Witness Name: Clara Swinson
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF CLARA SWINSON

Contents

I, Clara Swinson, will say as follows: -

1. The statement is a response to the personal Rule 9 request from the Inquiry dated 8 February, related to Module 1 (M1), preparedness for the COVID-19 pandemic. The material is true to the best of my knowledge; the Department of Health and Social Care (the Department, or DHSC) corporate statements are best placed to set out comprehensively the material and approach of the Department over this time period, with access to all departmental records.

2. I give information on my role, then on Pandemic Preparedness pre-pandemic (2009-20), then Future Pandemic Preparedness, and then the international picture. I make clear at the outset the Pandemic Flu Readiness Board (PFRB) is chaired jointly by the Emergency Preparedness and Health Protection Director in DHSC and the Director of Civil Contingencies Secretariat in the Cabinet Office (CO). I do not hold that position. I will therefore answer the questions posed to the Chair of the Pandemic Influenza Preparedness Programme (PIPP) Board but not the PFRB.

Role and background

3. I have been a civil servant since joining the civil service fast stream in 1997. I have been a senior civil servant since 2006, holding a number of roles in DHSC (previously DH). I have been a Director General (DG) covering international health and domestic public health issues in the Department since November 2016. Since that appointment I have reported to the Permanent Secretary, Sir Chris Wormald, and have been a member of the DHSC Executive Committee which oversees the management of the Department.

4. I work closely with the Chief Medical Officer (CMO) - first Dame Sally Davies and, since September 2019, Sir Chris Whitty - and the Deputy CMOs (DCMO).

5. I have both international and domestic responsibilities. My responsibilities as Director General have changed slightly between 2016 and the pandemic, depending on government priorities and the organisation of work within the Department. The number

of staff in my Group has varied from around 250 to around 650. There have been three main timeframes for my responsibilities as follows:

a. From November 2016 I was DG for Global and Public Health, with responsibility for Directorates on Emergency Preparation and Health Protection; European Union (EU) and International and Prevention Programmes; Population Health; and Health and Work Unit (a joint unit of the DHSC and the Department for Work and Pensions).

b. In December 2018, when the preparations for EU Exit and planning for a potential "No Deal" exit from the EU were the principal operational focus for government, the Population Health and Health and Work Directorates moved out of my portfolio to two other DHSC DGs. I continued to have responsibility for international work, emergency preparedness and health protection alongside the preparations for EU Exit. Given the scale of work and new responsibilities for the UK when it left the EU, the Department agreed to move to two separate Directorates within the Department in this area, one covering EU and Trade and one International, and I appointed two new Directors to these roles in early 2020.

c. From Jan 2020, my previous responsibilities did not change but, with the emergence of COVID-19, the Department set up an incident team led by the Operational Response Centre (ORC) in my EPHP Directorate. Over the course of 2020 my responsibilities extended to cover a large amount of COVID-19 specific work, with new Directorates on Social Distancing Strategy (later renamed Covid-19 Strategy); Covid Programme with responsibility for the COVID-19 Battle Plan; Covid-19 Vaccine Deployment; and the Therapeutics and Antivirals Taskforces (later combined to form the Antivirals and Therapeutics Taskforce). The new EU and Trade Director temporarily became someone who would also be responsible for this work, alongside the EPHP Director given the pressures of the pandemic. During this time, the incident teams worked 7 days a week over extended business hours (7am to 10pm) and so more than one Director was needed to manage the team.

6. The Department has Senior Departmental Sponsors for its agencies and arms' length bodies (ALBs). The sponsor oversees the relationship with the ALB and is supported

by a small sponsorship team made up of DHSC civil servants. I was the senior sponsor for Public Health England (PHE) from November 2016 to November 2018 and have been the senior sponsor for the UK Health Security Agency (UKHSA) since its inception in October 2021 (and for completeness, Jonathan Marron Director General was the senior sponsor for PHE from December 2018 until it was closed). This means that I had regular contact with PHE senior staff, I chaired the regular accountability meetings, and oversaw a team in my EPHP Directorate that worked with PHE day to day.

7. I am the DHSC DG responsible for international policy, bilateral relationships with other nations, and health work undertaken on a multilateral basis e.g. at the World Health Organisation (WHO), the G7 and the G20, and work funded by ODA – which is official development assistance, or the "overseas aid budget". On a day-to-day basis this work is led by my International Director and their team, working closely with colleagues in the Foreign, Commonwealth and Development Office (FCDO, previously FCO and DfID), CO, UKHSA (previously PHE) and others as appropriate. The leadership of the G7 and the G20 rotates on an annual basis, and may have a 'health track' in any given year, depending on the choice and priorities of the chairing country (i.e. in practical terms a focus in discussions or in joint resolutions on issues relating to health). The UK held the G7 Presidency in 2021. A health Minister normally leads the delegation for the annual World Health Assembly in Geneva, Switzerland. This is the decision-making body of the WHO and is attended by delegations from all those who are member states of the WHO. The Assembly seeks to determine the policies of the organisation, appoints the Director General of the WHO, and reviews and approves programme budgets. The CMO is the UK member of the WHO Executive Board, in the years that the UK is on the Executive Board. The executive board of the WHO is made up of 34 technically qualified members elected for 3-year terms. The next Assembly is from 21 – 30 May 2023. A health Minister also represents the UK at Ministerial health meetings of the G7 and G20, and there are a number of official-led meetings

8. I am the UK Senior Official on the Global Health Security Action Group (GHSAG), which is an informal network of the G7 nations plus Mexico, the WHO and the European Commission, set up after 9/11 to collaborate on health security issues, including but not restricted to pandemic preparedness. It covers all chemical,

biological, radiological and nuclear health threats. The Global Health Security Initiative (GHSI), whose secretariat coordinates the GHSAG, is an informal, international partnership among like-minded countries and organisations with a mandate to undertake concerted global action to strengthen public health preparedness and response to chemical, biological, radiological, and nuclear (CBRN) threats, as well as pandemic influenza. I first attended GHSAG in February 2017 and then became co-Chair alongside Canada in October 2018 (CS/1 - INQ000183335). In this role I attended and chaired regular meetings and teleconferences on global health security issues, to discuss policy priorities for the network, review progress on technical-level activities and assist in the preparation of annual Ministerial meetings.

9. I am the DHSC DG responsible for the relationship with the EU in respect of health and social care. Since 2016 this has involved a number of different phases including working with the EU whilst the UK was a Member State; health issues forming part of the negotiation of the Withdrawal Agreement and Implementation Period; leading the Department's planning for various withdrawal scenarios; and the relationship and obligations after the UK's withdrawal. On a day-to-day basis this was led by my relevant Director and their team, working closely with the CO, FCDO, Department for Exiting the European Union (DEXEU) and others as appropriate. While the UK was a member of the EU, an official from my team or PHE would attend relevant meetings of the EU Health Security Committee (HSC) and the European Centre of Disease Control. The EU HSC is an advisory group on health security at European level. It reinforces co-ordination and sharing of best practice and information on national preparedness activities. The EU Member States also consult each other within the Committee with a view to coordinating national responses to serious cross border threats to health. The HSC also deliberates on communication messages to health care professionals and the public in order to provide consistent and coherent information adapted to Member States' needs and circumstances. Shortly before we left the EU, it was agreed that the UK could attend meetings or agenda items of the EU HSC which covered the response to what became the COVID-19 pandemic (CS/2 - INQ000183337). I led the Department's work for Operation Yellowhammer, which was the planning scenario for leaving the EU without a deal.

10. I was the DHSC DG responsible for public health policy, both health improvement (e.g. smoking, obesity, nutrition) and health protection (e.g. vaccination, chemical or biological threats) for the period in paragraph 5a above, and for health protection in the periods in paragraphs 5b and 5c above. Health protection includes but is not limited to pandemic preparedness, high-consequence infectious diseases (HCID), anti-microbial resistance (AMR), vaccination and emergency planning and response. On a day-to-day basis this is led by my EPHP Director and their team, working closely with PHE/UKHSA and NHS colleagues, and cross-government with Home Office (HO), Department for Environment, Farming and Rural Affairs (Defra) and CO, including COBR (the government committee which deals with the response to matters of national emergency or major disruption).

11. Day-to-day responsibility for pandemic preparedness is within the Emergency Preparedness and Health Protection Directorate. A deputy director and team has day-to-day responsibility for Pandemic Preparedness policy, working closely with PHE (now UKHSA) and others. They are also responsible for, among other areas, emerging infectious diseases and antimicrobial resistance. The current Director of Emergency Preparedness and Health Protection is Emma Reed.

12. The PIPP was the DHSC led programme for the health and social care system's planning and preparedness for a potential future influenza pandemic in England from 2007 to 2022. The programme was governed by a programme board, the PIPP Board, which met for the first time in October 2007. The Board was attended by representatives from NHS England (NHSE), PHE, DHSC and CO and others as appropriate. The Board is responsible for setting the strategic aims and objectives of the programme and for coordinating the work of arm's length bodies to meet these objectives. The PIPP Board oversaw delivery of the Programme, including those areas where operational delivery was the responsibility of organisations which were not the DHSC's such as NHSE and UKHSA. The PIPP is dealt with in further detail below at paragraphs 30-35.

13. I was the Chair of the PIPP Board from 2017 to 2022. The Board met ten times. Given there was always a risk of other pandemics, and lessons to be learned from the present one, I ensured those meetings continued throughout the COVID-19 pandemic.

In 2022 the Board changed its scope to all pandemics and it was renamed the Pandemic Preparedness Portfolio (PPP). I continue to chair that Board.

14. As noted in paragraph 2, I am not the Chair of the PFRB, which is responsible for cross-government preparedness rather than the health and care systems. This is co-chaired by DHSC and CO. From 21 February 2018, Emma Reed co-chaired with Katharine Hammond of CO, Civil Contingencies Secretariat (CCS). Prior to Emma Reed, Helen Shirley-Quirk was the Director of Emergency Preparedness and Health Protection, and she was the first DHSC co-chair of the PFRB from 29 March 2017.

UK's Pandemic Preparedness 2009-2020

15. You have asked about key policies relating to preparedness and their effect, the funding and structure of health and social care and how that impacted upon preparedness, and what was done correctly in this time period, in relation to pandemic planning preparedness and resilience.

16. I cover below the overall approach, some reflections on areas of specific relevance to the COVID-19 response, the funding and structure of the health and care system and additional readiness which took place as a result of the work to prepare for EU Exit. These should not be seen as exhaustive of all the Department's work in this area: as requested, I have focused on the key policies. In addition, I would note that decisions on policy, funding and structures are ultimately for Ministers and the role of the civil service is to advise Ministers and to implement government policy. An example of the briefing provided to incoming Ministers on Global and Public Health, including pandemic preparedness, is provided (CS/3 - INQ000183334 pages 10-12).

Overall approach

17. The DHSC corporate witness statement for M1 set out our approach to pandemic preparedness and the twelve areas of work undertaken by the Department. In my view all twelve areas were essential to our preparedness for COVID-19. The health and care system requires preparedness, surveillance and capabilities for a range of risks and threats, including but not limited to those set out in the CO National Risk Assessment.

18. My responsibilities as the DG are to help protect and prepare the UK from a range of significant health threats. A number of the twelve areas are relevant to multiple risks; some of them are specific to pandemic influenza, which was also used as a basis for our response to a different respiratory disease i.e. COVID-19.

19. The twelve areas are as follows:

a. First, the maintenance of a permanent, cross-governmental emergency response capability within the Department, which was called the Emergency Preparedness Resilience and Response (EPRR) function. This is a dedicated emergency preparedness and response capability which can be "stood up", as required, to lead and coordinate responses to emergencies. It has been in operation within the Department since before 2009. This is a Director-led function in my Group.

b. Second, governance structures for preparing and responding to a pandemic. These included DHSC's PIPP Board, which I chaired as explained above, and supporting structures on individual projects; the Permanent Secretary regular meetings; and the pandemic risk on the Department's High Level Risk register. The PIPP Board was responsible for setting the strategic aims and objectives of the pandemic preparedness programme across the health and care system and for coordinating the relevant work in DHSC, NHSE and PHE.

c. Third, cross-government collaboration working with CO and others, including the devolved governments, assemblies and executives on preparedness. During my time in post this was coordinated by the PFRB which is the cross-government pandemic preparedness board established in 2017 in response to recommendations from Exercise Cygnus (see above and below).

d. Fourth, the pandemic preparedness programme. This was designed both to mitigate the risk of a pandemic and to prepare to respond to a pandemic should one arise. I will describe the work of the pandemic preparedness programme in more detail below.

e. Fifth, the availability and supplies of clinical countermeasures. This was part of the pandemic preparedness programme, ensuring the UK had rapid access to clinical countermeasures that could be deployed as part of the response. There was a centralised stockpile of relevant products (managed by PHE) with contracts agreed in advance for further stock, the development of a pandemic-specific vaccine, or the delivery of dedicated operational functions (e.g. the National Pandemic Flu Service). Full detail on the clinical countermeasures can be found in the DHSC corporate witness statement for M1 at paragraphs 245-254.

f. Sixth, surveillance capabilities to enable the following: early comprehensive assessment of the epidemiological and clinical characteristics of a novel virus; identification of severe cases and risk groups affected; and description of how the pandemic spreads, evolves and its impact. Responsibility for surveillance sat with PHE, which operated data collection and analysis through local public health laboratories. PHE also operated a range of specialist microbiology tests and services via four national centres, with routine scanning of open-source information internationally. PHE held membership of early alerting and reporting (EAR) mechanisms such as the EU's Epidemic Intelligent Information System (EPIS) and the European Surveillance System (TESSy) tool.

g. Seventh, threat assessments and response planning was informed by scientific advice, including through expert advisory committees (such as SAG (Scientific Advisory Group) and later SPI (Scientific Pandemic Influenza Group, a sub-group of the SAG), as well as the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and the CMO, DCMOs and Chief Scientific Advisors (CSAs).

h. Eighth, investment in research capabilities, such as The National Institute for Health and Care Research (NIHR), founded in 2006. I will describe how this helped in more detail below.

i. Ninth, the work of the operational delivery agencies, PHE (and its predecessor the Health Protection Agency) and NHSE. These core capabilities and functions were critical for the UK's response.

j. Tenth, a legislative framework for health protection. This was based upon the Public Health (Control of Diseases) Act 1984. Following recommendations from Exercise Cygnus (see below), there was preparation of draft additional legislation, which was later drawn upon at the start of the COVID-19 pandemic. A draft Pandemic Flu Bill had been prepared, which contained temporary provisions of an emergency nature to help manage the effects of a severe pandemic flu virus in the UK. This meant that when COVID-19 happened we were able to quickly put in place legislative measures to deal with this emergency situation.

k. Eleventh, international collaboration, including with the WHO, the EU, the G7 and G20 as set out in paragraphs 7-8 and 60-69 of this statement.

l. Twelfth, incident management and a number of test exercises, in order to learn how to improve our preparations and so better respond in future. Of particular significance for the pandemic readiness capabilities were measures developed following incidents such as the Ebola outbreak from 2014-2016, infectious disease outbreaks and EU Exit no deal preparedness - referred to as Operation Yellowhammer. In 2016, the Department also led on the preparation for and delivery of Exercise Cygnus, a cross-government exercise to test the UK's response to a serious influenza pandemic.

20. All of these twelve areas of preparations were useful, both for COVID-19 and for helping to ensure we were prepared for and able to respond to other threats and risks. It would not be right to judge the UK's preparedness solely through an understanding of the impact of COVID-19 in retrospect. Indeed, a number of events and issues have occurred across the ten-year period, as set out in the DHSC corporate witness statement for M1 in paragraph 228 and for example including the Manchester Arena attack in 2017, the Salisbury Novichok poisonings in 2018, and the Ebola outbreaks in 2014-16. The preparedness and system needed to be ready for these and respond to a range of incidents. The need to be prepared for these threats has remained throughout the COVID-19 pandemic; indeed, there have been a number of non-COVID-19 events to which we have responded, including Mpox in 2022.

Examples of areas of work specifically relevant to COVID-19 response

21. I will comment as requested on some areas of preparedness which were integral to the COVID-19 response. The health and care system response was designed around the Battle Plan which is covered in full in the DHSC corporate witness statements for Module 2. All elements of the Battle Plan had roots in our preparedness programme, being tailored and extended where necessary according to what we learnt about the emerging new disease.

22. Ability to respond was dependent on the capabilities and capacity of the system. This relates not just to funding but also to factors such as people, skills and experience, relationships within and between organisations, training, processes, facilities and equipment. I cover below the established system of scientific advice and surveillance, EPRR, vaccines and treatments, the Pandemic Influenza Programme, PIPP Board and PFRB, the funding and structure of the health and care system, and the impact of the withdrawal of the United Kingdom from the European Union.

Scientific advice and surveillance

23. The various scientific advice groups such as the Scientific Advisory Group on Emergencies (SAGE), NERVTAG and the Joint Committee on Vaccination and Immunisation (JCVI) were essential to our preparedness. These groups existed before the pandemic and meant that we had established groups of scientific expertise. NERVTAG held meetings to provide advice on COVID-19 in January 2020 and the JCVI was established and with experience of setting up sub committees for different disease, so ready to set up a structure to provide advice on immunisation for the prevention of a novel disease, COVID-19.

24. The Inquiry will no doubt be aware of the roles of these groups. These are not groups of which I am a member, but I set out their remit in broad outline below for ease of reference:
    a. **SAGE:** SAGE is responsible for providing COBR (Civil Contingencies Committee) meetings with coherent, coordinated advice and to interpret complex or uncertain scientific evidence in non-technical language. Typically, SAGE would meet in advance of COBR and the Government Chief Scientific Adviser, who chairs it, subsequently represents SAGE at COBR. When the

emergency has a significant public health component, SAGE is co-chaired by the Government Chief Scientific Adviser and the Chief Medical Officer. Since SAGE's inception, there were eight previous emergencies prior to COVID-19 when SAGE was activated. Expert participants at SAGE are determined by the scientific expertise needed for that particular situation.

b. **NERVTAG:** NERVTAG was established in 2014 to replace the National Expert Panel on New and Emerging Infections (NEPNEI), as well as to take over certain functions of the Advisory Committee on Dangerous Pathogens (ACDP, which continues). NERVTAG provides scientific risk assessments and advice over a wide range of subjects relevant to the threats posed by new and emerging respiratory viruses. The role of NERVTAG is to advise the CMO (and thus onwards to decision-makers) by providing scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory virus threats and options for their management. It draws on the expertise of scientists and health care professionals, including clinicians, microbiologists and public health practitioners, and colleagues in related disciplines. The scope of NERVTAG includes new and emerging respiratory virus threats to human health including strains of influenza virus (regardless of origin), and other respiratory viruses with potential to cause epidemic or pandemic illness, or severe illness in a smaller number of cases.

c. **JCVI**: The JCVI advises the UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. It considers and identifies factors for the successful and effective implementation of immunisation strategies and identifies knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered. It is an independent body which sits outside the Department.

Emergency Preparedness Resilience and Response (EPRR)

25. As explained above, the EPRR function exists to respond to a wide range of emergencies. This includes a pandemic and infectious disease outbreaks, but is not

limited to this, including for example terrorist attacks and contractual/operational incidents such as EpiPen shortages or cyber-attack. The EPRR function ensures a co-ordinated operational response by the health sector, and to support ministers for associated COBR meetings which provide cross-government co-ordination and decision making in the event of major emergencies. It is a 24/7 team, with two members of staff on call each evening, overnight and at the weekends.

26. Having the EPRR meant that we had a function that was used to responding to emergencies and had the necessary capabilities. We were able to stand up an incident team immediately in January 2020 that was used to working with colleagues in PHE, the NHS, CO and across government. It prepared sitreps showing the latest information; led the health response for the repatriation of UK citizens from Wuhan, other locations and cruise ships; prepared protocols for the UK's first COVID-19 cases and deaths; briefed Ministers and senior officials; and inputted to the COBR system. As the incident developed, we were able to expand the existing function with significant numbers of additional staff reprioritised from DHSC, ALBs and from other parts of Government. From February 2020 we extended the ORC to full shift working, operating teams 7 days a week, extended hours from 7am to 10pm, and overnight cover.

Vaccines and treatments

27. The speed and effectiveness of the COVID-19 vaccines programme was built on existing capabilities in the health system. These included an established regulatory system considering safety and efficacy by the Medicines and Healthcare products Regulatory Agency (MHRA); the statutory JCVI which was able to respond at speed to advise on eligibility; expertise in vaccines and public health in PHE; and experience and planning for very large-scale vaccines deployment in the NHS, including an annual flu programme offered to millions of people each year. The research and science base is also strong in the UK, both in government and the commercial sector.

28. Following the initial Ebola outbreaks, the UK Vaccine Network was established in 2015 and chaired by Sir Chris Whitty. The UK Vaccine Network undertook an analysis of the most likely pathogen types for which a vaccine could be useful, methods to shorten

time to vaccine production in an emergency, and the epidemiological conditions under which a vaccine would be most likely to be successful. It increased our preparedness for a pandemic as part of its work involved strengthening the UK vaccine research base over the period of 2016 to 2021 and funding the scientific research on vaccine technologies that would lay the groundwork for the UK research community's rapid development of potential COVID-19 vaccines. The UK Vaccine Network granted the Oxford University team £1.87 million which supported virus-based technology for a MERS-CoV vaccine in 2016. In January 2020 researchers showed that the MERS-CoV vaccine was a candidate to be adapted to the novel coronavirus, which became the Oxford/AstraZeneca COVID-19 vaccine.

29. In addition to vaccines, there was also substantial work on therapeutics. This started from the first stage of the pandemic, when clinical trials were put in place using existing government-funded research infrastructure including the NIHR. The UK was able to set up and report on research first on repurposed drugs for treatment of COVID-19, and then to research potential new treatments. The Department set up the Therapeutics Taskforce in April 2020 and the Antivirals Taskforce in April 2021, in collaboration with external experts. The Taskforces were amalgamated in April 2022. This work, and both Taskforces when separate, were, led by my Antivirals and Therapeutics Taskforce Director on a day-to-day basis. These built on existing capabilities on research, clinical, procurement, storage and distribution within DHSC, PHE and the NHS. The taskforces were responsible for identifying potential COVID-19 therapeutics; trialling these as part of an advanced programme of clinical trials; and making effective treatments available to UK patients.

The Pandemic Influenza Programme, PIPP Board and PFRB

30. As the Inquiry will recognise, following the H1N1 (commonly referred to as 'Swine flu') pandemic of 2009-10, and the Hine Review, the Government published a UK Pandemic Influenza Strategy in 2011. This set out the overall approach and a work programme was in place throughout the time period of M1, within DHSC and across the rest of Government. The Coronavirus Action Plan which we published in March 2020 drew heavily on the 2011 Strategy, within the context of what was then known about the new virus.

31. The Pandemic Preparedness work programme included Exercise Cygnus, a cross government exercise to test the UK's response to a serious influenza pandemic over three days in October 2016 (CS/4 - INQ000022792). This exercise was before I took up the DG role. The government accepted all of the Cygnus recommendations. After I began in post, the recommendations and action plan were developed and put to Ministers for agreement and decision. The PIPP Board and the PFRB took forward the recommendations and implementation. Within the Department, the areas of work included healthcare; adult community and social care; excess deaths; sector resilience; and cross government coordination: drafting a pandemic influenza bill; and understanding public expectations and reactions to a pandemic and ensuring effective communications arrangements are in place (CS/5 - INQ000183333). The aim behind this was to address the lessons outlined in response to Exercise Cygnus and it was done in order to ensure that we increased our level of preparedness for a pandemic. The PFRB took forward recommendations for other government departments.

32. The PIPP Board covered pandemic preparedness work across the health and social care sectors and set the work programme. It was the central DHSC-led programme involved in organising, directing and managing pandemic preparedness amongst DHSC and the other bodies it worked with: PHE and NHS England.

33. It was in operation between 10 October 2007 and 27 July 2022, and I was the Chair from March 2017. Since 8 November 2022 it has been replaced by the Pandemic Preparedness Portfolio. From March 2017 until the COVID-19 pandemic there were 6 meetings held on the following dates:

    a. 13 March 2017 (CS/6 - INQ000183339)
    b. 15th September 2017 (CS/7 - INQ000183343)
    c. 19th January 2018 (CS/8 - INQ000183344)
    d. 16 April 2018 (CS/9 - INQ000183342)
    e. 1 October 2018 – this meeting was partly chaired by me (CS/10 – INQ000183341).
    f. 8 October 2019 – this meeting was partly chaired by me (CS/11 - INQ000183340).

34. The Terms of Reference are exhibited at (CS/12 - INQ000022804). The purpose of the meetings was to provide oversight of the pandemic preparedness work that was in progress in DHSC, PHE and NHSE. The PIPP work covered the stockpiling of clinical countermeasures such as PPE items and pharmaceutical items; scientific and ethical advice for instance asking for scientific input into papers/guidance and establishing a Moral and Ethical Expert Group (CS/10 - INQ000183341); dealing with excess mortality; legislation for example overseeing the progress of the draft pandemic influenza bill; reasonable worst case scenario impact mitigation in the case of a pandemic (NHS surge and triage); surveillance; data; strategy and guidance; communications; and governance and assurance for example in the form of the PIPP Board Action Log and risk register.

35. The PIPP covered areas that became part of the Department's COVID-19 Battle Plan. The COVID-19 Battle Plan was how the Department organised itself in its response to COVID-19 and initially covered six workstreams which were agreed by the Prime Minister on 22 March 2020. These workstreams were: (1) resilience for the NHS and adult social care; (2) supply of key products and equipment; (3) testing widespread across the population; (4) technology accelerating new interventions; (5) social distancing to slow the rate of transition; and (6) shielding to protect the most vulnerable. We undertook preparedness based upon the following factors, which were central to the Battle Plan as it was then developed. To give the following examples the UK strategy for preparing for an influenza pandemic was based on minimising spread of infection and treating individual cases through:

    a. Surveillance and modelling;

    b. reducing risk of transmission through, for instance, infection control and PPE – this linked to the supply and social distancing areas of the Battle Plan

    c. minimising serious illness and deaths through stockpiles of antivirals and antibiotics - this linked to the supply area of the Battle Plan

    d. reducing pressure on primary care services and hospitals – this linked to the NHS resilience area of the Battle Plan

    e. advanced purchased agreements to guarantee access to pandemic specific vaccines - this linked to the supply area of the Battle Plan

f. vaccination when possible – this linked to the technology area of the Battle Plan; and

g. surge plans to deal with increased demand on health and care services in hospitals and community settings – this linked to the NHS and social care resilience area of the Battle Plan.

36. As I explained at the start of this statement, I was not present at the PFRB meetings and cannot provide a detailed response on its workings. In broad outline, the PFRB was the cross-government group for pandemic preparedness, co- chaired by CO and DHSC. It carried out work on a number of different areas, and these included the draft Pandemic Flu Bill I explained earlier; supporting Departments to assess and improve the resilience of their sectors to operate in a pandemic, particularly in respect of a reduced workforce; establishing a group of experts and advisers to advise government on moral, ethical and faith considerations in advance of and during a pandemic; working with the (then) Ministry of Housing, Communities and Local Government on local Resilience; and improving plans of the health and care sectors to flex systems and resources to expand normal capacity levels.

37. This contributed to the UK's preparedness for COVID-19 given the PFRB's prior analysis of non-pharmaceutical interventions such as school closures; workplace closures; cancellation of mass gatherings; port of entry screening; and the potential need for mass burials.

Funding and structure of health and care system

38. There were significant changes to the structure of the health and care system, implemented through legislation in this time period. The DHSC corporate witness statement for M1 sets out the roles and responsibilities of the different organisations in comprehensive and significant detail between paras 56-223. There were significant changes in the Health and Social Care Act 2012. These included the Health Protection Agency being merged with other functions to establish PHE, an agency which was responsible for both health improvement and health protection, and certain public health responsibilities moving to local government. There are pros and cons in combining these areas for public health, for example in working with the NHS and

Local Government across all of public health, versus maintaining a single focus on one function. During the pandemic, Ministers decided to decouple these responsibilities and again have a stand-alone organisation on health protection, the UKHSA.

39. Decisions on NHS, adult social care and public health funding were taken at each of the relevant Spending Reviews in this time period. Funding for the HPA, PHE, the NHS, and research and development is set out in the DHSC corporate witness statement for M1 at paragraphs 429 to 432. Decisions taken in the Spending Reviews tended to protect NHS frontline services while local government and non-NHS services were less protected. It is not possible to know the impact on pandemic preparedness if different decisions had been taken. As noted above, the ability to respond to the pandemic was founded on core capabilities in those organisations, including surge capacity, as well as the provision of new money for immediate emergency response in 2020.

Withdrawal of the United Kingdom from the European Union

40. In December 2018 the Cabinet agreed that a 'no deal' EU Exit was the government's 'principal operational focus' and this was communicated to departments. In July 2019 the new Cabinet agreed that 'no deal' was the government's 'central focus', with additional actions to ramp up preparations including daily meetings of the EU Exit Operations (XO) Cabinet Committee. I was the DHSC lead DG for EU Exit and significant resources in my teams were spent on preparing for various scenarios, including the EU Exit Programme (led by my International and EU Director) and in possible emergency response (led by my EPRR Director and the ORC). I established the EU Exit Oversight Board which coordinated the relevant work in my teams, the Department and across our ALBs. We also tested our preparedness through a programme of challenge and 'Red teaming'. This approach was valuable experience in setting up the COVID-19 Battle Plan, Oversight Board and star chambers.

41. As noted in the DHSC corporate witness statement for M1, the focus on EU Exit meant that other areas of work across the Department were paused or stopped, including some elements of pandemic preparedness. On the other hand, some of the preparedness for no deal led to improvements in resilience and capability which were used directly in our pandemic response. The work under Operation Yellowhammer

improved the Department's emergency response capability, and established a much better understanding of supply chains and impacts of supply chain disruptions which was utilised during the COVID-19 response. The UK also agreed continued information-sharing with the EU for pandemic response.

42. The Department established the Operational Response Centre with EPRR in January 2019. This brought together our capability on emergency response and responsibilities as a Category 1 responder with our planning and preparedness to manage a potential 'no deal' EU Exit. The ORC enhanced our capabilities as it created a system of shift working on a rota basis and provided improved training for a wider range of emergency responders, as I have explained above.

43. The Department established a new Continuity of Supply programme to mitigate the impact of border disruption to the import of medicines and medical products from the EU, under the Reasonable Worst Case Scenario planning assumptions prepared by CO. This included stockpiling around 6-weeks' worth of medicines and supplies (both government and private owned), supporting suppliers to be ready for new border checks, planning alternative ferry routes to avoid congestion between Dover - Calais where required, creating regulatory flexibilities and a dedicated emergency response function.

44. The Department established the National Supply Disruption Response (NSDR), led by the DHSC Commercial DG. The NSDR was designed to ensure that any disruption to supply was identified early, ideally before it has impacted; and to address supply shortages in medicines or other vital supplies. It was established to work with key suppliers, health services, and adult social care organisations to coordinate and manage actions to address supply incidents that might have occurred after the end of the EU Exit transition period (CS/13 - INQ000183336). It was based on existing processes for managing disruption, but and in preparation for an increased volume of disruption. It supported six supply areas identified across the health and care system: medicines; medical devices and clinical consumables (MDCC); non-clinical goods and services; vaccines and countermeasures; substances of human origin; and clinical trials. It was ready to operate at the various potential exit dates, but these were all extended until the UK left the EU on 31 January 2020, and under the Implementation Period border controls did not change overnight and so it was not needed. However,

it was therefore ready to go and was made operational at the start of the pandemic and played a significant role in PPE supply, as well as supporting the testing programme and Covid vaccination programme. Preparing for an EU Exit therefore led to vastly improved understanding and resilience of the supply chains for medical products.

45. On 23 January 2020, the European Union (Withdrawal Agreement) Act 2020 received Royal Assent. This was the legislation that implemented the withdrawal agreement negotiated by the UK and the EU. The UK was to leave the EU and enter a transition period on 31 January 2020. On 30 January 2020 I discussed and agreed with the relevant part of the EU Commission to urgently continue the UK's participation in discussions of the HSC on what became the COVID-19 pandemic. CO agreed that we could continue information-sharing and participating in relevant meetings on COVID-19 during the emergency (CS/2 - INQ000183337, CS/14 - INQ000183338). This was important as it meant we continued to attend the committee allowing the UK policy, technical and scientific leads to continue to share information on areas including the epidemiology of the new disease; the geographical spread; border controls; and later in the pandemic on vaccines, treatments and new variants. While some of this information is available publicly, through the WHO, or through bilateral conversations between national experts, the HSC is an effective established mechanism and there had not been time to establish a new mechanism with the EU, given our exit on 31 January 2020.

Future Pandemic Preparedness

46. You have asked me to comment on improvements to the UK's future pandemic preparedness including the PIPP and PFRB boards, systems, structures and processes. My response covers the scope of pandemic preparedness, and taking an all hazards approach and all routes of potential transmission; the importance of building core capabilities in the health and care system in addition to plans; and governance including the PIPP Board.

47. I have sought to learn lessons throughout the COVID-19 pandemic and to implement changes alongside maintaining the twelve areas covered above. The comments I

make here are in no way comprehensive in terms of what we have learnt nor what could be done in the future to prevent, prepare and respond to pandemics. There are rightly a number of very relevant studies, including the CMOs' *"Technical report on the COVID-19 pandemic in the UK"* which sets out learning across many areas of pandemic response, and the evidence and hearings of the Public Inquiry. There will also be a DHSC corporate witness statement on M1 lessons learnt.

48. In terms of the current position, the Government and public services including health and care are now over a year into implementing the Living with Covid strategy. The pandemic is still ongoing but the response to the current variants and the disease is based around effective vaccines, treatments and diagnostics, which is proving successful in managing the disease. There need to be contingency plans for a resurgence of cases, and active surveillance and preparedness for response if a new variant emerges against which the existing vaccines, treatments or diagnostics are not as reliable.

All hazards approach and routes of transmission

49. As I have stated above, it is important not to assume that a future pandemic will be similar to COVID-19. It could be another coronavirus with similar features, an influenza virus, or a novel pathogen from a range of sources. It could transmit in a similar way, or through another route. The DHSC corporate witness statements for M1 and M2 list the pandemics in the last century; while most are respiratory the HIV pandemic is still ongoing and the response has not been based around a successful vaccine. Whilst experts still advise that an influenza pandemic is the most likely, a range of other pathogens are obviously possible, and AMR is sometimes called the 'silent pandemic'.

50. A pandemic preparedness approach that follows the main routes of transmission means that preparedness can be based on broad categories, alongside potential specific pathogens. The five routes of transmission are respiratory including droplet and aerosol (e.g. COVID-19 or flu); contact or touch (e.g. Ebola/Lassa); sexual/intravenous (e.g. HIV); vector-borne (e.g. plague, Zika); and oral through food and water (e.g. cholera, BSE/vCJD). The remit letter to UKHSA and their surveillance and technical capacities cover all these routes.

51. Whilst out of scope of pandemic preparedness, emergency response plans and capabilities also need to cover non-biological threats such as chemical, radiological or nuclear risks, whether these are accidental or intentional. Diagnostics, supplies including PPE and treatment capacity are relevant for these threats as well as disease threats and so some elements can be considered together.

Core capabilities

52. Our future approach should also be aligned with wider resilience of the health and care system in terms of core capabilities for epidemics, shocks or pandemics. Whilst a pandemic can be a once-in-a-generation event, it is not predictable and we need to prepare for future pandemics alongside other major threats and risks, including infectious disease outbreaks, AMR or supply shortages. This would help prepare a system that is not based around plans but around core capabilities and resilience.

53. The Department needs to continue to maintain its EPPR function, and the ability to scale up incident management teams as needed. It oversees the pandemic preparedness work through the PPP Board, and has continued responsibility for pandemic policy, including in areas which are being reviewed in the light of the COVID-19 pandemic, such as the maintenance of clinical countermeasures, and the legislative framework. The research infrastructure, international work and contingency plans are also essential.

54. UKHSA needs to have core capabilities for surveillance, testing and diagnostics, science, and genomics, again in light of the lessons of the COVID-19 pandemic. Alongside the previous PHE functions, it has responsibility for maintaining the new capabilities set up during the COVID-19 pandemic at an appropriate and proportionate scale. These new capabilities were the Joint Biosecurity Centre (on data and surveillance), NHS Test and Trace (on testing infrastructure, provision and contact tracing), and the Vaccines Taskforce (on supply of COVID-19-specific vaccines). It is establishing surveillance across all threats, and all five main routes of transmission. Ministers set out the responsibilities and priorities for UKHSA on an annual basis in an annual "Remit Letter".

55. The NHS needs to maintain core capabilities in the ability to treat and isolate high-consequence infectious diseases, to respond to emergencies, to surge services and workforce if needed, to deliver large scale vaccine programmes, among other areas.

56. Decisions about funding and priorities are for Ministers, who need to balance a range of issues in the health and care system including current performance, with preparedness and insurance policies. These can be aligned, for example in workforce and training, ICU and general bed numbers, laboratory capacity and investment in new technologies and science such as genomics. Clearly there are sometimes trade-offs to be made, for example in UK self-sufficiency in critical supply versus value for money. There are also approaches that can be taken so that there is ability to scale up fast, rather than hold latent capacity; or to have call-off contracts for example for new vaccines.

Governance, including the PPP

57. In December 2020, the PIPP Board decided to reconsider the scope of the pandemic preparedness programme with expansion to include non-influenza pandemic threats whilst acknowledging that this should not be at the expense of pandemic influenza preparations "*in recognition that it remains the highest health risk on the National Risk Register*" (CS/15 - INQ000087221). In line with these changes, its title has now changed to the Pandemic Preparedness Portfolio (PPP). The future programme should include surveillance and scientific expertise, led by UKHSA, for threats of pandemic potential from all routes. It will also consider mitigations and preparedness for specific pathogens, e.g. H5N1, and for groups of diseases by route of transmission.

58. The strategic approach to pandemic preparedness needs to cover all elements of our previous response, refreshed and improved in light of the experience of the COVID-19 pandemic. It should include resourcing within DHSC, UKHSA, MHRA and the NHS, and CO should continue to convene across government for the many issues in non-health and care settings. Each department will be reviewing their preparedness in the light of the COVID-19 pandemic.

59. There is an understandable desire, having implemented the Government's Living with COVID-19 strategy, to move on from the pandemic and address other issues. Experts agree however that there will be future pandemics, and as I covered above, it should not be assumed that the next one will be similar to COVID-19. The inquiry can help to consider proportionate attention is given to the prevention and management of public health emergencies, including pandemics.

International

60. Finally, you ask a number of questions on international collaboration and potential improvements arising from my comments to the Public Accounts Committee on 12 January 2022 in a session about the government's preparedness for the COVID-19 pandemic: lessons for government on risk management. These questions cover how the WHO and Member States including the UK could be better prepared for emerging pandemics, progress on alert levels and the potential pandemic treaty; and about bilateral agreements including with the G7 on earlier pandemic alerts. I will comment briefly on these areas and progress made in the last year below.

World Health Organisation

61. Overall, it is important that the global health system has a WHO with sustainable financing for both core capabilities and emergency response; effective governance and ways of working; improved transparency of decision making; and confidence that Member States are meeting their international obligations with respect to the current International Health Regulations. It is also critical that WHO maintains and develops its technical, clinical and scientific expertise as a trustworthy and robust body, outside of political interference.

62. Discussions in the WHO and with member states have developed into negotiations on potential reforms and improvements to the International Health Regulations and the possible Pandemic Instrument. A Special Session of the Executive Board in November 2021 agreed to form an Intergovernmental Negotiating Body which has been established to consider reforms by May 2024. The scope is "to draft and negotiate an WHO convention, agreement, or other international instrument on pandemic

prevention, preparedness and response". The INB has agreed that it will include legally-binding and non legally-binding elements.

63. The UK is participating in those negotiations, and my international team are working with FCDO to represent the UK position, according to Ministerial views. Making progress on extending Member States' responsibilities to report outbreaks, to share information and to cooperate on response would clearly add to global health security. Successful negotiations will need to balance what is achievable for agreement by all Member States in terms of international obligations and national interests. Whilst a shared outcome may seem easy or obvious, there are complicated and controversial issues including equity of access to medicines, the role of national parliaments, and biosecurity. It is important also that a time-limit has been put on the negotiations so that these issues can be explored and the potential for agreement and conclusion is not allowed to drag on for years.

64. There have not been further international discussions specifically on an intermediate alert level in the WHO. It is worth noting that the WHO DG declared a new public health emergency of international concern on 23 July 2022 for Mpox, which was an appropriate alert for the extended spread or epidemic of an existing disease (CS/16 - INQ000183345). In September 2021 the WHO established a new Pandemic Hub for Pandemic and Epidemic Intelligence, bringing together pre-existing and new reporting and alerting mechanisms arising from the COVID-19 pandemic.

65. Turning to funding, there are reforms and improvements that could be made to the funding approach to increase the effectiveness of WHO. The UK is one of the largest funders of the WHO and contributes significantly also in terms of technical support. The UK pays its core contribution in line with all members, which is decided by a formula connected to the Member State's GDP. The UK also contributes large additional amounts of 'voluntary contributions', e.g. for specific programmes. More sustainable medium-term funding, for example a larger proportion of WHO budget coming from core contributions from all states, would strengthen the ability of the WHO to plan on a longer term basis without having high levels of uncertainty year-to-year on programme funding and emergency response. It would also lead to fairer system of contributions and reduce perceptions of political influence.

66. The UN, in collaboration with the WHO, is convening a one-day High Level Meeting on Pandemic Prevention, Preparedness and Response in September 2023 alongside the annual UN General Assembly. It plans to "adopt a political declaration aimed at mobilizing political will at the national, regional and international levels for pandemic prevention, preparedness and response." The UK will attend this meeting, which is planned at Head of State level. DHSC and FCDO officials will work to prepare for this meeting and declaration.

Multilateral and bilateral agreements

67. In addition to strengthening the WHO and international agreements, preparedness can be improved through other agreements where countries can agree to go further that that agreed between 194 member states. The UK continues bilateral and multilateral work, particularly with like-minded countries, in order to strengthen global health security, for example to share information on current disease outbreaks, to consider the most likely or severe risks and threats, and to cooperate on technical discussions in a range of scientific and clinical areas.

68. These include but are not limited to G7 and G20 health declarations, the 100 Day Mission, collaboration with the EU, Memorandums of Understanding between governments and/or public health agencies (the UKHSA for the UK), and the GHSI. As I covered above, the GHSI has a range of working groups on a voluntary basis between technical experts, including on pandemics, and work to improve early alert systems and information sharing on health threats.

69. There is also relevant work on tackling AMR, including by Dame Sally Davies as the UK AMR Global Envoy, and related ODA-funded programmes to help strengthen and build capability in public health in low and middle income countries such as the Fleming Fund. AMR is sometimes called the 'silent pandemic'. Improvements in core capabilities in these countries strengthen the global health security and response capability, and the UK and other developed countries can support preparedness capability and response in this way. Core capabilities include skilled and trained workforces, laboratory networks, surveillance systems, diagnostics, vaccination and

universal health coverage. Building these systems for any known disease will also improve capability for new or emerging pathogens and future pandemics.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 28/04/2023