



Why We Must Learn The Lessons Now

A call for a truly independent public inquiry by the UK Government

Consensus from BAPIO Think Tank Focus Group

The BAPIO Think-tank recommends that the Independent Inquiry establishes;

1. If the scientists did get the advice right (best practice at the time on protection, prevention of spread, detection of new cases, restriction of movement internal/external), and timely.
2. Whether the government adhered to its own mantra of '*following the science*' of acting on scientific evidence
3. If the policy effectively assessed the risk to and protected key workers, how should this be conducted in the future?
4. If the government had formed '*a protective ring*' for Care Homes and if the early policy of encouraging NHS Trusts to discharge patients without repeat testing, compromised the care of other residents and care, home workers,
5. If the disproportionate impact of COVID-19 on ethnic minorities and deprived communities was recognised in policy actions, so those at enhanced risk were appropriately prioritised if there was active engagement and co-designed provision of culturally appropriate timely information; if disinformation was tackled, and if there was an enhanced drive to vaccinate those at higher risk.
6. If there was recognition by the government of public health expert advice that a blanket national policy is ineffective. More local intelligence, engagement, and leadership should tackle the outbreaks seen in different regions.
7. If there was transparency and efficiency in the financial investment in tackling the pandemic - potential wastage and duplication from unusable PPE and the Nightingale hospitals), and the cost of private firms supplying testing, tracing and other equipment.
8. Urgently, the health-social care priorities for recovery; whether segregation of facilities, protected allocation of resources in dealing with non-Covid conditions, how the NHS might continue to function optimally in the event of a third or subsequent waves
9. If there is adequate action on pressures on the NHS workforce, the impact on their morale, wellbeing and measures that are required to manage these in the future.

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Background

On 1 June 2021, the UK recorded zero daily deaths due to COVID-19 for the first time since the pandemic began. From March 2020 till today there have been 4.5 million confirmed cases, more than 127k deaths and over 28 deaths per 1000 cases.[1] The UK presently has the sixth highest numbers of death in the world, after the USA, Brazil, India, Mexico and Peru. However, in January 2021 UK had the unenviable record of having the highest rate of death per million population in the world. There were many warning signals prior to the first wave, but despite that deaths soared to 57,808 between March 2020 and August 2020. The death toll during the second wave was even higher, with 89,963 deaths between September 2020 and March 2021. It is evident that the signals were ignored.

Using the most up-to-date data available, the UK Office for National Statistics, estimated the number of deaths from the week ending 13 March 2020 up to 14 May 2021 was 737,168 in England and Wales, which included 139,790 (19.0%) mentioning COVID-19 on the death certificate. During this period, the number of excess deaths above the five-year average was 112,834 deaths.[2] Therefore, over a quarter of million people appear to have died in the pandemic year due to direct or indirect effects of COVID-19. More than just numbers, each of these lives of UK citizens were interconnected, interdependent with a much wider network of family, friends and community. Each person had their aspirations, dreams and potential that the pandemic has cut short.

While the circumstances that led to the appearance of the SARS-Cov-2 novel coronavirus, and its spread across the world remains a matter of investigation, much scientific discourse and political debate, the fact that a quarter of a million lives were lost in the UK, remains undisputed. It is a general perception that a strong economy, a developed infrastructure, a stable political system, a mature public health organisation, and a universally accessible, public funded healthcare system should have provided the right ingredients for the UK to provide the best

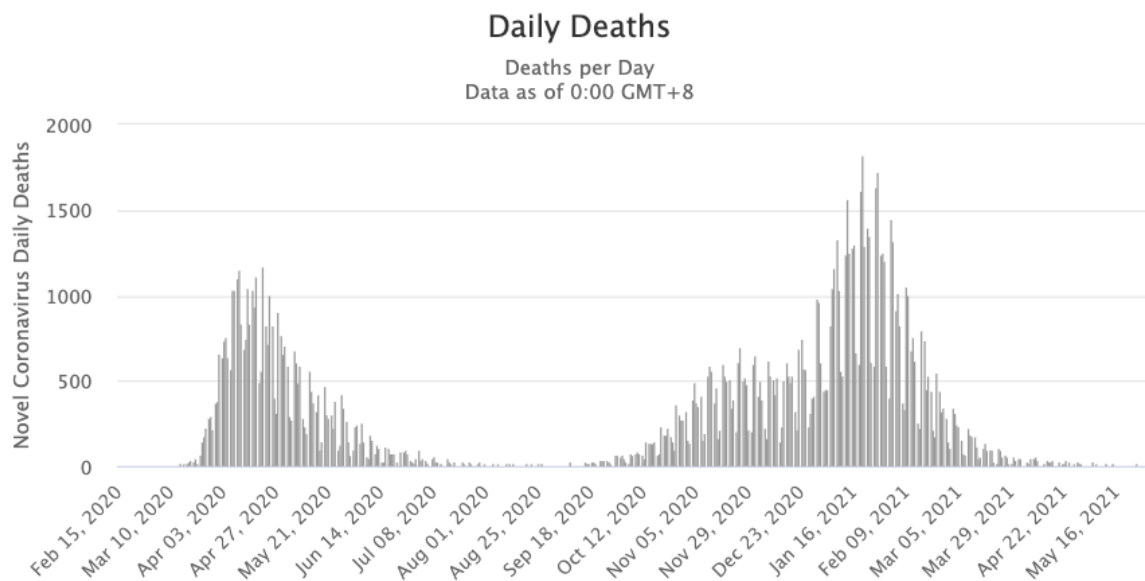
possible care for its citizens in the face of the unknown. The UK government's strategy of '*following the science*' and '*data driven decision-making*' was extolled as second to none. There was a clear plan of action developed by joint working of scientists, health experts and politicians working together on a shared, public platform. The motto of '*saving lives, protecting the NHS*' was afforded the highest government and public priority. Yet the outcomes for the UK are far from ideal.

The current UK government strategy appears to be investing in widespread access to testing, universal vaccination and lifting of restrictions, therefore restoring business as usual by the summer of '21. Yet, there are dangers of new variants (B.1.617+, the Indian or now called the Delta variant) emerging and taking hold, and the experiences from the second surge driven by the (B.1.117 or the Kent variant) are still raw. The UK economy is just rearing to go and the health service is planning a long road to recovery which might take decades. This is before one counts the long fall out of the 4.3 million people who are finding out what it is to live beyond COVID-19.

In autumn of 2020, nearly 25,000[3] and in spring of 2021, 4,000 citizens[4] signed a petition calling for an independent and immediate public inquiry into the first surge of the pandemic, with an aim to saving lives. The UK government responded and promised to look into this once the timing was 'right'. In the last week of May, UK parliamentary health select committee heard evidence from the ex-special advisor to the Prime Minister, Dominic Cummings on allegations of delays and mismanagement of the pandemic response[5]. As the UK recovers from the beating of the second surge, there is again a call for lessons to be learnt. In the parliament this week, Rt Hon Boris Johnson MP announced the government's intention of holding an independent public inquiry, but not until the spring of 2022. This set off a series of reactions from the wider public and within the healthcare professionals on the impact of the 'delayed timing of the inquiry'.



Daily New Deaths in the United Kingdom



Select Committees' Inquiry

The Health and Social Care Committee and Science and Technology Committee are holding a joint inquiry into lessons to be learned from the response to the coronavirus pandemic so far.[6] The two

Select Committees will jointly conduct evidence sessions examining the impact and effectiveness of action taken by the government and the advice it has received. Each Committee will draw on specialist expertise and call witnesses to consider a range of issues as given in the table 1.

Table 1: The remit of the Parliamentary Health & Social Care Select Committee Inquiry

- the deployment of non-pharmaceutical interventions like lockdown and social distancing rules to manage the pandemic;
- the impact on the social care sector;
- the impact on BAME communities and other at-risk groups;
- testing and contact tracing;
- modelling and the use of statistics;
- Government communications and public health messaging;
- the UK's prior preparedness for a pandemic; and
- the development of treatments and vaccines

However, there is growing public feeling that such a parliamentary select committee inquiry will not bring the true evidence to light. Therefore a truly, independent public inquiry is necessary. The British

Association of Physicians of Indian Origin is a voluntary, membership, professional organisation with a wide membership both within the diaspora from South Asian countries and beyond,



representing and linked with over 50 similar organisations in the UK. In its 25 years of existence BAPIO has worked for equality, diversity and inclusion as well as excellence in healthcare. BAPIO has an established methodology of debating and discussing topics of relevance through a Think-tank, which includes wide membership from the rank and file of the organisation as well as the executive members. The Think-tank is the forum for testing hypotheses, informing and developing consensus opinions which are then represented by the executive committee.

On the 1 June 2021, the BAPIO Think-tank arranged a focus group discussion on the topic of an independent inquiry for learning the lessons from the COVID-19 pandemic and considered the following:

- What should the inquiry consider in its remit?
- Why is it necessary to undertake an urgent and immediate inquiry?
- Who should provide evidence to the inquiry?
- Who should chair or be part of the inquiry committee?

Focus Group Discussion

Initial analysis of the transcription of the discussion revealed the following frequent words or phrases as presented in table 2.

Table 2. Analysis of the word frequencies from transcript

- Policy, question, public inquiry, consensus, early, government, Prime Minister
- Science, scientist's view, learn lessons
- People, vulnerable communities, affected people, money
- Pandemic, NHS, UK deaths, herd immunity, vaccination
- Geographical areas, lockdown, restrictions

The forum commenced by establishing the fundamental remit of an independent inquiry to determine: what happened, why did it happen, who is responsible, who is to blame, and how can we prevent this from happening? There was consensus that BAPIO needed to add a voice to the need to have an urgent inquiry, explaining why it's compelling and why it cannot wait until spring 2022.

The science

The first topic for discussion was whether the UK government implemented its own mantra of 'following the science' in enacting policies and interventions in its response to the pandemic. The consensus was that there was clear evidence that the science behind the personal protection, measures to prevent spread of infection, restriction of entry to the country and internal movements, access to testing for the vulnerable elderly in care homes[7], was either not listened to, partly implemented or delayed in its implementation. There was concern that the early scientific view (until the predictions from Imperial College research team[8]) and policy was of achieving 'herd

immunity'[9], the political view that 'this was just another flu epidemic', to accept the 'inevitable collateral damage' to the frail, vulnerable or elderly', and a false sense of security emanating from 'British exceptionalism'. [10]

There was agreement that in any pandemic with a novel agent, there will be uncertainty, and there has to be a precautionary principle applied based on best practice in pandemic preparedness.[11] However, the group believed that, because we haven't really experienced this at scale in the last century or so, the scientific knowledge was perhaps inadequate, and there may have been a lack of courage in the scientific community in the face of uncertainty. Combined with the lack of implementation of the established recommendations from 2016, led to the real delay in turning science into practice.

Recommendation 1:

That the independent inquiry establishes if the scientists did get the medical advice right (best practice at the time on protection,



prevention of spread, detection of new cases, restriction of movement internal/external), and if it was timely.

Following the science

The perennial question that has dogged the medical profession and the public is whether the politicians followed the science, and certainly when it comes to applying some of the scientific tools, including; communication; coordination; capacity for surveillance, testing, tracing and treatment; adaptability/flexibility of response; restriction of travel; and mutual support across borders, there is evidence that there was either a delayed or inappropriate roll out of established knowledge and practice. There was a total lack of leadership with the Prime Minister plainly ignoring the science of protection against the virus, and almost paying the ultimate penalty in doing so, and many in senior government ignoring social distancing and wearing face masks. The failure to lockdown at the right time cost lives. It has been shown in one study that only the national lockdown brought the reproduction number below 1 consistently in the first wave, and if it had been introduced one week earlier, it would have reduced the first wave death toll from 36,700 to 15,700. Barring vaccine forward planning, investment, multi-agency procurement and logistics, almost all other principles appear to have been suboptimal. [12–14] the group believed that there was a missed opportunity to learn from the countries in Europe, the Far East including New Zealand which implemented policies earlier and were seen to be effective while the UK was waiting for the pandemic to arrive. The group believes that the multi-factorial delay in implementing even established best practices from the UK and abroad, led to unnecessary additional loss of life.

Internal communications - SAGE & UK Government

There was speculation and a perception that there may have been failings and inordinate delays between the Scientific Advisory Group for Emergencies (SAGE)[22] committee formulating their recommendations and the information being listened to and acted on by highest level of the Civil Contingencies Committee also known as Cabinet Office Briefing Rooms (COBR COBRA)[23].

Recommendation 2:

That the Inquiry should establish clearly whether or not the government adhered to its own mantra of ‘we are following the science’.

Protecting front line workers

Early on during the first wave of the pandemic there was a rising mortality of front line workers particularly amongst doctors, nurses and care workers. There were many instances of bullying by senior managers where doctors and nurses were asked to work on Covid-infested wards without any or no personal protective equipment. There was also no test and trace facility, and when it was implemented it failed to target those who were saving lives of patients. Amongst the medical casualties from the pandemic there more than 90% of doctors and 70% of nurses. The government has continuously stated that it was protecting the NHS, but it failed to give adequate protection to the staff who run the NHS. As well as a high incidence of death, many have also been afflicted with the new condition, long-Covid.

Recommendation 3:

An Inquiry should establish why and how the government failed to protect key workers, and how this should be avoided in the future.

Protecting the vulnerable and high risk populations

The group discussed the perception that during the first surge, the government policy was entirely consumed by the aspiration to prevent the UK NHS from being overwhelmed. This led to the inevitable concentration of resources in hospitals at the cost of the intermediate, primary care and social care sector. The group heard instances from Healthwatch and local authorities in one particular part of the country, where there was clear restriction from any resources (money, testing capacity or personal protective equipment) being allowed to be used for care homes, social care staff and patients in such vulnerable positions. There was evidence for the instructions to discharge frail and elderly patients from hospital within the 14 day isolation period, without being able to ensure via testing that they were unlikely to spread infection to their local micro-environments during March-April 2020.[15] The group believed that these omissions



led to spread of infection within care homes and led to unnecessary loss of life for residents and staff.

Recommendation 4:

That the Inquiry establishes if the government had formed a 'protective ring' for the elderly in Care Homes, or was it callous in encouraging NHS Trusts to discharge patients back to Care Homes without adequate test and trace safeguards?

Disproportionate mortality related to economic deprivation & BAME population

The group were concerned about the causes behind a disproportionate number of deaths among socially deprived and Black, Asian Minority Ethnic (BAME) communities in the population and among key workers.[16,17] The group discussed the health impact of the policy blindness and lack of empowerment of the BAME populations resulting from the inherent legacy issues of racism, discrimination, social exclusion, barriers to progressing economically, lack of educational opportunities that leads to well documented significant variability in health outcomes as well survival in the UK. [17,18] This is also combined with a higher proportion of vaccine hesitancy in the same vulnerable and underrepresented groups, related to mistrust with the establishment.[19] The data analysis from the first surge demonstrated beyond any doubt that ethnicity was an independent risk for acquiring infection, a higher mortality and morbidity. In spite of this evidence, there was delay and ineffective policy decisions to provide additional protection or resources for the vulnerable. There was a patchy uptake of the risk assessment [20] and protection offered to BAME key workers [21], who featured heavily among the dead.

Table 3: Action points for policymakers: BAME professionals[16]

- engagement and dialogue thus informing a more appropriate level of support and resources needed
- government should address the instability and discrimination in the workforce which cause presenteeism

- government should ensure regular testing of the social care workforce especially those with caring responsibilities and frequent testing may reduce anxiety and ensure their safety both at home and work.
- increased psychological support for BAME staff and for this to be provided in a culturally appropriate manner. address the fear within the BAME workforce, better use of evidence and data to support and clearly explain the disproportionate impact of COVID-19 on the BAME workforce
- acknowledgement of the intersectionality of workers who have dual roles and of workers who have a disability.
- acknowledge the impact of structural racism in the workplace and show how this impacts on the ability of BAME professionals to challenge unsafe practices

The focus group participants agreed that an urgent understanding of the deeper, ingrained societal factors such as racism and discrimination that drove at least a significant proportion of the pandemic health disparities was required. Furthermore, the reasons why certain policies for enhanced risk assessment and protection that were formulated were ineffective, and how a greater engagement, empowerment of the BAME and underrepresented population/ professional voice could be heard and effective, co-developed interventions actioned. This can only be done if the choice of inquiry panel members are truly diverse, independent and representative of the disadvantaged groups. The group felt that only such a comprehensive process will save lives and therefore was the primary reason for calling for an urgent inquiry.

Recommendation 5:

That the Inquiry establishes if members of the BAME community in public should have been better targeted to ensure that there was culturally appropriate information, disinformation was tackled, and there was a drive to vaccinate those who were at high risk.



Geographical vulnerability

The group believed that there are definitely geographical vulnerabilities. Beyond, perhaps the ethnic minority argument, evidence from the understanding of the infectious disease triangle suggests the interconnectedness of the agent, the host and the environment in which these operate. Thus, as the UK is facing a new variant (B.1.617+ Delta) in the face of a new agent which is rapidly spreading through a highly susceptible population, which means that they are neither having full doses of vaccine nor living in conditions which are better ventilated with dire outcomes. Therefore the group felt that creating a differential policy that ensures adequate resources to protect the vulnerable (either the ethnic minority groups or more vulnerable geographical locations) is the only way to reduce the disproportionate outcomes. There was a clear difference in how Scotland tackled the epidemic, and to some extent Wales too. However, the same flexibility was not afforded to the devolved parts of England, even though some regions are larger than the devolved nations. Policies on controlling the pandemic were top-down, from central government flanked by NHS England, and therefore there was no differential policy based on a robust and sensitive risk assessment both at geographical hotspots and for vulnerable populations which include socio-economically deprived and BAME communities

Recommendation 6:

Is a blanket national policy effective, or should there should be more localism in tackling the outbreaks seen in different regions in England.

Inappropriate use of resources

The group discussed the concerns with the inappropriate use of public funds in the sourcing of PPE, the sourcing of testing capacity, the application of the digital Test and Trace system [24], much of which was proven to be too slow, faulty or ineffective in its core functions. Thus the siphoning away of resources from local government, social care, public health bodies for creating a central pool along with the Nightingale Hospitals were a significant policy error.

The group would like the inquiry to explore in depth the resources used in the various initiatives,

demonstrating that due diligence was applied in the choice of measures, the costs and the robustness of the outcomes required. For future pandemics, there should be an open, transparent policy of stockpiling appropriate equipment, robust system of sourcing new equipment that was fit for purpose and in adequate quantities as well as timely, plus having a system of logistics which was responsive to the needs of the nation.

Recommendation 7:

That the Inquiry establishes the financial cost of tackling the pandemic, the wastage and duplication such as from unusable PPE and Nightingale hospitals, and the cost to the NHS of private firms supplying test and trace, ventilators, and other equipment.

Non-Covid medical conditions

There was a general view that for almost a year since the pandemic started that the government seemed to have no policy in how to tackle the growing waiting list for non-Covid conditions because it had focused entirely on the pandemic. As well as that, the country seemed to be on the backfoot during the pandemic, being reactive rather than proactive in its policies. The group discussed how the Independent Inquiry may help to better prepare for the next wave and subsequent pandemics, the post-pandemic complications from COVID-19, and the hitherto hidden surge of non-COVID health conditions like cancer, heart disease, strokes, diabetes and mental health disorders that have been ignored during the pandemic year. There was a call for resources to be allocated to both COVID-19 and non-COVID activities including funding for crucial research that has been postponed or cancelled while the country reeled under the pandemic.

Recommendation 8:

An Independent Inquiry needs to establish as a matter of some urgency what priorities need to be achieved in dealing with non-Covid conditions as well as how the NHS might continue to function optimally in the event of a third wave.



NHS infrastructure and workforce

One of the crucial needs that requires examining in any inquiry is the lack of capacity (pre-during and post covid) in the NHS. The UK also has one of the lowest numbers of practising doctors per population (including GPs and hospital doctors) in Europe. The number of nurses is lower than comparable countries like France, Germany and The Netherlands. The UK also has fewer CT scanners (8 per million population compared to an EU average of 21.4) and MRI scanners (6.1 per million compared to an EU average of 15.4) than most other European countries.[25]

The NHS has one of the lowest bed bases in Europe, so while the UK has 246 beds per 100,000 people, Germany has 800 per 100,000. This dearth of beds is why A&E departments are so stretched during the winter, filled with patients who are waiting hours in a corridor or on a trolley for a bed, and also why so many people needing admission end up waiting in the back of ambulances to get into A&E.

Further, the NHS in England is short of around 100,000 staff, including 10,000 doctors and 50,000 nurses. This is more worrying when considering the

impact on the NHS of a backlog of over five million waiting, post covid.

Recommendation 9:

The Inquiry must establish the causes of pressures on the NHS workforce morale, wellbeing and risks and what actions are required to manage these in the future.

Summary

'I think that there will be very few who would disagree that we have got it wrong. I think there have been blunders.'

There was unanimity in calling on the Prime Minister and the UK government to urgently bring forward the inquiry, appoint a truly diverse, representative and independent panel with the skills and the courage to investigate the truth and be bold to speak truth to power.

We ask that this inquiry is truly independent of government, and that the chair of the inquiry is selected from a pool of notables with a proven track record such as Sir Robert Francis and Don Berwick.

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