Independent SAGE

<https://youtu.be/Tb0UNPPIGik?t=1929>

Unjum Mirza, Secretary, Victoria Line Branch of ASLEF union

https://youtu.be/bRtKxm_5lno?t=553

Latifa Patel, NHS doctor, deputy chair BMA representative body (Personal Capacity)

<https://youtu.be/CE0-QfCOMXw?t=4187>

Clare Phillips, operations manager supported living services for adults with learning disabilities

<https://youtu.be/Tb0UNPPIGik?t=4505>

Jonathan Portes, Professor of Economics & Public Policy at King's College London, and former senior civil servant

<https://youtu.be/cp4tqXWOS3I?t=5384>

Stephen Reicher, Professor of Social Psychology, University of St Andrews; participant in SPI-B (SAGE) and Advisory Group to Scottish CMO on Covid-19; member of Independent SAGE

<https://youtu.be/cp4tqXWOS3I?t=505>

Michael Rosen, author, poet, broadcaster, former Children's Laureate, Covid-19 survivor

https://youtu.be/NrS6_GCXtDE?t=198

Dr Helen Salisbury, NHS GP, columnist for BMJ, Oxford University, teacher/trainer undergrad medical students and postgrad doctors

<https://youtu.be/ReR5LtgyPpk?t=5835>

Gabriel Scally, President Epidemiology and Public Health Section, Royal Society of Medicine, Visiting Professor of Public Health, University of Bristol, member of Independent SAGE

<https://youtu.be/UVIPRxdRx7Y?t=4669>

Jan Shortt, Gen. secretary National Pensioners Convention

<https://youtu.be/ReR5LtgyPpk?t=4730>

Mary-Ann Stephenson, Director, Women's Budget Group

<https://youtu.be/CE0-QfCOMXw?t=672>

Holly Turner, NHS children's mental health nurse, CAMHS service, GMB union rep

<https://youtu.be/UVIPRxdRx7Y?t=4019>

Rachel Sumner, Snr Lecturer in Psychology, School of Natural & Social Sciences, University of Gloucestershire (with co-researcher Elaine Kinsella)

<https://youtu.be/cp4tqXWOS3I?t=2710>

Matt Western, MP for Warwick & Leamington – statement read out by Counsel

https://youtu.be/_MmH8ABPAIw?t=6324

Dr David Wrigley, GP in Carnforth, North Lancashire, Deputy Chair BMA, co-author 'NHS for Sale' and 'NHS SOS'

https://youtu.be/NrS6_GCXtDE?t=2491

Aliya Yule, Access to Healthcare organiser, Migrants Organise

<https://youtu.be/CE0-QfCOMXw?t=5585>

Zahra Ali (Fatima Az- Zahra Ali) School student

<https://youtu.be/cp4tqXWOS3I?t=7078>

APPENDIX 3: ADDITIONAL VIDEO TESTIMONY SHARED WITH THE PEOPLE'S COVID INQUIRY

Our thanks to the following contributors:

Sandra Daniels, Chair of Reclaim Social Care (now renamed Action 4 Inclusion): 'During the pandemic, there was very little acknowledgement of the impact the pandemic restrictions were having on disabled women'

<https://youtu.be/Tn10sjyhF6I>

Greg Dropkin, Merseyside Keep Our NHS Public activist and statistician, discusses the reasons he believes Government inaction caused thousands of unnecessary deaths.

<https://youtu.be/AqtN4-OXNRo>

Dr Lola Fakoya-Sales GP registrar, who also worked shifts in A&E during the pandemic, talks about her heart-breaking experiences as the COVID pandemic hit.

https://youtu.be/3Rc_1laqlYs

Dr Phil Hammond, NHS doctor, journalist and comedy writer/performer talks about what the Government could have done differently and the need for the public inquiry.

<https://youtu.be/35tdMRcznBU>

Janet Harris talks about her experience as one of the founder members of the Sheffield Community Contact Tracers, a voluntary group.

<https://youtu.be/fgKwpX8drwY>

Jatinder Hayre talks about his experiences as a medical student on the wards during the pandemic and where he thinks the Government went wrong.

<https://youtu.be/eGctehtZ26E>

Lisa, social care worker, shares her reasons for stopping work as a social care worker. Shared with the Inquiry by the Stand Up For Social Care campaign organised by Unison North West.

<https://youtu.be/AcfVdgYvCqk>

Marielle shares her experiences as a care worker. Shared with the Inquiry by the Stand up for Social Care campaign organised by Unison North West.

<https://youtu.be/k1v89kUsmdQ>

Stacey Richardson, a paediatric nurse working in the NHS in the Northeast, talks about her experiences during the pandemic.

<https://youtu.be/mOFPnYizgZ0>

James Skinner, Campaign and Programme Lead for Medact, a membership organisation for health professionals, talks about a range of issues impacting on migrants during the pandemic.

<https://youtu.be/SohhSN3JmAE>

Judy Stewart tells us about her experiences as part of a locally run initiative called the Sheffield Community Contact Tracers.

<https://youtu.be/88DNvZ8yPWY>

Dr Aaminah Verity who qualified as a GP during the pandemic, shares powerful testimony about life as a GP working in community and hospital settings.

<https://youtu.be/41-iAas2SKQ>

Bob Williams-Findlay, disabled activist, gives his view on the Government's failures during the pandemic.

https://youtu.be/zeOWk8_lmhE

Aliya Yule, Access to Healthcare organiser for Migrants Organise, talks about how deep distrust of the government and fear of data sharing is affecting take up of vaccines.

https://youtu.be/2oYg_KNUIAQ

APPENDIX 4: PRELIMINARY FINDINGS

Released 7th July 2021

Finding 1: Public health policy

1. There has been an inconsistent, ill-prepared, and miscommunicated policy of measures to counter the pandemic. Government claims to be 'following the science' have been without foundation: Exercise Cygnus was ignored in 2017, public health principles are ignored through 2020 and 2021.
2. There has been a delay in recognising the gravity of the situation caused by a failure of leadership.
3. The deaths of 150,000 people, most of whom died needlessly, have been the result of incompetence; disrespect and arrogance prevented the government from meeting bereaved families. Timings of lockdowns and failure to put in place travel restrictions and quarantine contributed significantly to accelerating the spread of COVID.
4. There was ongoing failure to heed fundamental public health principles, largely developed in the UK, of responding to infectious disease outbreaks (find, test, track, isolate with support). The Covid virus for the foreseeable future cannot be eradicated.
5. This has been compounded by cuts to public services in the preceding decade that negatively impacted population health resilience before the pandemic. Underlying poor health and pre-existing inequalities left the UK vulnerable with England having the highest excess all-cause mortality rate among 23 European countries in the first five months of 2020. Also resulted in increased mortality and hospitalisations,

with these conditions being more common in deprived populations.

6. Failure to trust the public, treated as the problem rather than part of the solution.
7. Vaccines alone cannot be relied on globally: the UK relying on a single strategy of vaccines, and the vaccine nationalism that goes with this, is undermining an effective pandemic policy – in the UK and internationally – variants are being allowed to spread.
8. There is still time for a coherent policy of elimination (of community transmission of the virus) and efforts to achieve local/regional elimination as a necessary accompaniment to successful universal vaccination.
9. These measures would obviate the need to rely on nation-wide lockdown measures (as has been achieved in other countries – Australia is currently locking down areas where the Delta virus is spreading), damaging as they are to mental health, wellbeing and the economy.
10. The overwhelmingly unequal impact on the poor, the disabled, the Black, Asian and minority ethnic community and women is locked in to social and racial inequality, prejudice and economic disadvantage – these are strongly linked to the conditions of urban living.

Recommendation 1

That established public health measures, supported by the WHO and known to be effective in lowering everyday risks, be urgently implemented in the UK, including:

- a. Effective find, test, track, isolate services with economic support for isolation and quarantine.
- b. Based in local public health and local

authorities in liaison with an effective national public health system.

c. With effective protection against aerosol transmission by the wearing of masks and sensible social distancing in enclosed indoor spaces.

d. Employment of strict border measures for infection-control purposes.

Recommendation 2

That medium to long-term health policy addresses social inequality, including overcrowding, poor quality housing, food insecurity, investing in recovery that tackles the root causes of health inequalities including:

a. Integrating health considerations into future housing and urban development with healthy housing and equitable access to public spaces for safe physical activity for travel or leisure to build future resilience.

b. providing and regulating guidelines to ensure adequate ventilation in enclosed spaces, notably workspaces and schools.

Recommendation 3

That the UK fulfils its international obligations to prevent the spread of disease by ensuring global distribution of vaccines and support for technology transfer and IP waiver, and by the termination of vaccine nationalism.

Finding 2: Health of the population and a healthy economy

11. The NHS needed protecting because it has been appallingly run down.

12. A healthy economy depends on a healthy population. To present pandemic

measures as a choice between the economy and the health of the population was at best misguided, and at worse, a deliberate attempt to sow division between the public and private sectors.

13. The most disadvantaged fared worse – their fate sealed by those social determinants of health in major part outside of healthcare and marked by social inequality.

The NHS should not have been left so weakened

14. The inquiry heard how government policy that imposed savage reductions on the NHS, primary care, social care, and as you have heard, on public health, for over a decade in the name of austerity, led to a crippled health and social care system, in no state to cope with even the workload of normal times, let alone a pandemic. It is no wonder government adopted the slogan ‘protect the NHS’; the NHS is here to protect the people, yet the people protected the NHS, and many paid for this with their lives. The inquiry heard for example from Lobby Akinnola, whose healthy father died at home from COVID without ever being seen by, or speaking to a doctor, because he and his family followed government advice which was to only call NHS111; NHS111 is a triage system, not a healthcare professional; had Lobby’s father been seen by a doctor, and admitted to hospital, he might well be alive today. Is it any wonder those who gave us their personal testimonies were angry?

Invest now for the future

15. A pandemic was anticipated; it was what led to Exercise Cygnus. Yet government ignored the outcomes of its own exercise. Government let PPE stocks dwindle and degrade, and then denied there was a problem. At the very least this

calls for an apology, and a transparent resolution to ensure the nation is better prepared in the future. This was what the UK did when it was crippled by WWII – it invested for a better future.

Public services for public benefit: an NHS for all

16. There has been high praise for the NHS, yet this rings hollow, when the NHS is being systematically undermined by a growing private healthcare sector. A substantial parallel private healthcare sector leads to progressive erosion of public healthcare by cherry-picking the easy cases and the worried well, and poaching staff, and leaving the public sector to provide training, and the care of those with long-term and complex conditions. Instead of investing in the NHS, the pandemic has been used to underwrite the private healthcare sector with public funds; Captain Tom, the centenarian who walked his garden again and again for the NHS would have been appalled to know that the X million he raised was but a small proportion of the public funds squandered on a private sector that took resources away from the NHS and failed to deliver. These actions have left the public service even weaker and even less prepared for the next challenge.

The pandemic provides both rationale and opportunity to invest in the NHS and a public sector health and care service that could once again be the envy of the world; the UK did this in 1948 and can lead the world again now. This investment includes not only hospital beds, but the workforce, primary care, diagnostic labs, social care, and public health. We do not dismiss the private sector, but to promote it in favour of the public sector does the nation a huge disservice and weakens us for the future.

Finding 3: The NHS and its staff

17. There have been dire repercussions on a public health system and infrastructure severely under-resourced prior to the pandemic.

18. The failure to maintain the NHS and social care meant they went into the pandemic on their knees (political ideology went above public welfare, Exercise Cygnus was ignored, and this policy persists).

19. Staff have been faced with clinical situations where they were unable through no fault of their own to provide the standard of care they know is safe. Staff witnessing greater deaths and injury and being unable to respond meant they sustained what the Inquiry heard described as 'moral injury'.

20. The Inquiry heard that staff morale is in dangerous decline: in many cases exhausted staff are leaving or merely waiting for the chance to do so. This arises from long hours in dangerous conditions sustained over 16 months. Morale is further damaged by the derisory financial pay award below inflation.

21. What has become manifestly obvious to the panel is that both those who work within the service as well as the facilities have become exhausted and decimated by austerity policy predating the pandemic, by the overload of the pandemic itself and by a deliberate diversion of funds into the private sector.

22. As a result the NHS has become a fractured and fragmented public service in dire need of urgent, effective reinvestment and commitment to it from government to avoid the risk of impending collapse.

Recommendation 5

That it is possible, and urgent, to restore and grow NHS capacity and NHS staff morale with a statement of commitment to public services, backed up by urgent real terms restoration of level of funding to expand the NHS workforce and reinvigorate the publicly provided NHS and its workforce.

Finding 4: Funding of private sector at the expense of the NHS and public health

23. The UK public health infrastructure was side-lined because of an ideological fixation with the private sector despite obvious failures.

24. Procurement failed due to a culture of cronyism. There has been grotesque financial wastage, profiteering and unmonitored, even unlawful procurement. (Confirmed by NAO reports.)

25. The private route (e.g on PPE) has failed badly and cost lives. Restoration of NHS capacity must start immediately to achieve safe NHS care of all patients as soon as safely possible.

Recommendation 6

That the previously universally admired performance of the NHS can be restored if the Government ends its policy of bypassing and undermining public services in favour of contracts to the private sector on procurement and to provide clinical services for NHS patients in place of NHS provision.

Finding 5: Governance, transparency and accountability

26. The incompetence of government ministers (the catalogue of bad decisions, dishonesty and cronyism) – Matt Hancock undeclared shares,* contracts for contacts,** circumstances of his resignation.

27. Centralisation of decision-making has been a failure – PPE procurement and distribution; public health policy of testing, contact tracing and isolation; block procurement of private hospital capacity; public health population measures including lockdown.

28. The prevailing needs expressed by citizens in terms of principle are:

- a. Basic unvarnished truth and transparency by those responsible for policy: the public duty of candour.
- b. An unreserved acceptance of responsibility.
- c. Effective accountability entailing removal and potential prosecution, especially where there have been clear violations of the fundamental human rights enshrined by articles 2/3/6/8 of the ECHR or grossly negligent acts or omissions by government or its agencies or where unlawful activity linked to the pandemic has been determined by the courts or by Select Committee of the House of Commons.
- d. Apology and compensation where death, injury or loss of livelihood have ensued from unlawful activities.

* Matt Hancock owns shares in NHS-approved firm. BBC News. 16 April 2021 (accessed 18 Nov 2021) <https://www.bbc.co.uk/news/uk-politics-56768601>

** Damning emails that prove Matt Hancock misled the public about his friend's Covid contract. Daily Mail online. 27 June 2021 (accessed 18 Nov 2021) <https://www.dailymail.co.uk/news/article-9728949/The-damning-emails-prove-Matt-Hancock-misled-public-friends-Covid-contract.html>

Finding 6: Public judicial inquiry

Our prime finding, from the evidence we have heard from the public behaviour of politicians handling the pandemic, is that from the start it has been and continues to be a government unfit for the purpose of safeguarding the health of the nation.

For four months the People's Inquiry has steadfastly ensured that the voices of the bereaved, the experts and the citizens on the frontline have been heard, recorded and acknowledged. For four months we have done the job declined by the prime minister and which he has no real intention of carrying out when it matters most – which is right now – not when it is politically convenient for him some years in the future.

This stark dereliction of public duty is compounded by a serious democratic deficit in which there is no effective challenge within the parliamentary system, nor respect shown by government to accountability at law. Even when caught on camera it is brushed off until the individual at the heart of handling the pandemic finally capitulates when faced with the extraordinary catalogue of malpractice and untrammelled abuse of power linked to the pandemic.

Recommendation 7

An independent public Judicial Inquiry is needed NOW. This has been accomplished in the past and can be repeated.

Its object would be twofold:

1. to reinstate and reinforce the fading principles upon which our society is based – duty of candour; transparency; acceptance of responsibility; accountability; and trust; by establishing the truth about the advent,

preparation, advice, decision-making and spread of the virus

and

2. to examine and re-evaluate the policies best suited to combating this pandemic in its current phase and in the future, the underlying causes, combined with its disproportionate impact upon the vulnerable, those in impoverished circumstances are often those most exposed to risk.

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FURTHER INFORMATION

The full version of the report, including detailed accounts of all the sessions and more, is available at:

www.peoplescovidinquiry.com

Summaries, witness statements and supporting evidence are available session by session at:

www.peoplescovidinquiry.com/join-our-sessions

Further evidence in the public domain is collected at:

www.peoplescovidinquiry.com/evidence

Media coverage of the inquiry is available at: www.peoplescovidinquiry.com/press

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THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place fortnightly from 24 February-16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

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