HOUSE OF COMMONS

Defence Committee

Oral evidence: Defence contribution to the UK's pandemic response, HC 357

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Watch the meeting

Members present: Mr Tobias Ellwood (Chair); Stuart Anderson; Sarah Atherton; Martin Docherty-Hughes; Richard Drax; Mr Mark Francois; Mr Kevan Jones; Mrs Emma Lewell-Buck; John Spellar; Derek Twigg.

Questions 1-42

Witnesses

I: Professor David Alexander, University College London; Dr Jennifer Cole, Royal Holloway University of London; and Bruce Mann CB.

Examination of witnesses

Witnesses: Professor David Alexander, Dr Jennifer Cole and Bruce Mann.

Chair: Welcome to this Defence Committee hearing. Today we are considering defence's contribution to the UK's pandemic response. We will explore, with three experts, the role and contribution of the Ministry of Defence in responding to the crisis and to other contingencies, but with specific reference to the current pandemic.

We will cover four themes: first, the UK defence preparations for any pandemic outbreak; secondly, how the Government and the MoD have adapted their plans in response to covid-19; thirdly, the contribution of the MoD and the Armed Forces during the pandemic crisis; and finally, what lessons should be learned from the Armed Forces' role in responding to covid-19.

We are joined today by three witnesses: Professor David Alexander, professor of risk and disaster reduction at University College London; Dr Jennifer Cole, a research fellow in anti-microbial resistance and Associate Fellow in Resilience and Emergency Management at the Royal United Services Institute; and Bruce Mann, who has held a number of senior roles in the MoD and the Cabinet, including director of the Civil Contingencies Secretariat. Ladies and gentlemen, thank you very much for your time today.

I will press straight on and invite John Spellar to open up the questions.

Q1 **John Spellar:** Thank you, Chair, and I apologise to our witnesses if I disappear before the end of the hearing. *[Interruption.]* I am not sure what is happening, but we seem to be getting feedback.

Chair: We can hear you fine, so keep going.

John Spellar: Okay. I am due to attend a debate in the House of Commons shortly, so I might have to disappear.

To kick off, a pandemic—not a specific pandemic; just a pandemic—features quite highly on the national risk register. Did our preparedness match up to that ranking?

Bruce Mann: I would like to be precise about this, if you will forgive me. There are two international risk registers that relate to infectious diseases. One of those relates to a pandemic, which is an influenza pandemic. If it helps, I can run through all the preparations on pandemic preparedness made in my time during the late 2000s.

We had the swine flu pandemic in 2009, of course. Lessons were identified and reviewed after that by Dame Deirdre Hine. There is a wealth of material there, and there is the global health security index, which is some kind of international validation. Swine flu is one infectious disease on which—certainly in 2010, when I retired from the civil contingencies orb—

Dame Deirdre Hine found that the preparations were effective, and the UK was quite highly rated on the global health security index. I am afraid that I do not know what happened after 2010, as I moved on to other things.

The second thing on the national risk register is an emerging infectious disease outbreak that the national risk register assesses as being of medium impact and affecting potentially several thousand people but, by implication, with relatively fewer fatalities. I would fundamentally distinguish preparation for an influenza pandemic from preparation for an epidemic involving a novel human infectious disease such as the coronavirus. I am sorry to split hairs on that, but it is worth distinguishing them at the outset.

On the subject of preparations for what we have experienced—the coronavirus—there are an immense number of lessons to be learned. Ministers have commented publicly in some areas where there are lessons to be learned. We are looking at the national risk register. The Committee might want to look at the national risk assessment, which is the classified document underneath that. That has a medium-scale outbreak on the rather miserabilist scale of catastrophe that is the risk register. That is much less than what was experienced by the UK and all other nations around the globe.

In my view, there are questions about risk assessment, there are probably questions about preparedness, and there are probably questions about attitudes and expectations of Ministers and senior officials going in as to how bad it might be. For me, everything starts from the national risk register.

Q2 **Chair:** Jennifer, do you want to add to that?

Dr Jennifer Cole: There are a couple of points that I would add—by all means, Bruce, please come back on this after. When the first public iteration of the risk register came out, the threats and hazards were on the same risk register; there was a single register for man-made disasters and natural disasters. Again, pandemic influenza was at the top. They were then split into two, so that the threats and hazards were separate. Once that split came, there was a lack of funding and a lack of resources for the non-man-made threats.

Although on paper there were a lot of policies and a lot of preparedness for pandemics, it hit the resources that were available to run exercises at local authority level within different agencies. It was not seen as a sexy, James Bond movie threat anymore, and it took the eye of the ball a little bit.

Part of that is because, whatever money and resources have been available for preparedness, it has always been played down on the non-man-made threat side; it has always been the first thing to be cut. We see that with Operation Cygnus, which was massively scaled down from what was originally planned. It has been very difficult for organisations to plan

in the way they need to. That also prevents some of the cross-Whitehall planning.

An influenza pandemic or a novel disease outbreak was never just about the medical response; it was always going to be about the supply chains and the schools, and about how we would support vulnerable members of the community. Again, those are not necessarily military planning assumptions, and neither are they planning assumptions that any other organisation has a responsibility for, so they are the things that easily fall through the gaps when you are putting those preparedness plans into action and looking at who is responsible for them.

I am loth to say it is a lesson identified, because I do not think it is one that we were unaware of or that would have taken anybody who has a history of working in emergency planning by surprise. But if we can put those back at the top of the agenda, that would certainly be a good outcome from this.

Q3 **John Spellar:** But why do you think that was? In the past it was recognised that a pandemic would arrive at some stage. In fact, going back 20-odd years, the assumption was that it was actually a bit delayed. How did it manage to fall off the agenda? You said that nobody has responsibility, but surely it is ultimately the Cabinet Office's responsibility to pull those together.

Dr Jennifer Cole: It is the Cabinet Office's responsibility—again, please correct me if I am wrong, Bruce—to advise and to come up with the plans and the policy. Who is actually responsible for making sure that those are regularly exercised and implementable? It is still a very grey area. In terms of the resources not being there, it is to do with public sector cuts in general. When everything is cut back, your priority is on what is in front of your face. We have seen periods, particularly around programmes such as New Dimensions, where a lot of PPE that would have been useful for this would have been stockpiled and gradually dropped out of being stockpiled, because the money and the resources are not there anymore. There are general issues with public sector cuts that tie into this.

To be perfectly honest, I think swine flu was almost seen as crying wolf. At the time that swine flu hit we had been, as you said, overdue for an epidemic. Here it came, and it was a little bit of a sniffle—it was almost seen as a joke. Even the World Health Organisation's messaging on that did not do any favours in preparing us for a much more serious one a few years later.

Looking at how you hit the public messaging is actually quite interesting. This was very serious—swine flu was a huge issue for the NHS and for the intensive care beds—but actually, for the majority of the people on the street, it was seen as crying wolf and as a bit of a fuss over nothing. Then, 10 years later, the real deal comes along and people remember swine flu.

It is quite interesting to look at the behavioural messaging and at how swine flu played into that, because the World Health Organisation was

lambasted for taking everything too seriously, and for scaring people and frightening the world over nothing. There are some real lessons to be learned about how we handle this.

Having said that, I think that the Government have handled the messaging on this incredibly well, hitting the sweet spot between getting people to take it seriously and not panicking them enough that they switch off to the messages. I think that has been excellently handled.

Bruce Mann: If I can just add to Jennifer's point, I am going to agree with Mr Spellar. We deliberately took the attitude in the period 2005 to 2009, when we put preparedness plans in place for an influenza pandemic, that it was a whole-of-society approach. That was the health sector, the economy, the banking system, the central services, the voluntary sector; it had to cover all aspects of society. While the Department of Health, as it then was, was in the lead of a very large part of the response, we shared that leadership jointly with the Department of Health, putting the weight of the Cabinet Office—picking up Mr Spellar's point—behind the Department of Health but also into areas that the Department of Health genuinely could not reach, such as the banking sector, essential services and so on. So I agree with Mr Spellar's point: there has to be joint activity for dealing with emergencies, as the impacts and consequences go across all aspects of society.

Professor David Alexander: The question was, "Was the UK adequately prepared for the pandemic?" In my view, it was not. Pandemic planning simply came out of the previous SARS pandemic of 2002 to 2004, in which 8,000 people were infected in 29 countries and 777 died. That was stopped by concerted international action, among other things. However, over the period from 2003 to 2009, a series of scientific and social scientific papers were written that essentially defined the scenario. I first heard it in 2008 and by then it was very detailed.

Since then, once a year I have been teaching it to my students. I am amazed to find how similar the real event, when it arrived in 2020, is to what I have been teaching, and not because I am particularly brilliant, but simply because this was a well-known scenario that had been widely shared. I heard it from an epidemiologist who gave a talk and started it by saying "It is my job to tell you something you don't want to know and ask you to spend money you haven't got on something you don't think will occur." Essentially, that was it.

However, let us remember that there were three important exercises—Common Ground, Winter Willow and Cygnus—and they all came up with very clear recommendations about what needed to be done. I think a lot of planning went on between 2005 and 2013. Thereafter—this is the sensation I get, but I cannot really verify it—the planning was overshadowed by the need to plan counter-terrorism and, latterly, the need to plan for the risk of a supply-chain failure associated with Brexit, the result of which was that pandemic planning took a back seat.

However, there is also a substantial gap between planning and the implementation of plans, and that gap became very large. Actually, pandemics in the public version of the risk register have consistently been in the top right-hand corner of the diagram, which means they are the most likely risk and would have the greatest consequences. It was very well known in the 2000s that the consequences of a pandemic would be at least as great in the socioeconomic field as they would be in the political field and *[Inaudible.]*

Chair: David, can I ask you to pause there? Mark Francois, can you press mute? Sorry, David. Carry on.

Professor David Alexander: The socioeconomic consequences were known well enough. One question that remains is the difference between a SARS-type pandemic and an influenza pandemic. I really shouldn't say anything about that because I am not an epidemiologist, but I think that in emergency management terms it does not matter a great deal. The decision makers in emergency planning and management require information from the health, medical and epidemiological community. Very often what they require are extremely simple answers. Of course, we do not have extremely simple answers. The answer, instead of yes or no, is usually "maybe", or "We will see when we have the data." Nevertheless, we have to go ahead in making decisions on the basis of pretty simple pieces of epidemiological information, even though what is behind them is tremendously complex. But I think we accept that we knew what we had to do by 2010.

Q4 **John Spellar:** Thank you. Interestingly enough, you mentioned the possible impact of Brexit planning, particularly looking at supply chains. Is the view of your colleagues that that started to supersede everything else at that time and basically used up all the available bandwidth?

Professor David Alexander: Yes. I have had conversations with a number of emergency managers who have told me that. By the way, they have also told me that if a second wave comes, at present they are absolutely exhausted and so are their resources, and that perhaps is rather worrying.

Returning to Brexit, they were essentially putting all of their efforts into Brexit. There were many other things that needed to be done, but they did not have the time or capacity to deal with them. Everything else had to be paused while they dealt with the need to plan for everything, such as the UK coffee supply. There is a coffee economy that has 24 hours of autonomy. The coffee supply has to be ensured. Apply that to many different things, from medicines to meat and goodness knows what else. That is what they were dealing with daily in a fairly frantic manner, they told me.

Q5 **John Spellar:** Bruce, do you have any comments on that from your experience?

Bruce Mann: Not really, as I was out of Government by then. I am afraid that I have no strong view—only what I read in the newspapers, which I do not think is safe enough to go on.

Q6 **John Spellar:** If I can come back to all three of you. Okay, they were having to deal with one crisis, but is it basically the case that they did not have the methodology, or indeed had not been doing the effective exercising to ensure that they were ready to go when a pandemic, which you agree had been anticipated, struck?

Bruce Mann: Best practice is ideally to have a plan that is relevant to the threat you face. Although there were influenza pandemic plans, I would have said that there ought ideally to have been a plan that was of the necessary scale, involving the right people—we will come back to that, I am sure—to deal with a novel infectious disease.

If I may pick up Professor Alexander's point, I think the distinguishing difference is that we know influenza; mankind has been fighting it for over 100 years. We have drugs, medical procedures and the basic science. Those are not necessarily there for dealing with a novel infectious disease such coronavirus.

I completely understand what David says about all of that being known by 2010, but some of the defences that would otherwise have been there for influenza—like antiviral treatments and so on—are not there for coronavirus. Therefore, anybody engaged in the emergency response is starting from a weaker position—starting on the back foot—because some of the mitigation measures are not there and therefore the plan has to start on that basis too. That would be the test I would raise, together with the national risk register. If it is shown in the national risk assessment that the expectation in the Government was that this would be an outbreak of several thousand people with a relatively low number of fatalities—again a point that would need to be checked—that would have influenced thinking, picking up on Jennifer's point, in the very early days of the disease.

John Spellar: Thank you very much and thank you, Chairman. I am afraid I now have to go to the main Chamber.

Chair: Okay. Thank you. If we can now turn to some of the operations that the MoD have performed in connection with civil society. Sarah Atherton, do you want to take us forward on this one?

Q7 **Sarah Atherton:** Thank you, Chair. Good afternoon all. The Civil Contingencies Act places no statutory responsibility on the MoD to plan and prepare for civil emergencies, but the military have been utilised in crises such as foot and mouth. What lessons did we draw from previous military involvement in civil crises for today's pandemic?

Professor David Alexander: If you look at the very broad picture, and perhaps I am being a little too academic, I believe that there is a process of civilianisation of emergency management, which has gone on at

different paces in different countries, but it is a process that needs to go on and that is necessary to manage the modern emergency.

I also think it is somewhat necessary to get out of the military way of thinking in managing emergencies. The countries that cope best are those that do so, providing that they then put in place an adequate structure for managing things in a civilian manner.

What I want to avoid at all costs is coming over as anti-military. I spent a year of my life teaching at a military university and it was one of the best experiences of my career. I have got tremendous affection and respect for the military. I often find, though, that military commanders when I talk to them about these issues say that they would really rather deal with defence matters because that is what they are really there for, and with the slimming down of modern militaries, they find themselves easily overstretched when they have to do big things on a civilian front.

Whereas 50, 60, 70 or 100 years ago, the only forces in the field in many places would be military ones, what we really need to do is build up the civilian forces and civilian mechanisms, planning and management structures at all levels from local to national, and in so doing involve the population in that. One of the great lessons that must be learned from this pandemic is the need to involve people better. The countries that have coped best seem to be those where there has been the best form of disciplined involvement of the population in a civilian exercise to get this whole thing under control.

I would not wish to minimise the military's capabilities and the absolutely marvellous work they can do in terms of, for example, setting up field hospitals and transportation. Very necessarily, the Oslo agreements on these things say that in humanitarian actions, military forces should be under civilian control. That is an agreement signed by many countries and also upgraded afterwards and renewed.

I think, though, that civil protection in this country needs a fillip; it needs to be pushed forward and improved. I recall that in London a year or two before this, there was a big initiative that was then somewhat stifled by the Brexit problem that put everything on a back burner, to get together civil organisations, faith-based organisations and volunteer organisations. Britain is not a country where civil protection volunteerism is well developed. I am speaking to you from Italy—I am a dual national with Italian and British citizenship. In Italy, there are 3,600 volunteer organisations, and 36 federated nationally. In the last four major disasters, they have put more volunteers into the field than the local population. It is a tradition that goes back 776 years, and it connects people with the system very well.

In Britain, we need better ways of connecting people with the system, especially when you are requiring people to do things, and when one of the ways to tackle the pandemic is to get the prevention, control, testing, tracing and so on into the community. The further civilianisation of emergency management will help that. It will also help with the process of

making this more inclusive ethnically, gender-wise, age-wise and in other respects.

Q8 **Sarah Atherton:** Thank you, David. Can I ask the same question to Jennifer and Bruce?

Dr Jennifer Cole: I will go first. I refer you back to some work that we did at RUSI, going back to about 2010, called "Defence without an enemy". It looked at what we needed to think about in terms of our Armed Forces, going into a century where the major threats were likely not to come from state actors invading your borders, but more likely to come from severe weather and emerging diseases. What that meant, in terms of defending your country against those threats, was getting out of a military mindset that looks for enemies, and having a whole-of-society response. What we had lost from some of the civil defence from the cold war planning—it disappeared and did not really go anywhere else.

Definitely in there is a way that we think about things. What are we actually looking to do? Are we looking outwards at where the threat has come from—we have seen the dangers of that in the US response to this—rather than looking at how we band together and strengthen society internally against the issues that it is causing? Within that, as David mentioned, is the need for a volunteer organisation—a volunteer force—that is ready at a society level to step into that.

Bruce, you commissioned RUSI to do work on community resilience back in about 2008. We did a comparison of some international models, and one of the things that we found was that the countries that responded best to strategic shocks, whether they were large terrorist attacks or flooding events, were the ones that regularly had to deal with small events.

The two exemplar case studies were the Chinese earthquake response, which went down to literally having an earthquake warden on every street who people knew to look to as the person who knew what to do if the ground started to shake; and the hurricane states in the US, when it went down to a very local level in the rural communities. That trained people and prepared them. It meant that they knew what they needed to keep in their homes to survive for two weeks. That is one of the things that we realised was not in place here. We say panic buying very loosely, but people were told to go and stock up for two weeks and they did, and then everybody seemed to be surprised that that had emptied supermarkets.

That brings with it a lot of additional skills that are needed. For instance, in the hurricane states in the US, one of the things they did is train people to be insurance company enumerators who could go around, assess damage and report it back to insurance companies so that insurance claims got settled more quickly. It meant that they knew where the vulnerable people were. They knew where the very elderly who lived alone were. They knew where people with mobility difficulties who could not get to shelter very easily lived. They knew where homeless people were.

That very localised ability to understand and know your community, and be able to operate in your community and talk to the people within it, is very important. We don't have that in the UK. We have some organisations. The voluntary organisations are largely populated either by retired people—they do a good job, but there is also a need for people in their 20s and 30s to be part of that—or by people who add expertise at the weekend to their day job during the week. Therefore, when something like this happens, they are likely to be completely overworked and overburdened during their day job. Just at the time that their surge capacity is needed, it is potentially less available. Those are two things that we need to look at very carefully.

One of the challenges with that has always been that, if you have that body of people in place, how do you keep them interested, busy and on board in the times when not a lot is happening? The model I would look to on that is particularly Israel. Its ambulance service is largely staffed by volunteers at a ratio of about 10:1 professional ambulance staff to volunteer first aiders. The volunteer first aiders do three or four hours a week each, but if you need 10 times as many of them, they can all do their four hours at the same time.

Looking at how to scale up in those kinds of responses is very valuable. I have a slide that I sometimes give in emergency planning lectures of military first aiders helping out. The reason I use it is because the person who is most prominent in that slide is a military reserve, a St John's Ambulance trainer, and an ambulance paramedic in his day job. On paper, that can sometimes look as if you have three separate people—three separate lots of resources—but in fact you don't, you have one.

Conversely, as we civilianise some of the emergency planning, we rely more and more on that civilian expertise and so we lose our redundancy, so that is a very delicate balance to consider. As we scale down the military and rely more on the reserves, those reserves have other jobs as well. Quite often, the expertise they are lending to the military is expertise that may be needed in twice its capacity during these times of crisis.

How you recruit, finance and train and how you keep such a force active and up to date is a clear issue, but I think the kind of things we are likely to face in the 21st century are likely to mean that they are needed more and more often and therefore keeping them engaged in between one crisis and the next may not be the problem it has been at times in the past.

Q9 **Sarah Atherton:** Thank you. Bruce, would you like to comment?

Bruce Mann: David, I saw your hand go up. Did you want to come back on what Jennifer has just said?

Professor David Alexander: Only very briefly, thank you. In the town that I am in here, the volunteer ambulance service was founded in 1535. It is absolutely rock solid, and it is also very modern. The point about it is that there is a culture of civil protection that connects the people with the

system to the point that the system is the people and I think that is very effective.

Q10 **Sarah Atherton:** Bruce, would you concur?

Bruce Mann: Yes, of course. I think there are two parts to the answer to this question, which are under the umbrella of "the whole of society", the phrase we keep coming back to, especially for the major emergencies, which are a whole-of-society effort.

Starting with the military, we may or may not come back to the point you raised at the beginning about responsibilities in law which are on some bodies but not on others. I would be happy to come back to that. On the role of the military and the lessons learned, I think what we tend to see in this country is a bit groundhog day—a bit rinse and repeat. We keep hearing the same things. Foot and mouth was a classic example, I will give a couple of others. There were perhaps weaknesses in risk assessment, but there were certainly weaknesses in preparedness in the Ministry of Agriculture of the day. There was insufficient capacity and capability which meant the military had to be called in to bail out, as it were, civilian Government organisation.

Similarly, if I take a couple of examples from my experience in the summer floods of 2007, you may remember that water supply was lost to some parts of south-west England, which was a weakness in risk assessment and preparedness. The particular water pumping station was not prepared for major flooding, despite being next to a major river, which meant that the military had to be brought in to help the civil authorities deal with an emergency.

Similarly, overnight we asked the military to build a defensive barrier around a switching station near Gloucester which, had it been lost, would have meant that power was lost to many hundreds of thousands of people in south Wales and the south-west for a very long time. Again, that was a very short-notice request. Based on a failure of risk assessment, the switching station was built on a flood plain and did not have adequate defences.

As I say, what we tend to see at the moment is a repetitive cycle of weaknesses in risk assessment, weaknesses in preparedness, meaning short-notice calls to the military, especially, to come in and bail out the civil authorities. So we made it one of our objectives, very fundamentally, and here I absolutely agree with David, that it is not a respectable position for the public authorities not to be sufficiently prepared. You can call that civilianisation of emergency planning if you want. I would say that if civil authorities have a responsibility in the emergency preparedness field, they must fulfil it, and calling in the military in that way—in a way that is not pre-planned—is a sign of failure.

It is a deeper sign of failure that worries me: if there are those weaknesses that we have described, there are also weaknesses in taking prevention action to try to prevent the risk from arising in the first place.

That switching station was built on a flood plain and did not have adequate defences. The water pumping station that I described had all its electricity circuits and everything else, all its major control systems, where they could be flooded if the river it sat alongside flooded. I just give those as examples. So actually, in risk management terms, the issue is not only the weakness in the response phase, but the weakness in prevention, which stops the risk arising in the first place so that you don't need the heroics.

Where we have drawn on the military in my time—I can reel off a dozen examples—has tended to be in three areas. The first is organisational capacity and capability, at which the military are brilliant. They are organised, disciplined and innovative people. If there is a problem to be fixed, they are absolutely brilliant at fixing that problem. That's the first point.

The second is that they have assets. They have fewer assets than most people think, but they have airfields, bases, trucks and skills. Of course, we drew on Aldermaston after the Litvinenko poisoning, Porton Down after the Skripal incident, and so on. So there is a wide range of capabilities that can be drawn on.

The third point is that they are a ready source, in an emergency, of just ordinary people capacity. There were 1,000 people to build a defensive wall around the switching station. I don't know how many thousand people there were to distribute water from Cheltenham racecourse around the south-west of England.

Those are the areas in which we have tended to use the military—we might pick up on them in later debate—and in all three areas they absolutely excel.

I am going to pick up on the point about community resilience, because I fundamentally believe in it. I took over in the Civil Contingencies Secretariat in 2004. Government bodies were not good enough, at that time, at fulfilling their emergency management responsibilities. The Civil Contingencies Act and the programmes we put in place aimed to improve that. But we realised in about 2007, especially with the major flooding, foot and mouth and so on that we saw then, the need for a whole-of-society effort and, in particular, that not only could not just the voluntary sector but communities, individual households and families play their part, but Government had a responsibility to help them to play their part and a responsibility to business to help business to prepare.

So we launched two things. The first was the national risk register, to try to give the public some view of what we were seeing in a secret document—some view that would help them to prepare and would help businesses, of course. The second, as Jennifer has said, was the community resilience—that is the name we use in the UK—initiative, to try to help and give some Government support to communities who wanted to prepare for themselves; that was usually passed through local authorities.

I absolutely agree with David Alexander and Jennifer that, in a whole-of-society approach, getting the community engaged is fundamental and has to go beyond the voluntary sector. The community resilience initiative is now actually an international initiative. There is a group of countries that have joined together to take that work forward, and Italy is one of the leading members. All that is great. Has it gone far enough inside the UK? Absolutely not. Should it be—*[Inaudible.]* Yes.

Chair: Thank you. We have got two people that want to come in here. First, Martin Docherty-Hughes, and then Mark Francois.

Q11 **Martin Docherty-Hughes:** I have got to admit I was really taken by David's comment about the people, because I don't know about the rest of the Committee but sitting here in Scotland—because this is the Defence Committee of the United Kingdom of Great Britain and Northern Ireland—we have not had a death in six days linked to covid-19. We have also had community resilience in place—there was legislation back in the early 2000s. I am not saying it is perfect but what type of bail-out of civil societies or civil governance are we talking about here? I have not seen the military having to be used for the type of work that is being done for example in floods in the south-east of England. There was some activity in the borders last year but some of the stuff you see is due to cuts, as I believe Jennifer alluded to earlier, in terms of civil support, so you can't say that civil society or civil authorities have to step up to the plate just because of legislation. Surely they need to be invested in as well.

Chair: We do need to make some progress so, Jennifer, if you want to quickly come back in—then Mark to follow.

Dr Jennifer Cole: I would say one thing is for those groups who want to be supported, from what I remember the set-up in Scotland was very good. I remember in particular Shuna Mayes in the Scottish Government was a real champion of this and a real champion of that kind of community engagement, which I do think makes a difference. I think also in Scotland—obviously not all parts of it; I am generalising: the more remote parts of Scotland, who kind of know they are on their own, are more incentivised to have those community structures in place. It would be interesting to see the difference between some of the more remote rural areas and the cities in that regard, as to how it was dealt with.

I think the big issue is, and particularly for the devolved Administrations—and obviously we are seeing quite a different picture in Wales—actually these need to be very local responses. It is looking at what works well for your locality. One of the things we found from the international comparisons is that a lot of the groups who made you think, "These are great examples of citizen engagement; they are really get-up-and-go"—the motivation was that actually they thought they were too far away from the administrative centres for anybody to care about them. They thought if there was a shortage of resources they would be bottom of the list, and therefore they organised themselves against that. So I think sometimes it is looking at what will motivate the communities, and how you help

support them through that motivation, rather than a very top-down approach of telling them what they ought to do.

Chair: Thank you. There are lots of detailed questions—all good stuff—but we have got lots of things we still want to get on to and we are approaching halfway already. Mark Francois, over to you.

Q12 **Mr Francois:** Thank you, Chairman. Just a quick question in principle. I want to challenge a statement made a few minutes ago when we were told that really the civilian authorities should be able to cover all of these contingencies rather than have to involve the military. If the military have a capability that can assist the civilian authorities, as they clearly did, why should it be a civilian monopoly? In other words, why should the taxpayer spend the same money twice?

Professor David Alexander: The UK influenza pandemic preparedness strategy of 2011 says, "Where civil capability or capacity to provide an essential service is exceeded due to a pandemic, and if all other options to provide it have been exhausted, then the Ministry of Defence… would attempt to provide assistance through the normal processes, if it has suitable resources available." I think, however, that first we have to ask does it have suitable resources, and is it right that they be used.

I remember speaking to a military liaison officer for Wales about halfway through a recent year and he said that they had done 109 civilian operations at that point, and it struck me as being rather a lot. Some of these are simple hire-a-helicopter-type operations. Perhaps the helicopters should not be hired by the civilian authorities to do civilian things from the military, when they are military helicopters to do military things.

In terms of voluntarism, the question would be to what extent can the military prop-up of the civilian organisations be replaced by voluntarism, perhaps. There are three types of voluntarism: spontaneous, organised and incorporated. Spontaneous simply means people who want to help, and we have seen huge demonstrations of that, with very large numbers of people plus organisations informally springing up all over the country to do things like deliver *[Inaudible]* or whatever.

Organised voluntarism means training and equipment. Incorporated means that the organised voluntarism is part of the system and, therefore, it interacts in a programmed way, possibly governed by law. For example, voluntarism in Italy—

Q13 **Mr Francois:** Sorry, but we are quite tight for time. This was civilian led. We followed the advice of Public Health England, including when they told us to scale back testing, when nearly every other country was scaling up testing. We have third highest death rate in the world, so the civilian-led response has not exactly covered itself in glory, has it?

Professor David Alexander: No, but the answer is not to use a military response instead—that could have been considerably worse, in my opinion.

Chair: Okay. We will move on, but the concern is that the skillsets that were touched on before—the organisational capabilities and the strategic thinking—are not utilised enough. I think where Mark was heading with this is that the one Department that is trained to think over the horizon and to work out what to do in an emergency is the MoD. We saw many of the decisions made eventually that, I believe, the strategic thinkers could have got to far faster. There seems to be a stigma attached—I saw it in my local authority, not bringing in the Army, not putting their hand up to say, "I need the military"—because that is a sign of failure. We need to make progress. Stuart, will you take us on—quite nicely—to the National Security Council and the structures behind all this?

Q14 **Stuart Anderson:** This question is to all three of you, but I would like Bruce to open on it, because you touched on it earlier with having the right people involved. I want to take it one level higher and talk about having the right bodies involved. Were you surprised at the lack of involvement, throughout the pandemic, of the National Security Council, as the crisis developed, or was COBRA the right body for this?

Bruce Mann: Let me take those in turn. First, I only know about the involvement of the National Security Council from what I read, especially what Lord Peter Ricketts said—I am going off that. I would be very candid about the limited degree to which the National Security Council looked at civil contingencies even in the years before the pandemic happened. That was very disappointing. A point that we might come back to is why civil contingencies drop down people's radar screens when there are no crises.

In terms of what people label COBRA, it is a room in a facility but, in answer to your question, it is important to zero in on the people, whether they are competent, trained and have the right aptitudes. Here I will agree with Mr Francois, which maybe we will come back to—are they the right people? Are they the right nature of people, do they have the right training, do they have the right skills, do they have the right aptitudes? I would say that, having spent a lot of my career in the Ministry of Defence, but I believe that very firmly.

Secondly, there is governance—the crisis co-ordination or whatever, that links all of those things together. There may be lessons to be learned about the rooms and facilities, perhaps with benefit, but I think that the lesson to be learned—moving back to the previous question, as the Chair said—is whether the people who are around that table have the competencies, aptitudes and training to manage that crisis, whether that is in COBRA or wherever it is.

There are also those further down the chain, remembering that it is not just what happens at the strategic level; it is what happens in the Department of Health and Social Care or in PHE—all of those organisations in a crisis need the people who have the competence and attitudes to be able to manage a crisis. I know you are disagreeing with David Alexander here, but that is where I think there are strong lessons to be learned from drawing on defence people and defence techniques.

Q15 **Stuart Anderson:** Thank you, Bruce. I would concur. David, I would be interested to hear your views. I disagreed with your previous comments that if the military had been involved earlier then the death toll or the outcome would have been worse. Can you expand on the question I just asked, and link it into what you just said before?

Professor David Alexander: Perhaps I should not have said it in that way. I think that we could have done more to create a better system in the 2010s and 2020s, which we are now in, to improve civilian emergency management. There is a fundamental difference between military emergency management and civilian emergency management. It is important to get out of the military way of thinking in emergency management. I have seen examples of how that has been counterproductive, despite the fact that military thinkers are obviously capable of thinking very well indeed, in strategic terms.

That does not mean that civilian thinkers are not capable of doing that as well, if they are adequately trained and ready for it. It happens very well in other countries. I don't see why civilian civil protection needs will necessarily grow out of military origins. In fact, they can grow out of trained inclusiveness and utilising the knowledge that we have of emergencies and how to manage them, that comes from various international sources.

Q16 **Stuart Anderson:** Thank you very much. Jennifer, I would love to hear your view, but I will look to the Chair, because I am conscious that we need to move on with time. Have we got time for Jennifer, Chair?

Chair: A quick word, Jennifer, if you want. You don't have to answer every time. We have lots of other questions that we need to plug on with.

Dr Jennifer Cole: I will just make one point. That strategic planning capability and strategic thinking are clearly needed in this kind of emergency. Rather than asking if the military are the best people to provide it, the question I would ask is, why isn't there anywhere else that can provide it? The military is not necessarily the best organisation for it to sit with. That does not mean that at the moment it is not the military that have the people who are most capable, but I would question whether the military is the best place that that capability should sit.

Q17 **Chair:** That is the fundamental question that we are struggling with at the moment. Behind Lord Deighton, who did *[Inaudible]* is a massive military capability, but nobody actually sees that. Why? Because their *[Inaudible]* is thinking outside the box, and very quickly.

That is the balance between policy makers: we have policy makers doing delivery and operations. The fundamental question that we are asking ourselves is should there be a better delineation between those who set the policy and those who do it? That has led to what Mark Francois was hinting at. There was poor decision making of getting stuff done, which is why we *[Inaudible]*.

We need to press on. Richard Drax, do you want to take the conversation forward with the next question, to do with integrated thinking.

Q18 **Richard Drax:** I would be interested to hear from all three witnesses and thank you for coming this afternoon. Could Bruce reply first, when I have asked my question? Is the MoD sufficiently integrated with Whitehall and wider emergency planning, and was it inevitable that defence resources would be needed? Are the civil agencies simply unprepared?

Bruce Mann: Two or three points on that, very quickly then. The answer is sort of yes and sort of no, with a tendency towards no, I would hope. I try to work for greater integration but, in the event, we weren't successful.

As has been raised before in this debate, in the Civil Contingencies Act 2004 we were able to place legal duties on a whole range of public sector bodies, to take emergency preparedness seriously. We even had the voluntary sector covered in that. What we did not cover were Government Departments and the Armed Forces. What is underneath that is considerations that were very significant at the time, and are probably still so, which are accentuated threefold or fourfold.

First, although the military defence has a wide range of capabilities, at the time when we were looking at it in taking forward the Bill, the point was made to us very firmly that the military was heavily committed in Afghanistan, Iraq and elsewhere. David read out some language, roughly in the same space, which was that they could not guarantee that they would be available at the time. They would do best efforts, but they could not guarantee that they would be available at the time. Therefore, we walked away from the legal mechanisms of integration involving the Armed Forces that we placed on a whole range of other authorities. That is the first point.

The second point is that we did say that they must none the less be integrated in Whitehall planning and in planning at a local level—in the local and regional resilience forums that we had for a while. I have to say that the armed forces—usually the local brigadier—have usually, in my researches, been absolutely punctilious about doing that. So in terms of *[Inaudible]* planning and being around the table when there is an emergency, they are there and they are punctilious about being there.

The real difficulty with integration is actually at ground level. We have the police and emergency services, local authorities, social care and everybody, who are absolutely integrated on a day-by-day basis. They deal with that locality and that locality's problems on a day-by-day basis. They know each other and know the streets in a way that is always going to be difficult for the armed forces to do. At that level of integration, which is the operational response at local level, it is always going to be hard for the military to integrate because they are just not on the streets every day dealing with that area's problems.

Should they be integrated at the Whitehall level? Should they be integrated at the *[Inaudible]* obligations that they might or might not fulfil? I hoped in 2004 and indeed in the review of the Act that we did five years later that we would be able to make more progress. We were not able to do so for operational reasons, but I think it is—

Richard Drax: Bruce, can I cut in, because I know we are very short on time?

Mr Francois: Please do!

Q19 **Richard Drax:** Very briefly before I ask the other two, do you think the civil agencies are simply unprepared? I am not talking so much about the fire brigade and the emergency services—clearly, they are all integrated. I am talking about Public Health England, the national health service, and all the organisations that really have been tested during the covid pandemic. Are they simply unprepared?

Bruce Mann: Yes; clearly, they are. There are lessons to be learned, very clearly, and quite a lot of those Ministers have said that there are lessons to be learned. Yes, they were underprepared for this emergency—absolutely no question. The key question is the one asked by Mark Francois, which is how you would engage the military in preparing for a pandemic.

Chair: Everybody is conscious that we will not get through the number of questions, so I will ask everybody to keep their answers shorter. Martin wanted to come in very quickly here.

Q20 **Martin Docherty-Hughes:** Who is unprepared? Is it the Department of Health and Social Care in Whitehall or is it the Departments of Health in Cardiff, Belfast or Holyrood? This is the Defence Select Committee of the United Kingdom of Great Britain and Northern Ireland—whether I like it or not—but what I am hearing is a narrative that is quite disjointed because it does not reflect the historic reality of healthcare provision across these islands. I am just looking for clarity on that point.

Bruce Mann: I am not sure that I am quite getting your question but let me attempt an answer. I am going to go back to my previous point—

Martin Docherty-Hughes: The question that you were asked is if the civil authorities are not up to scratch—I am not saying that any part of the United Kingdom has been perfect in this pandemic—could you be a wee bit more succinct about which Departments and which Governments we are talking about?

Bruce Mann: I can talk only about processes rather than about Government. It is clear, to the degree that the military has to be brought in, that the civilian organisations are underprepared—that is the point I made before. That would be a starting point for asking, "Which of those organisations are underprepared?"

Q21 **Mr Jones:** This is the real issue, isn't it, Mr Mann? I sat on the 2004 regulatory scrutiny Bill, and what we had in place before 2010 was regional resilience forums. I also sat, in a previous life, in an emergency planning cell in the north-east. What happened was that Government Offices were abolished, for example, so that was broken up, which led to a disjunction of function between different local authorities, certainly in the north-east of England, for example. You have also had, through this entire pandemic, a Government who have tried to run things directly

from London, rather than engaging locally. Abolishing Government Offices was a huge mistake, because I know, when I was a Minister involved with Cumbria floods, it was a good intersection between Whitehall and that region.

Professor David Alexander: If I might intervene, I was a member of a regional resilience forum until it was abolished. It was an interesting experience, but we had no resources, and that hobbled what we could do. One thing we have explored with PACAC is why the Civil Contingencies Act 2004 was not invoked for covid. That is an interesting question. The Chancellor of the Duchy of Lancaster, a Cabinet Office Minister, said that he thought it was too extreme to use.

Countries, by and large, tend to have a basic law for the civil protection system that they have. Ours is surely the Civil Contingencies Act. Not to use it when we have an existential threat, the biggest disaster of the past 70 years, is really rather odd. I am not sure at all, having tried and failed to read it, that the covid Act is capable of taking its place. One thing that a good Act could do would be to define more clearly the role of the military in civilian emergencies, while at the same time setting up more of a system, bearing in mind that—to simplify perhaps even ridiculously—civil defence is top-down and civil protection is bottom-up, but if the local resources are not there, it is not going to work.

Q22 **Martin Docherty-Hughes:** Jennifer, can I come to you first on the skills and capabilities that the armed forces bring to these situations? Do civilian authorities understand the capabilities offered by Defence and know how best to employ them in certain situations? I will come to you gentlemen in just a moment.

Dr Jennifer Cole: With most of them there is not a straight yes or no answer. How well they understand them, and how up to date that knowledge is, depends on how much interaction they are able to have with them, particularly through live exercises—and I think very much live exercises, rather than table-top exercises. A good example is that in some of the response to the Ebola crisis we saw a disconnect, with, I think, Médecins Sans Frontières assuming that the military had the personal protective equipment to deal with infectious disease, whereas what the military have is CBRN suits, and the military assuming that Médecins Sans Frontières would have that personal protective equipment because they are a medical organisation and they do hospitals, and actually neither of them had it. If they had had a live exercise and sat down and looked at what equipment, that would have been obvious before they ended up in a situation where both were making assumptions about the other and neither had it.

We saw time and time again in table-top exercises assumptions that were made on equipment or capabilities that the fire services had 25 years ago but do not have any more, or that the military used to have 25 years ago and do not have any more. A particular example that I can remember is assuming that the military would have the capability to rebuild a railway track that had been washed away by floods; 25 years ago, the military

would have had that equipment, but it had gone in the meantime, and nobody else had it instead. That kind of understanding comes from live exercising. There is absolutely no second best to that.

Q23 **Martin Docherty-Hughes:** I am just conscious of time, so thank you for that, but can I quickly ask Bruce and then David?

Bruce Mann: No, clearly they do not. That is not a criticism. There is such a wide range of capability in the Armed Forces and Defence that unless they have lived and worked with the Armed Forces—I take the point about exercising—it is unlikely that any civilian authority will know about them. That is why the military must be integrated in the planning and response, so they can lift their hands up and say, "We have capabilities that you can use here." The answer is that I don't think they do, and I think it would be quite difficult to do. That is my first point.

My second point is about scale and availability. What is quite important is that sometimes the civilian authorities think the military have assets on a much bigger scale than they actually do. Having a true understanding of the capabilities and their scale—how many medics, trucks and JCBs they have—is really important.

Professor David Alexander: Proper emergency planning should involve creating scenarios, which are not predictions of the future; they are a range of possible outcomes of what might happen. The use of this scenario in the emergency plan is to identify needs in such a way that it can be worked out how to satisfy them.

This might mean that if we have identified a need, then we start to think, "What will we do about it? Will we use the military?" If the answer is yes, we have to ask, "Do they have the capabilities and are they capable of joining in at the right time?" and other questions of that kind.

Clearly, that sort of thing was not done. You see that particularly in the case of personal protective equipment, where, if you are not going to stockpile it, you have to have arrangements to get it made and transported in appropriate timespans to an appropriate quality standard, and that was not done. So evidently, for pandemics in general, SARS or influenza pandemics, I don't think they have really thought through how they might incorporate the military and what alternatives there might be to them.

Q24 **Martin Docherty-Hughes:** Would that include trying to send the RAF to Turkey to pick up PPE that did not exist?

Professor David Alexander: I think mistakes are always made in managing major emergencies. There are three ingredients to an emergency: improvisation, plans and procedures. The plans direct the procedures, and the purpose of those is to reduce the improvisation to a minimal level. What we have seen in covid is frantic improvisation on a panoramic scale, and that will not do; it is tantamount to negligence.

Q25 **Derek Twigg:** What is your assessment of the emergency planning

capacities in the civil sector?

Dr Jennifer Cole: I think it really comes down to the resources that have been put into it. When the Civil Contingencies Act first came in, there was a flurry of employing emergency managers, of having resilience managers. Over time, that was scaled back further and further, so that in a hospital that employed an emergency planner, whose job was to plan for emergencies at that hospital, that job would then go and be incorporated with the business continuity manager; that would then go as well. You would end up with risk and emergency planning and business co-ordination coming under the head of security. When you talk about capability, the question is, where are the resources for that capability? It is not that people are not capable of doing that, if they have the resources to do it.

The difference between the civilian sector and the military is that for civilian emergency planners, it is very rarely the only part of their job. It is normally a small part of their job and they wear nine other hats, each of which takes up their time with more pressing needs in retrospect than the emergency planning side does. When they have things they have to do today, they do not have time to spend on what might happen in the future.

That is where the biggest issue is. It is never top of the agenda, as Bruce said. It seems to slip down the agenda in between every emergency that we have. The next time one comes around, it is not there any more, and we ask ourselves why. This is not a lesson identified; this is something that we know and comes up after every single one. If we expect those resources to be there, we have to fund them. We have to look at where these jobs should sit, and is there the salary for that job? Is there the salary to attract somebody good into that job? Is there the salary for it to be a full-time job? Is there the will for that to be top of their agenda and to be the thing that takes up most of their time? And we must not keep cutting back these resources and then wondering why they are not there when we need them.

Professor David Alexander: I published an article in *The Guardian* and a letter in *The Sunday Times* in which I suggested that emergency planning in the UK has been under-resourced, ignored and underrated for far too long. I do think that that is the case. I do think that much more could be done to weld it into a system to create the connections between the parts of it, to train and employ better emergency managers. I think sometimes that we still live in this sensation that somehow Britain does not have disasters. We do not call them "disasters"; we call them "major emergencies" or "civil contingencies". But the fact is that Britain does have disasters and it has got one right now, and it needs emergency planners.

One of my students is emergency manager and planner for the NHS in Cardiff, and is utterly exhausted and barely coping. I got quite a lot of feedback on the two things that I published from the emergency planning community. It exists, it is out there, but it feels very beleaguered at the moment.

Q26 **Derek Twigg:** Going back to Martin's question, and trying to drill down to the detail, how would you rate the performance of the various planning and co-ordination structures across Government, the devolved Administrations and at regional level? I think that Martin was trying to push that point before, and I think we are just trying to get some more detail about what your view is of that. Can we start with Bruce?

Bruce Mann: I am not involved in the response, and therefore I find it very hard to judge; I am just working off what I read in the newspapers and that, as I have said, is always slightly dangerous.

I think there are three very big lessons, which I identified right at the beginning. What were the expectations going into the crisis? Was there adequate risk assessment and preparedness done, even before this crisis emerged? That would be the first lesson. The second would be about the competencies of the people engaged at every level; it does not matter whether it is at national level, or inside one of the delivery agencies. Do they have the right aptitudes, and competencies, and so on? That would be the second lesson. The third would be about the availability of the right training, the right equipment, the right drugs, the right PPE and so on. I think we have some deficiencies in all three of those areas.

Q27 **Derek Twigg:** I think the question specifically is, does anyone have a sense—this is for anyone, including David and Jennifer—of how these structures worked across the different areas, from the Government, the devolved Administrations and regional levels? David or Jennifer, do you have a view on that, or some information?

Dr Jennifer Cole: I would say that, rather than the devolved Administrations at any level, it comes back to whether there is somebody who will really champion it. I mentioned Scotland, and Shauna Mayes, who used to work in Scottish emergency planning and may well still do, was a real champion of this. Kathy Settle was, too, up in the north-east. They were people who really believed in this, and grabbed it and ran with it. Whether that is in a region of England or in one of the devolved Administrations, it seems to be very personality-led. Then, if that personality goes, and if the interests of the person who takes over are elsewhere, a lot of that institutional knowledge seems to go with them.

Similarly, we saw that with flooding and the fire service, as well—people like Paul Hayden, who was a chief fire officer and really knew a lot about flooding, and cared about it. After him, there was never really that personal drive for that again. So, whether the processes are set up in the right way, it is still reasonably hard within the public sector to be a career emergency planner. It is not seen as a job that will get you to the top.

So, of the people who do it, it tends to be perhaps younger, more junior staff, who do it as a stop-gap on the way to something else. If they are young, it is a step in their career on the way to something else, or it is people at the end of their career who are looking for a bit of an easy ride at the end. You do not tend to see people who stay around in emergency

planning and civil contingencies in the civilian sector for 20 or 30 years, in the way that you see the military stick with it for that long.

Going back to something that was mentioned earlier—the gap between the policy makers and the operational. One thing that you see in the military, because of its structure, is operational soldiers who know what it is like to dig a ditch, to lay a train line and to put up emergency communications. They then go into working in the MoD on the policy side. They work on the policy and see the policy issues, then go back into the field and see how that is actually implemented. That is probably the only organisation involved in it that works on that level. The people who make the policy in the fire brigade do not tend to have the operational experience before or after they have been involved in the policy side. Similarly, the policy makers within the NHS have, by and large, not been on the frontline. They are not always MDs; they are quite often administrators. Being able to span those operational and policy spheres is something on which the structures in the civilian world at the moment do not allow us to do well. I do not think that is between devolved Administrations or between different regions; it sometimes comes down to the personalities and the people involved.

To some extent, perhaps as we see more of these events and more people have experienced them time and time again, we may actually build up some of that expertise. The Olympics probably pushed it on quite a lot. There were people who did a lot of centralised procurement, logistics and transport arranging around the Olympics, and who gained skills that they could keep and that may well have been useful this time. It is that ability to span the operational and the strategic worlds that is the key to this, rather than the localisation of it.

Q28 **Chair:** Jennifer, that is a really helpful insight. David, do you want to quickly reply?

Professor David Alexander: Only to second what Jennifer said. In civil contingency, there are three types of people: apostles, bureaucrats and neophytes. The apostles really believe in it and do a great deal of good; the bureaucrats primarily want to honour the letter of the law; and the neophytes are young—they could become one or the other. The skills that the military have in marrying the practical with the strategic are something that, in training and education, we try to promote in a civilian manner by teaching them the theory. The theory in this is rather distinctive, because it is only any good if it can be immediately utilised for some practical purpose, but we also try to ensure that they get the experience and the expertise that they also get from the job experience of the work itself. What I am trying to say is that we do not need to rely on the military for these things if we can build up the system as it needs to be built up.

Chair: Thank you very much indeed. We have touched on healthcare. Sarah Atherton, do you want to take us forward in this area?

Q29 **Sarah Atherton:** We have spoken about the devolved Administrations as

a homogeneous group, but we know that has not been the case with the response to the pandemic. I am a Welsh MP and we have had 16 MACA requests fulfilled in Wales, for which we are extremely grateful. In Wales, healthcare is devolved to the Welsh Government, and it is well known and well documented that we have had extensive delays in responding at the right time in the right way. Has decentralisation of healthcare helped or hindered the pandemic response? I think Jennifer mentioned Wales before.

Dr Jennifer Cole: I would say, again, that the more centralised things are, the more you can deal with a wide-scale emergency more quickly, but equally, the more likely that places on the edges will get forgotten. My feeling is that, rather than this being an issue of devolved Administrations, it is an issue between the public and private sectors. The places that are left behind are largely the parts of the NHS—whether that is NHS England, NHS Wales or NHS Scotland—that have been devolved to the private sector: the private care homes, private community care, private care of the elderly. That is largely because once those are profit-making companies, they are looking to cut corners wherever they can. Did they know they were meant to stockpile PPE? They probably did, and they probably didn't care. The staff they are employing cannot afford to buy their own equipment quickly when they know they need it. They are travelling on crowded public transport at peak hours. The inequalities in society, and the inequalities of some of our employment structures, are being writ large by this emergency. If we want to be able to protect everybody in society, we also need to protect the people who will protect them.

Professor David Alexander: This is quite a difficult question, but it is worth bearing in mind that in any major disaster or emergency, the theatre of operations is always local, no matter how large the event itself. Therefore, there has to be a degree of local organisation, and the better that is—the more developed it is—the more likely one is to succeed.

Covid has demonstrated that there is huge potential for voluntarism to be developed in this country. Having tried to do surveys of voluntarism worldwide, I also think that in the 2020s, we are now out of the age of spontaneous voluntarism and into the age of properly incorporated, organised voluntarism that is resourced. Resourcing voluntarism is a cheap way around this, because you are not paying salaries—or are paying very few salaries—which is often one of the biggest costs involved. Training and equipment can be provided to volunteer organisations, and they can then assist. I agree entirely with what Jennifer says about the privatisation issue. I think that has been particularly acute where you have had agency staff who have spread the virus around two different care homes.

Bruce Mann: I am going to pick up on a point that David made, which is that in the end, all emergencies are local. Having local bodies who know the local community dealing with a local problem is immensely powerful. The point about decentralisation is more about whether you need to make a change between how you manage in peacetime, if I can call it that, and

how you manage in a major emergency. It may be that in a major emergency, you have to change your operating style away from decentralisation and all those different roles and responsibilities and so on that are there in peacetime, and move to a completely different operating model to get stuff done quickly.

Sarah Atherton: Thank you, Bruce; I agree with that. Thank you, Chair.

Chair: Martin, did you want to come in quickly?

Q30 **Martin Docherty-Hughes:** Yes, Chair; it would be remiss of me not to come in on the question of decentralisation to devolved Governments. *[Interruption.]* Forgive me; my office phone now goes off while I am in the middle of a question. The National Health Service in Scotland was set up as a separate body in 1947, so I am wondering why there is a problem in our three panellists giving an answer to this. It has been around and very separate for a long time.

Professor David Alexander: I do not agree. The NHS has been around for a long time—a lot of institutions have—but they have changed significantly during that period.

Chair: Bruce, any thoughts?

Bruce Mann: On that point? No. The point I made, which was about the operating style, would be the operating model in Scotland, starting with NHS Scotland. I was putting forward a general concept, not going into specific organisations.

Chair: If we may, we will press on. Thank you for that, Sarah. Mark Francois, do you want to take us towards the joint biosecurity centre?

Q31 **Mark Francois:** I agree with what Bruce said: the Ministry of Defence's resources are clearly not of the same scale as those of the National Health Service. But for the record, in 2014, the MoD deployed to Sierra Leone under DFID request to fight the Ebola virus. It established, in effect, a super-field-hospital outside Freetown, saved large numbers of lives, and did not lose a single member of personnel while doing it. The armed forces proved that they were extremely professional at fighting a highly contagious disease.

Also, for the record, my partner is an NHS radiologist, and she spent a lot of time through this pandemic working with covid-infected patients, so I take no lectures from anyone about how brilliantly our NHS frontline staff have done. But, David, I was particularly disappointed to hear your suggestion that if the military had got involved in this campaign fighting the pandemic earlier on, even more people might have died. Would you like to reflect on that statement? Some people might find it deeply insulting.

Professor David Alexander: In the first place, I didn't say that, and nor would I. In second place, I do agree entirely that the NHS have been magnificent. There is no doubt whatsoever about that, but we needed to

ensure that the civil authorities did not abdicate their responsibility for this crisis. I think the argument rests there.

Q32 **Mr Francois:** I think the record will show what you said. Dr Cole seemed to imply that, in fighting this pandemic, all public sector good, all private sector bad. I disagree. For instance, when we get to the mother of all public inquiries—and it is an open secret that at some point we will, whoever chairs it—one of the criticisms of Public Health England will be that they took a "not invented here" approach. For instance, when the World Health Organisation was saying, "Test, test, test" and lots of other countries were ramping up their testing, Public Health England advised the Government to scale it back. Labs all over the country—private labs, Dr Cole—were begging to be involved in the testing programme, and PHE consistently refused and demanded that they monopolise the testing. That is one of the reasons we were massively late in testing people. Why is it that, in a pandemic, only the state is, in your opinion, able to respond effectively? I say again, with the third-highest death rate in the world, our statist response has not necessarily proven to have been perfect, has it?

Dr Jennifer Cole: I would say again, and I reiterate David's words, that that is not what I said. I would ask you not to twist our words.

Q33 **Mr Francois:** You consistently criticised private sector organisations whilst praising public sector ones. All I am asking for is a more balanced approach.

Dr Jennifer Cole: I did not do anything quite as binary as that. What I said was particularly to do with care homes. I was talking particularly about care homes and whether they had the PPE. There is a huge difference within care homes, particularly with private care homes.

Mr Francois: I think you mentioned agencies as well, didn't you?

Dr Jennifer Cole: No, I didn't. I think that was—

Mr Francois: You did.

Dr Jennifer Cole: No, I didn't. Okay, you can go back and check my words. I don't—*[Inaudible.]* The point I was making is that there are times when things need to be standardised. Standardising is much easier when you have complete oversight. Things that have been phased out of that centralisation are sometimes quite difficult to bring back in very quickly. You need standardisation of testing. Whether that should have been scaled up more quickly is a different issue. One of the things we did take our eyes off the ball with was the importance of track and tracing in terms of science that we did not have in the plans and how that can be brought in.

Q34 **Mr Francois:** Sorry, but why did all these other countries, who had a much more mixed economy in testing, like Germany, have a far lower death rate?

Dr Jennifer Cole: I think there are all sorts of reasons for that. One of the biggest issues in the UK is the number of separate introductions of the

virus that we had in the UK. That has been very different to other countries, and that is probably a lot of the difference between the way the virus spread in England and the way it spread in Scotland and Wales. Simplifying this to that degree does not help the argument at all. I said we need better integration of the public and private sector, not public sector good, private sector bad. We need better integration of the two and better mechanisms for the two to work together. We have seen parts of private sector-controlled healthcare that have fallen off the edges. There will equally be examples of private sector healthcare that has been much better. Some private sector care homes, for instance, have been far, far better than NHS care homes, because the money is put into them. That is the difference. There are parts of the private sector—

Q35 **Mr Francois:** For instance, a lot of private hospitals helped take up the cancer workload that NHS hospitals had to delay because, obviously, they were focusing on covid. Then, the military helped to build the Nightingale hospitals in virtual record time, which, mercifully, were not really required—certainly not to their full capacity. I well remember the footage of soldiers putting those hospitals together; not NHS bureaucrats with clipboards. Do you accept that Public Health England actively tried to keep private laboratories out of the testing programme earlier in the pandemic?

Dr Jennifer Cole: No, I do not accept that. That is not—*[Inaudible.]*

Mr Francois: Well, let's wait for the public inquiry.

Mr Jones: Chairman, can I come in on that?

Q36 **Mr Francois:** I have got my last question, and then we can have Kevan, yes? My last question is: when the Chief of the Defence Staff, Sir Nick Carter, gave evidence to the Committee last week, he said in terms that the armed forces had rather downplayed their contribution—important though it was—because they thought it was important that the NHS was seen to be in the lead, and that the armed forces did not try to take too much of the limelight, although I think this Committee would greatly commend what both the NHS and the armed forces did. For the avoidance of doubt, would you like to take this opportunity to praise the armed forces for what they did in support of fighting the pandemic? Just to clear matters up.

Dr Jennifer Cole: Yes, and I do not think anybody has suggested otherwise. The military have been fantastic. They are always the cavalry, they are always there when we need them, and nobody is questioning that. What we are questioning is whether it is right that the rest of the public sector has so few resources that they have to consistently call on the military to deal with whatever disaster or crisis occurs, and whether the military is the best organisation and the best set-up to manage that going into the future.

Professor David Alexander: I would like to be kind to the military and say that they be allowed to concentrate on defence, which is what they do superlatively well—as well as what they have done in the pandemic—to

give them a bit of a break. Nobody is suggesting that the military or the NHS has necessarily done things badly, but what we are suggesting is that perhaps one of the lessons of this pandemic is that certain things could be done better. We therefore need to keep an open mind about how to organise them in such a way that they are done better. I think, if anything, it wasn't so much a system problem as a bad decision making problem. The question, therefore, is who made the bad decisions.

Mr Jones: On testing, Mark, you're just wrong. One of the big mistakes is that they excluded local directors of public health from being responsible for track and trace. They went to a national system with Deloitte, and there was no standardisation of tests, so there were different qualities of test. The information was not shared locally, and you got a situation, for example in County Durham, where because they were not getting the resources, they took the decision locally to do testing. I am not for or against using the private sector, but in this case, mistakes were being made in countless areas. National contracts were let. The people on the ground who actually knew how to do test and trace, because they do it—directors of public health—were not given the responsibility by the Government to do it. They were excluded from the process. It is no good blaming them.

Mr Francois: But, Kevan, hang on. There were private sector labs on the record around the country screaming at the Government to be allowed to help, and time and again, they were turned down. Why?

Mr Jones: Because they had taken the decision nationally to do one system with Deloitte and there was no standardised testing. If you really wanted to do test and trace properly, it should have been given to local directors of public health, who could have instigated it, but it was a decision taken by the Government nationally to do that.

Chair: Can we call a—

Mr Francois: But on whose advice?

Mr Jones: Well, I don't know. If the Government take the decision, it is their decision.

Mr Francois: I think you might find it was on PHE advice, Kevan.

Mr Jones: You don't have to follow advice, Mark, as you well know.

Q37 **Chair:** Mark and Kevan, please. Can you listen to the Chair? We are here to speak to our witnesses. Much as I am enjoying this, can we return for the last 15 minutes to where we need to go next?

I think it is my question next, focusing on the MoD and this fundamental political question about involvement at the top level of the armed forces. There is an expectation that we are going to see a second wave hit not just the UK, but wider afield. Knowing what we know now and what the MoD has done, do you see a more advanced role for the MoD in dealing with a potential second wave, which may be larger than the original? Can

I put that question to David?

Professor David Alexander: I think the military will probably have to take up the slack in the absence of other alternatives, given that those people I have talked to and associated with who have been working on decision making and operations in the response to covid are now pretty exhausted. Their resources may be somewhat exhausted, but they personally are exhausted, and they fear that, during a second wave, capabilities may degrade. I do not think that the highest level of decision making has really reinforced their ability to cope with a second wave, and therefore I think there will be little alternative but to make further or more use of the military in order to manage the situation in the event of a substantial second wave.

Q38 **Chair:** Thank you. Jennifer, did you want to add anything to that?

Dr Jennifer Cole: The one thing I would say about where I think the military could be used more than they are relates, in military terms, human terrain mapping—actually understanding what is going on in communities. We talk about the military as a professional body, but they are made up of people who live in parts of the country. Quite a lot of them, particularly in the other ranks, come from families and areas that are very different to those of the policy makers, so perhaps use them for some focus groups and some understanding of what it was actually like for their families. How easy was it for them to get food? How easy was it for them to support elderly relatives whose care workers were not working for a few weeks? What could they do at that local level, back in their local communities, to ease some of those real community pressures on the more vulnerable parts of society? That might involve transport. It might involve being able to drive key workers so that they don't have to go on public transport. It may be distributing PPE so that it is more equably distributed. It is that looking at the role of the military within society and what we can learn from the military of the on-the-ground requirements of different parts of society.

Q39 **Chair:** Thank you for that. To Bruce, turning to command and control, messaging is paramount in dealing with this continuing emergency. On command and control and messaging, we have had an example this week, in terms of whether or not to wear face masks.

I go back to the Kosovo intervention, where a man called Jamie Shea, who you might remember, was a regular contributor in updating everybody and anybody on what was going on, on a daily basis. The No. 10 5 pm briefings are now less often, and yet the emergency continues. The initial message was very straightforward: stay at home, protect lives, save the NHS. It is now getting more complicated.

The military are actually very good at swift, clear communications. I am picking up from the conversation today that perhaps we are dealing with a cultural challenge—a reticence to use the military because the nation is not used to seeing the military contribute to supporting civilian operations, as previous generations were. That is why they are not utilised in the way that many of us who are closer to the military would

like to see.

Bruce Mann: Interestingly, I was part of the operation at NATO headquarters behind Jamie Shea and the Kosovo operation from about a month in, when Prime Minister Blair, the US President and others recognised that communications had to be radically improved. That is when we started doing things very differently.

There are two important principles in what you are saying. First, there must be regular communication with the public or whatever. One of the first things we did was to get Jamie Shea, or the people around him, to go out three times a day to tell people what was going on in the operation in Kosovo and why we were fighting that conflict. Regular communication was one of the points that you made, and I fundamentally agree with that.

Secondly—this is not a new lesson; it was in the lessons learned report after foot and mouth, and it is usually in all the other major lessons learned reports—we need absolute clarity of communication. If you want to get a message across, especially if it is a message about how people can take action to protect themselves and their families, you have to be utterly and completely clear in your messaging. Regularity and clarity are the two key watchwords, which you referenced, Mr Chairman. I would not say that that is absolutely and only a military skill, but there is a great deal that we can learn from defence and the military generally in the civilian case about how to do that regularity and clarity well.

Chair: Thank you for that. I turn to Emma Lewell-Buck, who wants to talk a bit about what other countries are doing. Other countries are, of course, affected by this as much as we are.

Q40 **Mrs Lewell-Buck:** Thanks, Chair. Sorry for the late arrival. Good afternoon, everyone.

I just want to explore a bit further what the Chair referred to. We have seen in the news today that there are a predicted further 120,000 UK deaths coming this winter. What should the Government be doing to ensure that they are better prepared this time than they were at the outset of the pandemic, and how far should they be engaging our armed forces in that? Is there anything, both positive and negative, that we could learn from other nations, and that other nations could learn from us in their responses to the pandemic? In other words, what should we and shouldn't we be doing? I am happy for anyone on the panel to come in on that.

Dr Jennifer Cole: One thing that we will have when we come to the second wave in winter is some experience from the southern hemisphere countries that have gone through it. One thing that is very interesting in Australia, which is hitting its flu season now, is that its number of flu deaths has gone down dramatically because of people self-isolating, wearing masks and observing better hygiene. To some extent, the covid situation is helping with that.

What we can do, which we have never done very well in this country, is encourage people to have the flu vaccine, because it protects others around them. We now have got the message into people's heads that a lot of the behaviours are about protecting people more—*[Inaudible.]* We should push messages that protect other people.

We know much better how to protect the vulnerable in care homes. We know very well how to shield. Projections are projections, not predictions. What they do is allow us to prepare for that as well as possible. If we can get those messages across early, we can help to embed those behaviours ahead of the second wave hitting. What we also have to do is then make sure that if the second wave is not as high as it was projected to be, it is made clear that that is because we took the preventive measures required, not because the projection was incorrect. That is a very important message to be able to get across, and sometimes it is one of the hardest ones for the public to understand.

Q41 **Mrs Lewell-Buck:** Jennifer, you mentioned that we know better how to protect the vulnerable in our care homes. We do know how better to protect them, but the guidance and the policy around that have not changed. The Health Secretary confirmed to me this morning that it won't be changing in advance of the spike come this winter, so what is it that needs to be done to better protect vulnerable people in care homes? We know how to do it, but the Government guidance does not say how to, and they are not prepared to change that.

Dr Jennifer Cole: I think that what happened the first time around was not necessarily that the guidance was wrong or was not there; it was that the virus spread before anybody realised. The asymptomatic and the mild case spread had much more of an impact and meant that it was much more widespread within society before we acted. We could have closed down this country in the middle of January. The minute we had person-to-person transmission, this country could have closed down. It didn't. Right or wrong, in retrospect, there is no point in looking back. Most of the care home deaths were already on that trajectory by the point at which we closed down, and by the time there was sufficient PPE around for people who worked in care homes. We know that now. We can make sure that that is in place.

Most care homes now, as far as I am aware, are temperature checking guests when they come in. They insist on guests wearing masks and washing their hands. At one of my friends' care homes, people are still not able to see their relatives. There is a Perspex screen—it is almost like prison visiting—and you are on one side of the Perspex screen, and the person you are visiting is on the other. There are ways we can protect care home staff. If they have no choice but to travel on public transport, perhaps we can provide them with taxis.

Q42 **Mrs Lewell-Buck:** Can I quickly interject? A colleague referred earlier to the speed with which the Nightingale hospitals were built. Should they have been used for people who were getting discharged from hospitals into care homes? The figures that we have for them show that the

Nightingales have not, by and large, been used. They have been sat empty while people were left to die in care homes.

Dr Jennifer Cole: They have, and it is one of those difficulties. No plan survives first contact with the enemy. Building the temporary hospitals was always in the plans, and we didn't know—again, when we were starting to build those and putting those processes in place, we were not 100% sure exactly how many cases were asymptomatic and how many people were passing it on. I don't think, with the best will in the world, we could have not built those Nightingale hospitals. What we should have done as well as, or instead of, that is very easy to see in retrospect. It is always very easy to see that in retrospect.

We are going into a winter flu season and potential second wave with immensely more knowledge of how to control this disease than we had in February and March of this year. What we need to do is to make sure that those lessons that we have identified, both from the UK and from countries like Australia that are already hitting their flu season, are taken on board. That is where I would go back and ask: are these messages getting to the right people? Who is making sure that they are complying? Is there any actual regulation? Is anybody going around and inspecting? Is anybody going around and talking to care home managers and checking what they have put in place? We know where the precise vulnerabilities are now, and we know how to address them. That is what we need to make sure we do as we go into the winter.

Mrs Lewell-Buck: I think David wanted to come in.

Professor David Alexander: Thank you. Not only is it important that communication be done well—in other words, that is clear, consistent and forthright—but it is a question of who is communicating. I think the Italians have done this pretty well, in as much as the Prime Minister, for example, has behaved in an absolutely exemplary way, and that has transmitted itself to the people. The daily briefing has been a mixture of the civil protection authorities flanked by the chief epidemiologist, and that has given an air of the right people saying the right things. That is another point.

The situation with the Nightingale hospitals we should compare to disasters in general, when field hospitals tend to be consistently underutilised or, if they are utilised, used mainly for general medicine, rather than disaster-related care. There may be an opportunity to transfer some general medicine to the Nightingale hospitals. It is not really a question of having more capacity; it is a question of how you use it, the logistics of how you use it and, no doubt, the medicine and clinical aspects as well.

On a second wave, let us bear in mind that at least four countries at present have second waves, of which the worst is in Iran, a very interesting country to study. It is having to grapple with a second wave which looks as though it might be worse than the first wave. That is something to bear in mind and to consider, because what was wrong early

on was, principally, failure to take decisive early action at a time when dissemination of the disease could have been reduced—it could not have been stopped, but it could have been reduced. That would have required careful study of what was happening in other countries, and what they were doing about it, but that came to the fore rather late. If we have countries that are beginning to grapple with the second wave, we need to learn from them fast and consider whether what we are learning from them can be applied and adapted to UK circumstances.

Chair: Thank you very much indeed. We are up against the clock now. I very much appreciate all the thoughts and contributions, not least from my own Committee members—that always keeps us on our toes, and I appreciate it very much indeed.

I thank Professor David Alexander, Dr Jennifer Cole and Bruce Mann for your thoughts today. This will clearly continue to move forward. It has just occurred to me that perhaps the Committee ought to visit one of the Nightingale hospitals, to learn more from that perspective. I thank you very much indeed. We will return to this subject later with some of the military personnel who are helping on the frontline. On behalf of the Committee, I say thank you to all of you.