Witness Name: Christopher Stephen Wormald
Statement No.: 4
Exhibits: CW4/1-CW4/50
Dated:

UK COVID-19 INQUIRY

FOURTH WITNESS STATEMENT OF SIR CHRISTOPHER STEPHEN WORMALD

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1. I, Sir Christopher Stephen Wormald, Permanent Secretary of the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

INTRODUCTION

2. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 6 February 2023 made under Rule 9 of The Inquiry Rules 2006 (the Request) asking for a witness statement in connection with Module 1 of the Inquiry, focussing on the topic of assessing and planning for inequalities and vulnerabilities within the context of health-related civil emergencies.

3. As this is a corporate statement on behalf of the Department of Health and Social Care (the Department) it necessarily covers matters that are not within my own personal knowledge or recollection. Where a matter is within my personal knowledge, I have sought to make this clear. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

SECTION 1: THE CLINICAL CONTEXT TO EQUALITIES

4. At the outset I should note that equalities and improving health and wellbeing are at the heart of all the Department's functions. In line with the principles and values that guide the NHS, the Department is committed to ensuring that resources are maximised for the benefit of the whole community, making sure that nobody is excluded, discriminated against or left behind.

5. These principles and values, which are reflected in the World Health Organization's August 2008 Commission on Social Determinants of Health report, 'Closing the gap in a generation: health equity through action on the social determinants of health' (the 2008 Report) and the February 2010 Sir Michael Marmot review, 'Fair Society, Healthy Lives' (the Marmot Review), can be seen in the medical practice of clinical prioritisation, i.e., identifying who is most vulnerable and taking the necessary steps to protect them, and are perhaps best illustrated in the context of a pandemic by the prioritisation of the giving of vaccines, assuming a limited supply, to those most in need first (CW4/1, CW4/2).

6. At an individual patient level clinicians from all disciplines are trained to consider risk factors in making clinical diagnoses and to make management plans based on those risk factors. Age, gender, ethnicity, sexual orientation, pregnancy and other protected characteristics are often relevant to diagnosis or treatment (although not always, and seldom all of them). Clinicians undertake this as part of normal good clinical practice. The possible range of serious medical conditions that would be likely in a pregnant woman would be completely different from a man over 70 for example. The importance is however variable depending on the condition, and in the case of pandemics and epidemics on the infection. For the last major pandemic, HIV, sexual orientation and ethnicity were, for example, potentially very important in considering increased risk, older age was not; in COVID-19 sexual orientation had no major relevance in clinical decision making but older age, and ethnicity did.

SECTION 2: THE DEPARTMENT'S APPROACH TO EQUALITIES

7. The Department's approach to its equalities duties is not just limited to those requirements set out in the Equality Act 2010 (EA 2010) but also includes, for example, the duty in section 1C of the National Health Service Act 2006 (the Act), as inserted by the Health and Care Act 2012, which in part reflects the 2008 Report and the Marmot Review, to

reduce inequalities between the people of England with respect to the benefits that they can obtain from the NHS. Further detail in respect of these duties is set out below.

National Health Service Act 2006 (NHS Act 2006)

8. Section 1C of the Act places a duty on the Secretary of State to have regard to the need to reduce inequalities between the people of England. This is in respect of both access to health services and the outcomes achieved, including any benefits that may be obtained by them. This duty encompasses the Secretary of State's functions in relation to both the NHS and public health. Section 1B also places a duty on the Secretary of State to have regard to the NHS Constitution in exercising his or her functions in relation to the health service.

9. The Department's purpose is to support and advise the Government's health and social care Ministers by shaping policy and assisting in the setting of the strategic direction for the health and care system. Through this the Department fulfils the Secretary of State's statutory duty under section 1 of the Act to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of people in England and in the prevention, diagnosis and treatment of physical illness. The Department secures funds for the NHS and remains accountable for this funding, which is allocated to the most appropriate local level.

10. The Secretary of State also has a statutory duty under s. 2A of the Act to take steps he considers appropriate to protect public health in England and a power under s. 2B to support public health improvement. The principal route for the discharge of these responsibilities was through Public Health England (PHE), with both the Department and PHE having responsibilities for planning for and managing the response to emergencies and health protection incidents and outbreaks in an extended team working across Government.

11. The Secretary of State's overarching general duties under sections 1-1G and 2A of the Act do not apply to social care. Rather the Care Act 2014 places a duty to plan and secure adult social care services on 152 local authorities in England and recognises the local authority's duties to promote wellbeing when providing care and support services. The Department is responsible for setting national policy and the legal framework for social care whilst the Department for Levelling Up, Housing and Communities oversees local government funding and the financial framework.

Equality Act 2010

12. Pursuant to Schedule 19 of the EA 2010, the Department is subject to the Public Sector Equality Duty (PSED), found at section 149(1), which states that in the exercise of its functions, it must have due regard to the need to:

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

13. The Department, as a "service-provider" to the public, is also subject to section 29 of the EA 2010 which imposes a duty not to do anything, in the exercise of a public function, that constitutes discrimination, harassment or victimisation. More specifically, it is not to harass, victimise or discriminate: as to the terms of the service provided; by terminating the provision of the service; or by subjecting a person to any other detriment.

Human Rights Act 1998

14. Under section 6 of the Human Rights Act 1998 (HRA), the Secretary of State is required to act in a way that is compatible with the European Convention on Human Rights (ECHR), except in limited circumstances. Furthermore, under section 19 of the HRA, the Secretary of State has a duty to provide a statement confirming that the provisions of any Bill laid before Parliament are compatible with the ECHR.

15. In terms of how the Department approaches its duties in respect of equalities, any such impacts are routinely assessed and taken into account during the formation of policies and the decision-making process, which generally takes place in the usual Government fashion, i.e., by the provision of submissions to the decision-maker(s).

16. The Department also recognises that there are multifaceted socio-economic reasons that lead to inequalities in health, as well as systemic failures in institutions to recognise and address the health of particular groups, including those from ethic minority backgrounds, women, the LGBTQ+ community and those with disabilities. The Department's work is aimed at reducing the differentials in life expectancy between those and other such groups and the average through a 'whole system' approach and that is inherently central to the preparation for any pandemic.

17. In respect of the Department's governance, it has run training for staff in respect of PSED since at least 2016, it has overarching equality objectives (and has done so for a number of years) and it mechanisms in place, for example templates for submissions, to ensure that equalities are considered. These matters are considered in further detail below.

Training and equalities

18. The PSED team lead the oversight of capability and assurance of PSED in the Department by supporting and encouraging staff to focus on considering equality from the perspective of improving outcomes for people, rather than as a legal duty or process, and aims to ensure that equality is put at the heart of all policy and decision-making. The PSED team offer support by delivering training and other initiatives on PSED, answering queries and providing advice, critically reviewing Equality Impact Assessments, and is responsible for the Department's Equality Objectives and the publication of its PSED annual report.

19. Since at least 2016 staff in the Department have been trained internally on the PSED. The course was established as a 'Policy Certificate' and policy officials at all levels were encouraged to participate.

20. The training course is delivered by the Department's PSED team in conjunction with legal advisors from the Government Legal Department. It is intended to give attendees a general overview of how to comply with the PSED and makes clear that senior civil service is responsible for ensuring that it is considered and addressed in each policy area.

21. The training has, at a minimum, been run quarterly, although demand has necessitated it being run more often. An example set of the training slides is exhibited to this statement (CW4/3).

22. The training has been supplemented by the PSED team providing an 'equalities analysis' template on the Department's intranet, which policy teams were encouraged to use (CW4/4). Further, from 2018-2020 the PSED team also provided a bespoke service offering comment and challenge on individual policy team's draft equality and analysis templates.

Departmental equality objectives and annual reports

23. The Department's equality objectives for the period 2012-2013 were: 'Better Health, 'Better Care', 'Better Value', 'Successful Change', 'Our Partners' and 'Us' (CW4/5,

CW4/6). Each of these was supported by detail as to the underlying equality objective. For example, the equality objective for 'Us' was *"To ensure that the Department has a motivated and engaged workforce that represents the community that it serves, at all levels in the organisation – through the provision of relevant policies and guidance, learning and development, and targeted initiatives."* These objectives were extended to apply throughout 2014 as set out in the Department's annual report on equalities (see further below) (CW4/7).

24. The Department had different equality objectives for the period 2015-2018 and 2019 to 2023 (CW4/8, CW4/9).

25. The Department's equality objectives make clear that tackling equality issues is a priority that should be embedded throughout the Department and its work and the Department ensures that this has been done by producing an annual report setting out, by way of representative examples, how each of the equality objectives has been met in any given year (CW4/7, CW4/10-CW4/17).

Departmental governance

26. As indicated above, the Department has a template for submissions to ministers where a decision is required on a policy issue. The template includes a checklist that highlights the PSED as something that must be considered by the team developing the policy. A further section in the template concerns legal duties and reminds teams that they need to provide advice on legal duties, including under the EA 2010, and that they should be working with the Department's lawyers on this.

27. In addition to the submissions template the Department undertakes bi-annual assurance meetings (or 'BAM') with each Director General Group. These are chaired by me and attended by the Director General and Directors for that Group. The BAM process ensures that where issues arise during the year, they are appropriately reported and discussed. The BAM process also contributes to the arrangements in place to address identified weaknesses and drive improvements.

28. In 2018, following a Government Internal Audit Agency internal audit on equalities assurance, the BAM slides were updated to include a field to report on PSED matters (CW4/18). In March 2020 the PSED field in the BAM slide pack was updated following the Government Internal Audit Agency follow up report on equalities assurance (CW4/19). The

amended slides improved the comprehensiveness of the returns on PSED from each group and the revised approach remains in force to-date.

29. This important background sets the scene for the Department's approach to pandemic preparedness.

SECTION 3: EQUALITIES IN PANDEMIC PREPAREDNESS

Introduction

30. Pursuant to section 2 of the Civil Contingencies Act 2004 (the CCA) the Secretary of State for the Department is under a duty as a Category 1 responder (as designated by paragraph 9 of Part 1, Schedule 1 of the CCA) to assess and plan for emergencies. A pandemic or another health-related matter would be encompassed by the definition of emergency provided at section 1(1)(a) of the CCA.

31. As a piece of legislation, the CCA is 'owned' by the Cabinet Office (CO) with 'human disease' identified on the Government-owned National Risk Register of Civil Emergencies (2017 edition) (NRR) (CW4/20).

32. The Department was identified by the Civil Contingencies Secretariat (CCS) as the lead government department (LGD) for pandemic preparedness, response, and recovery under the CCA. The Department is the LGD for three infectious-disease related risks in the NRR: the risk of an influenza-type disease pandemic (which is the highest-rated natural hazard risk in the NRR), the risk of an emerging infectious disease (which is an acute risk) and the risk of antimicrobial resistance (which is now classified as a chronic risk). The Emerging Infectious Disease risk incorporates the risk of a High Consequence Infectious Disease (HCID) outbreak or incursion.

33. The Department maintains a Director-led Emergency Preparedness, Resilience and Response (EPRR) function to assist the Secretary of State in discharging their duty under section 2 of the CCA, with the EPRR leading on planning for and responding to incidents where there is a potential risk to the public's health.

34. In the specific case of planning for an influenza pandemic, the Department has, since October 2007, maintained a Pandemic Influenza Preparedness Programme (PIPP) and Board (the PIPP Board). Until March 2017, the PIPP Board was chaired by the Chief Medical Officer (CMO). Since March 2017, it has been chaired by the Director General for Global Health. The PIPP Board is attended by representatives from NHS England (NHSE),

the UK Health Security Agency (UKHSA) (previously Public Health England), the Department and the CO. The PIPP Board was responsible for setting the strategic aims and objectives of the programme and for coordinating the work of stakeholder organisations to meet these objectives.

35. Whilst the Department did factor potential impacts on specific groups, including those with protected characteristics under the EA 2010 and people with other kinds of inequalities and vulnerabilities, into its planning for an influenza pandemic and other potential health-related emergencies, such planning can only take matters so far until the precise nature of the emergency becomes known. By this I mean that precisely which groups are vulnerable will depend on the particular circumstances of the emergency. Even within respiratory diseases the target vulnerable groups can be very different. The highest mortality from COVID-19 is in the oldest age groups, with risk decreasing with age and with children at very low risk. The 1918 influenza pandemic (Spanish flu) mainly affected the very young and elderly, but also had relatively high mortality rates in young adults. Another example is the groups at risk in respect of the HIV/AIDS pandemic, who are manifestly different from those who were at higher risk from, for example, the 2009 swine flu pandemic. This uncertainty means that planning for those with vulnerabilities necessarily carries a degree of imprecision and could only be carried out at a high level of generality.

Particular steps taken/relevant documents

36. Following the recommendation of the then CMO in their 2005 annual report, a Committee on Ethical Aspects of Pandemic Influenza (CEAPI) was established. The CEAPI developed an ethical framework that was published as a draft for comment by the Department in March 2007 (CW4/21, CW4/22). The aim of the framework was to assist planners and strategic policy makers with the ethical aspects of decisions before and during an influenza pandemic. The framework made the point that:

> *"In thinking about the principles, decision-makers will need to use the best information that is available to them at the time (for example, about the likely effects of a particular approach). Whether or not a decision was ethically appropriate has to be judged relative to the situation that existed at the time it was made, rather than by reference to facts that only become apparent at a later stage."* (CW4/22)

37. The principles established by the framework were: (1) treating people with concern and respect, (2) minimising the harm that a pandemic could cause, (3) fairness, (4) working together, (5) reciprocity, (6) keeping things in proportion, (7) flexibility and (8) good-decision making.

38. In November 2007, the Department published a suite of documents concerning 'Pandemic Flu' (CW4/23-CW4/26). The core document was a joint Departmental/CO document titled 'A national framework for responding to an influenza pandemic' (the 2007 Framework), and it recognised that achieving the strategic objectives in response would require the development of operational response arrangements (CW4/23). The purpose of these arrangements would be to maintain normal services for as long and far as possible during a pandemic, whilst recognising that the challenges presented may require the curtailment of certain services, potentially partially to allow the diversion of resources or protect those who may be particularly vulnerable.

39. The 2007 Framework at paragraph 6.2 set out the major elements of a UK response to an influenza pandemic, one of which was 'ensuring that those who are vulnerable or affected receive appropriate treatment and care' (CW4/23).

40. In addition to the 2007 Framework, the CO and Department published a document titled 'Responding to pandemic influenza: The ethical framework for policy and planning' (CW4/27). The document was based on the principles identified by the CEAPI in its 2007 document (detailed above) as underpinning the following tenets: (1) everyone matters, (2) everyone matters equally, but this does not mean that everyone is treated the same, (3) the interests of each person are the concern of all of us, and of society and (4) the harm that might be suffered by every person matters, and so minimising the harm that a pandemic might cause is a central concern. The purpose of the document was to assist planners and strategic policy makers at national, regional, and local level, before and during a pandemic.

41. As part of the November 2007 suite of documents, the Department also published guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England within the context of planning for an influenza pandemic (the 2007 PCT Guidance) (CW4/28).

42. Section 2.2 of the 2007 PCT Guidance contained 'Key planning assumptions', although it rightly noted that,

"…the epidemiology of an emergent influenza pandemic virus and its clinical behaviour cannot be predicted with certainty. Plans will have to be adjusted as new information becomes available." (CW4/28)

43. The 2007 PCT Guidance goes on to outline that primary care trusts are responsible in planning for an influenza pandemic for, amongst other matters, 'identifying and taking into account the needs of vulnerable and seldom heard groups'. Section 5.5 of the PCT Guidance provided further assistance for primary care trusts in identifying such vulnerable and seldom heard groups (CW4/28).

44. The 2007 PCT Guidance was prepared with the assistance of the Joint Committee on Vaccination and Immunisation (JCVI). The minutes of a JCVI meeting held on 17 October 2007 record that when considering the development of a strategy on pre-pandemic vaccination it was noted that:

"A key point in the discussion on the use of pre-pandemic vaccines was that the level of protection afforded against a newly emerging virus strain would not be known in advance." (CW4/29)

45. The minutes of the JCVI meeting go on to then consider the prioritisation of pre-pandemic vaccination by group:

"There was broad agreement that the available scientific evidence supported the strategic approach of stockpiling pre-pandemic vaccine. The Committee agreed that, while universal vaccination was the preferred option, should prioritisation be necessary, then the following groups, in no particular order, should be targeted: health and social care workers, children under 16 years and vulnerable groups such as those identified for seasonal influenza vaccination. The Committee did point out, however, that the groups might be subject to modification or internal re-ordering in the light of scientific developments, vaccine availability at the time of a campaign and real time knowledge and the scientific and clinical impact of the pandemic virus." (CW4/29)

46. Alongside and in addition to the 2007 Framework, the Department also published "Pandemic influenza Guidance on planning for vulnerable groups" in August 2008 (CW4/30). This was a draft guidance for comment that was updated in July 2009 and renamed to 'Pandemic influenza: Guidance on meeting the needs of those who are or may

become vulnerable during the pandemic' (the 2009 updated Guidance) (CW4/31). The introduction noted:

> *"For the purposes of this guidance, 'vulnerable groups' refers collectively to a wide range of people who face particular challenges in accessing mainstream public services, including health and social care.*
>
> *However, in relation to pandemic flu, the term 'vulnerable' can be extended to mean anyone who is known to be vulnerable or may become vulnerable in the course of the pandemic."*

47. The 2009 updated Guidance continued in the introductory section to set out the purpose of the document:

> *"The purpose of this guidance is to emphasise the need for vulnerable groups to be taken account of in the pandemic flu plans drawn up by primary care organisations and their partners (NHS trusts, foundation trusts, local authorities and the third sector). The guidance is for England only.*
>
> *All plans for the flu pandemic should be sensitive to the demographics of local populations, taking account of ethnic and cultural backgrounds and the geographical dispersion of residents. This is important to ensure adequate communications and access to services and treatment. In addition, the consideration of vulnerable groups and individuals within the population is essential to good pandemic flu plans."* (CW4/31)

48. The main objectives of the 2009 updated Guidance were to:

- *"prevent people who are or may become vulnerable from being discriminated against or excluded from care during the flu pandemic.*
- *encourage the development of effective and resilient local response plans for the pandemic that take account of the needs of vulnerable people.*
- *minimise the impact of the pandemic on vulnerable people who are known to health and social services*
- *minimise the impact of the pandemic on individuals who become vulnerable as a result of it.*
- *promote partnership working and integration of local response plans, for example between social care services and primary care."* (CW4/31)

49. Following the suite of 2007 documents the PIPP Board presented its 'Programme Outline Business Case' (the OBC) for the Pandemic Influenza Preparedness Programme in July 2008, which was the culmination of substantial preparatory work. The OBC set out the various cases (strategic, economic, commercial, financial and management) for a series of procurements under the PIPP (CW4/32). The OBC was premised on work previously carried out (such as that indicated in the JCVI minutes above) to identify vulnerable groups.

50. As part of its work in preparing for a pandemic, the Department commissioned and received a number of research reports under the umbrella topic, 'Behavioural Responses to Pandemic Influenza in the UK'. These reports considered, where relevant, the potential impacts of at risk or vulnerable people (CW4/33-CW4/40).

51. An example of emerging information about a virus informing the Department's planning for responding to it is presented by the 22 October 2009, 'Swine Flu, Guidance for planners' document (produced by the CO and the Department), which notes that, *"…children under 16 are significantly more susceptible to the virus…"*. Going on to consider the question of vaccination, the document sets out that:

> *"…Scientists are clear that vaccinating those people in at risk groups will be highly beneficial in preventing more serious illness in vulnerable people. Swine flu vaccine is now becoming available to NHS and social care staff and those in high-risk clinical groups."* (CW4/41)

52. The October 2009 'Swine Flu, Guidance for planners' built upon earlier work by the Scientific Advisory Group for Emergencies (SAGE) in May 2009, which produced a paper titled 'Situation Analysis of swine origin influenza H1N1 (H1N1swl) in the UK' that considered population vulnerabilities (see page 9). SAGE recommended (at page 36) that:

> *"…surveillance should now focus on determining severity of infection and age-related susceptibility to provide the best possible comparative data with seasonal influenza. This analysis should take account of age-related information and evidence of impact in potentially vulnerable populations."* (CW4/42)

53. The Department's 'UK Influenza Pandemic Preparedness Strategy 2011' (the 2011 Strategy) had a section on 'Ethical principles for pandemic preparedness' that adopted the 2007 ethical framework, which, it noted, had been reviewed by the Committee on Ethical

Aspects of Pandemic Influenza in light of the experience of the 2009 swine flu pandemic (CW4/43).

54. The 2011 Strategy was also accompanied by a separate 'Analysis of Impact on Equality', which carried out an analysis of the document by reference to the 2010 Act (CW4/44). The analysis contained 'lessons learned' from the 2009 swine flu pandemic. The analysis concluded (emphasis in the original):

> *"The UK Pandemic Preparedness Strategy 2010* [sic.] *should not impact differently on protected groups in any significant way. The strategy's primary focus is on identifying* ***all*** *symptomatic individuals and providing a route to treatment that eases pressure on primary care and other services. Steps have been taken to mitigate potential differential impact by ensuring that communications will be available in a range of languages and formats and that access to treatment is available via more than one route and is available in different languages (online)."* (CW4/44)

55. In 2013, the Department's EPPR function consulted on the introduction of new regulations to provide updated health protection powers and duties for use at England's ports and airports. As part of this process, an 'Equality Analysis' was produced in the usual way to have regard to the provisions of the 2010 Act (CW4/45).

56. As laid out in the M1 Corporate Statement, the Scientific Pandemic Influenza Group on Modelling (SPI-M)

> *"provides expert advice to DHSC and wider UK Government on scientific matters relating to the UK's response to a pandemic. The group may also provide advice on other emerging human infectious disease threats as required.*
> *… Advice from SPI-M prior to the COVID-19 pandemic primarily took the form of a "modelling summary". This represented the SPI-M Committee's consensus view of the epidemiological modelling evidence available at the time and the possible implications for planning, and was periodically updated as necessary following SPI-M meetings. It was not a statement of DHSC or wider government policy"*

57. Consistent with the comments highlighted above, section 3.4 in the 'Modelling Summary' published in November 2018, the most recent version prior to the COVID-19 pandemic, notes that:

> *"In the early stages of a pandemic, the groups for whom the risk of complications or death is greatest will not be well known. However, groups identified as being at a higher*

risk of complications or death from seasonal influenza are likely to be at a higher risk of complications or death from the pandemic strain. As the outbreak progresses, surveillance data will accumulate, and it may be possible to better identify risk groups and estimate key disease parameters. If the pandemic starts abroad, reasonable estimates of some (but probably not all) disease parameters may be available by the time the disease reaches the UK. However, if the pandemic starts in the UK, no such estimates will be available initially." (CW4/46)

58. In January 2019, as part of the cross-Government Pandemic 'Flu Readiness Board (PFRB) work programme, it was agreed that a moral, ethical and faith advisory group should be established to provide specialist advice before and during an influenza pandemic. This led to the creation of the Moral and Ethical Advisory Group, the first meeting of which took place on 25 October 2019 (CW4/47).

59. The CO's 2019 National Security Risk Assessment (NSRA) (CW4/48) contains full scenario assessments for 'Human and Animal Disease' with the point being made about an influenza-type disease pandemic that,

*"**Impact on vulnerable groups***
Mortality and morbidity patterns for pandemic influenza are complex to understand. In general attack rates are highest in children and decrease with age. At the same time the likelihood of death, if infected, generally increases with age (although there is also an increased risk of death in the very young). Taken together these phenomena can combine to increase the proportion of influenza deaths overall which occur in younger adults of working age, as was clearly observed in 1918 (a severe pandemic) and 2009 (a mild one). The precise pattern of morbidity and mortality will vary according to the pandemic strain and cannot be predicted in advance, emphasising that high quality real-time surveillance is a critical capability.

Whether the influenza virus particularly affects one sub-set of the population or not, it is very likely that there will be an impact on vulnerable populations due to the wider impacts of the pandemic on public services and critical national infrastructure. In the [reasonable worst case scenario]*, those with existing health and social care needs may not be able to access their usual services either because of increased demand, fewer staff or planned cancellations to divert resources to dealing with the pandemic.*

There could also be further impacts upon other vulnerable populations, due to the higher rate of staff absence due to ill-health. This may make some safeguarding procedures more difficult." (CW4/49)

60. The NSRA contains further consideration of the potential impacts on vulnerable groups when considering the risks from emerging infection disease.

61. The draft Pandemic Influenza Bill (prepared following Exercise Cygnus) was subject to an analysis resulting in a report dated 16 December 2019 providing a summary of the impacts of its clauses (CW4/50). Annex A of the document contains an equalities assessment that

had been carried out for the draft, including mitigation measures where it was identified that clauses may have an impact on equalities. For example, Annex A notes that temporary school closures might be felt disproportionately by disadvantaged children, and so to mitigate that adverse impact, it was proposed that the relevant department would not claw back early education entitlement place funding that local authorities receive.

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: 10.05.2023