UK COVID-19 Inquiry

Module One Closing Statement on behalf of the Department of Health and Social Care

2 August 2023

Introduction

1. COVID-19 was a huge shock to the entire world. Our resilience as a society was tested. The question for this Inquiry, for our society and for this and future governments is how to turn the pandemic into change and improvement so we can mitigate the impact of any future pandemic as far as possible. The Department has carefully considered all the witness evidence in this module, both written and oral. It wishes to express its particular gratitude to the witnesses from the Covid Bereaved groups from all four nations, for the fortitude they have shown in the evidence they have given and for their palpable commitment to seek to improve matters for the future. Further, the Department echoes the sentiment expressed by the Chair of the Inquiry that the abuse targeted at members of the Covid Bereaved groups is cruel and unwarranted, and giving evidence in public against the backdrop of such abuse demonstrates real courage and commitment.[1]

2. These closing submissions set out the position of the Department of Health and Social Care ("**the Department**") based upon the evidence heard so far. However, the Department identifies that it may wish to alter its position as the Inquiry progresses and further evidence is heard. The Department is committed to learning lessons and implementing change where necessary.

3. Having listened carefully to the evidence in module one, the Department agrees with the view expressed by the Government Office for Science in their oral closing submissions,[2] that the principal issue which needs to be discussed by the whole of society is how much we want to invest in contingency planning for future pandemics. As per the evidence of Professor Chris Whitty, the measures taken for pandemic preparedness are a form of "insurance".[3] Governments are often, understandably, focused on managing immediate concerns rather than long term structural, organisational, and operational requirements needed for pandemic planning; as Sir Oliver Letwin put it, "the wasp in the room attracts more attention than the lion outside".[4] The dedication of funds to some areas of contingency planning is already accepted; for example, as Sir Patrick

[1] Matt Fowler transcript 18.07.2023, pp.9-10, p.20, ll.15-19.
[2] Matthew Hill's closing submissions on behalf of the Government Office for Science, transcript 19.07.2023, p.47, ll.15-25.
[3] Professor Chris Whitty transcript 22.06.2023, p.108, ll.18-25, p.109, ll.1-22.
[4] Sir Oliver Letwin first witness statement, p.11, §36.

Vallance indicated, in our armed forces.[5] The Department submits that civil contingencies, including health emergencies, should be seen and planned for in the same way; and that there are choices about the scale of the contingencies and how and where such investment is focused. The Department's view is that to maximise the benefit of investment, there could be particular benefit in capabilities which can be utilised in non-pandemic periods and in response to a range of potential risks which may arise.

Five key lessons

4. The Department continues to believe that the five most important areas where it has learnt and has made changes in respect of preparedness (as identified in our opening submissions) are as follows:

   (1) **Creation of a "toolkit" of capabilities which can adapt to deal with whatever public health risk emerges, rather than a fixed plan against specific threats or viruses.** The evidence from module one has been clear that, given the unpredictability and range of possible future pandemics, it is unrealistic to try to create a specific plan for each possible new threat.[6] Instead, the Department recognises the need for future pandemic preparations to focus upon developing a "toolkit" of capabilities which can flexibly pivot to address different emerging threats and are backed up by sufficient resources so that they can be "scaled up" quickly.[7] Such resources include having global communication and data systems to identify emerging High Consequences Infectious Diseases ("**HCIDs**") with rapidity, testing capacity which can be increased rapidly to identify the spread of the pathogen on a wide basis, if needed, and sufficient stockpiles of medical countermeasures which can be distributed across the UK, again as quickly as possible.[8] The Department has already begun work on this, by expanding its approach to clinical countermeasures to cover the five main routes of transmission and commissioning a review of our emergency preparedness countermeasures in order to ensure that our approach is applicable to a broader range of pathogens with pandemic potential.[9] Further, the United Kingdom Health Security Agency ("**UKHSA**") has responsibility for maintaining the capabilities established during the COVID-19 pandemic which includes the Joint Biosecurity Centre (on data and surveillance), NHS Test and Trace (on testing infrastructure, provision and contact tracing), and the Vaccines

[5] Sir Patrick Vallance transcript 22.06.2023, p.159, ll.17-24.
[6] Sir Chris Whitty second witness statement, p.39, §5.11.
[7] Sir Chris Whitty transcript 22.06.2023, p.95, l.25, p.96 ll.1-9, p.100 ll.6-15. Sir Patrick Vallance transcript 22.06.2023, p.160, ll.2-11.
[8] Sir Chris Wormald sixth witness statement, p.14, §51.
[9] Chris Wormald sixth witness statement, p.15, §54.

Taskforce (on developing vaccine technologies).[10] The Department recognises that maintaining and developing these capabilities will enable us to be better prepared for a future pandemic virus or disease which, as Professor Mark Woolhouse stated, may be even more transmissible and deadly than COVID-19 was.[11]

(2) **Resilience matters.** The Department recognises that central to pandemic preparedness is the underlying resilience of the health and social care system.[12] As a society, there is a need to consider how levels of core capacity for day-to-day health and care services can remain resilient and be expanded to meet demand when faced with a health emergency.[13] These decisions are taken by the Government on a regular basis and are already well debated in society. The Department accepts that at the time the pandemic struck, the adult social care sector had structural challenges which damaged its resilience.[14] It also notes that the NHS is run at capacity, and therefore has little spare flexibility in the system when shocks occur. It is also the case that public health funding, like most other forms of funding, was not protected in the same way as the NHS during the period covered by this Inquiry. The Department has recently set out its plan to improve the resilience of the adult social care system in its "Next Steps to put People at the Heart of Care" plan published in April of this year.[15] The plan outlines the government's investment in driving greater adoption of technology across social care, improving access to training and qualifications for the social care workforce, addressing services to support unpaid carers, and increasing the support offer across adult social care. Further, in relation to health, the Government has backed the recent NHS Long Term Workforce Plan, the first comprehensive workforce plan for the NHS which commits funding to train more staff, retain those staff and reform the way staff work.[16]

(3) **There must be the ability to "scale up" quickly**. The Department has reflected that a key lesson learnt from the pandemic is the need for plans and the ability to scale up staffing and equipment necessary to address and mitigate the spread of a disease quickly assuming that it will impact all of society.[17] In advance of a pandemic taking place,

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[10] Clara Swinson witness statement, p.22, §54.
[11] Professor Mark Woolhouse transcript 05.07.2023, p.148, ll.4-15.
[12] Clara Swinson witness statement, p.22, §52.
[13] Dame Sally Davies transcript 20.06.2023, p.151, ll.1-17.
[14] Emma Reed witness statement, p.8, §36.
[15] Next steps to put People at the Heart of Care: a plan for adult social care system reform 2023 to 2024 and 2024 to 2025 (publishing.service.gov.uk).
[16] https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.1.pdf.
[17] Sir Chris Whitty transcript 22.06.2023, p.97, ll.1-9, p.108, ll.3-7. Sir Chris Whitty third witness statement, p.22, §7.3.

goods, equipment and other protective measures which we can predict will be necessary in any pandemic (e.g. diagnostic facilities and skills, science and research, and potential non-pharmaceutical interventions ("**NPIs**")) need to be ready to be used, with plans in place as to how they can be scaled up quickly. Such measures can then be used to contain and mitigate the impact of the pandemic, while medicines, vaccines and other clinical responses to a new disease are developed. While the importance of this is evident, as already highlighted, the extent of any latent surge capacity can only be determined after society asks itself what proportion of available resources we are willing to invest in "insurance" against a future pandemic.[18] To answer this question, technical advisers need to be explicit with political leaders about how much varying levels of insurance will cost to reduce the impact of a pandemic by varying amounts, and in turn political leaders need to be transparent with society about the choice between having insurance against future events and investing in immediate pressures and emergencies.[19] As previously identified, the Department's view is that to make that decision easier, investment in scaled up capacity should, where possible and relevant, be used in non-pandemic periods and be helpful in addressing multiple potential risks.

(4) **Use diagnostics and data.** The Department recognises that data is central to providing good public health advice and services to all parts of society.[20] The paucity of data at the start of the COVID-19 pandemic meant, as Sir Patrick Vallance put it, the UK was "flying blind" more than we would wish to.[21] The Department accepts that the scale up of diagnostics to enable comprehensive data on the spread and extent of the disease was limited in the first phase of the pandemic. The Department's view is there are two areas of data collection that are crucial in a pandemic response, one which can be prepared and one which must be put in place at speed after the pandemic starts. First, is an over-arching data and diagnostics architecture which can be developed and utilised in non-pandemic periods to provide good information and intelligence about ill health and social care services. The Department accepts that prior to the COVID-19 pandemic, this underlying architecture was undeveloped in some aspects of the health and social care sector.[22] However, as the COVID-19 pandemic progressed wholesale data collection from all parts of the health and social care system was undertaken in a way not done before which has

[18] As identified in Matthew Hill's closing submissions on behalf of the Government Office for Science, transcript 19.07.2023, p.47, ll.15-25.
[19] Sir Chris Whitty transcript 22.06.2023, p.108, ll.18-25, p.109, ll.1-22.
[20] Sir Chris Whitty second witness statement, p.30, §3.69.
[21] Sir Patrick Vallance transcript 22.06.2023, p.167, ll.22-24.
[22] Nigel Edwards transcript 13.07.2023, p.55, ll.9-15. Sir Chris Wormald seventh witness statement, p.2, §6.

undoubtedly improved government processes for the assembly of data.[23] For example, the NHS Race and Health Observatory was established with the explicit mission of ensuring data by minority ethnic status is gathered regularly;[24] the Office for Health Improvement and Disparities was set up tasked with collecting data to identify and address health disparities;[25] and, the National Situation Centre was established which inputs and analyses data from a variety of different sources by data scientists.[26] The second area of data collection necessary for any pandemic response is specific data on the nature and effect of the disease, gathered from international and national sources, and health and community settings. While crucial, this can only be gathered and integrated once the disease emerges. Vital to being ready to extract disease-specific data is the provision of disease-specific diagnostic testing via laboratories, equipment and staff which can be scaled up quickly.

(5) **Prepare for future threats, not just for COVID-19.** Pandemic preparedness should not seek to prepare for the pandemic which has just happened; instead, pandemic plans need to take account of and be responsive to all the modes of transmission of communicable disease pandemics or major epidemics which could in the future occur, namely respiratory, touch, oral, blood and vector.[27] The epidemiological experts have made clear that while pandemics have always happened and will inevitably continue to happen, their precise nature cannot be predicted in advance.[28] As Professor Chris Whitty identified, the previous major pandemic in the UK was HIV; a sexually transmitted and blood borne virus with little or no similarities to COVID-19. [29] Further, the evidence has also shown that it is difficult to anticipate what will *become* of the next HCID outbreak.[30] As explained by Professor David Heymann, MERS and SARS and the various plans developed and exercises undertaken in relation to them, were very different to COVID-19.[31] It takes time and expertise to undertake the relevant genomic sequencing, to understand how the virus transmits and to make and

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[23] Professor Chris Whitty third witness statement, p.25, §8.5.
[24] Professor Michael Marmot and Professor Clare Bambra transcript 16.06.2023, p.69, ll.13-17.
[25] Dame Jenny Harries transcript 26.06.2023, p.126, ll.5-9.
[26] Sir Patrick Vallance transcript 22.06.2023, p.171, ll.4-10.
[27] Clara Swinson witness statement, p.21, §§49-50. Emma Reed witness statement, p.9, §38.
[28] Professor David Heymann transcript 15.06.2023, p.63, ll.21-22. Professor Chris Whitty transcript 22.06.2023, p.111, ll.5 – 17. Professor Jimmy Whitworth transcript 14.06.2023, p.106, ll.9 – 16. Sir Mark Walport transcript 21.06.2023, p.36, ll.15-18. Professor Mark Woolhouse transcript 05.07.2023, p.113, ll.10 – 22, p.125, ll.3-7. Sir Chris Wormald sixth witness statement, p.2, §7. Professor Chris Whitty second corporate witness statement, p.22, §3.34.
[29] Professor Chris Whitty second corporate witness statement, p.22, §3.34, p.75, §7.2, p.38.
[30] Dr Hammer transcript 14.06.2023, p.113, ll.15 – 25. Sir Mark Walport transcript 21.06.2023, p.19, ll.7-14. Sir Chris Wormald sixth witness statement, p.3, §9.
[31] Professor David Heymann transcript 15.06.2023, pp.15-38. Also highlighted in Sir Chris Wormald's sixth witness statement, p.3, §§10-12.

manufacture tests, medicines and vaccines, with no guarantee of success for any individual product. Therefore, whilst the UK has the ambitious target along with the other G7 nations of the 100 Day Mission to respond to future pandemic threats,[32] it is recognised that any future planning must take account of the need for social measures while clinical treatments and vaccines are developed.

Health inequalities

5. In addition to those five key lessons, the Department recognises that the Inquiry has heard important evidence regarding socio-economic health equalities, and that it is right to consider what more could be done to tackle and reduce these. Prior to the COVID-19 pandemic planning focused on clinical health inequalities rather than broader socio-economic inequalities.[33] The work done on identifying and addressing clinical inequalities in pandemic planning was vital in the COVID-19 response and the Department is committed to continuing this. However, while many of those clinical inequalities (for example those with heart disease, diabetes etc) are disproportionately more prevalent in some socio-economic groups than others, it is accepted that there was not specific focus upon those groups in the UK's pandemic planning.

6. The Department's view is that while pandemic planning needs to take account of all health inequalities, tackling and reducing health inequalities cannot and should not be done only whilst and when the country is responding to a pandemic. Instead, the government and society should consider how best to improve the underlying health of the population and address health inequalities in "normal times", so that when a pandemic emerges the whole population is as resilient as possible. The Department would submit that it is the role of the NHS, public health bodies and social care to, at all times, manage and assist in lessening health inequalities, and the Department seeks to support and aid this work in the following ways: (a) work with government as a whole to improve the structural issues beyond the provision of health and care to improve the underlying health of the population in multiple ways (e.g. by tackling obesity or poor housing on a cross governmental basis) (b) ensure equality of access to treatment, and encourage marginalised groups who can be reluctant to engage with public health, the NHS and social care to do so (c) ensure that treatment is provided fairly to everyone, particularly those marginalised and discriminated against who often have significant health difficulties (e.g. by studying the way that certain diseases and illnesses impact upon one social economic or ethnic group more than another and ensuring that this is

[32] Clara Swinson witness statement, p.26, §68. Sir Chris Wormald sixth witness statement, p.2, §7.
[33] Sir Chris Wormald transcript 19.06.2023, pp.149-151.

recognised and funding is given to researching such illnesses) and (d) ensure that the outcomes of such treatment are as equal as possible. The Department also recognises that reducing health inequalities "on the ground" is best understood and addressed by local bodies, who have knowledge of local vulnerabilities and existing relationships with more vulnerable communities to provide support both generally and specifically where a health emergency takes place.[34]

7. The need to tackle heath inequalities in non-pandemic times is further necessary given it is impossible to predict and plan for what the unequal impact of a future pandemic may be. As Professor Chris Whitty explained in evidence, while every pandemic will affect those from poorer socio-economic backgrounds most, the reasons for this, the mechanisms by which it occurs and the way in which it can be countered, will vary based on the specific nature of the pandemic; this makes preparing specific measures to address that disproportionate impact difficult, as to do so you need to know the causal pathway for each route of transmission which only becomes evident once the pandemic develops.[35] It also means that any planning for vulnerabilities that may arise during a pandemic necessarily carries a degree of imprecision.[36] Further, as explained in Professor Michael Marmot and Professor Clare Bambra's report, the causes of inequalities are multifaceted; many are long standing, fall outside health and care delivery, and are affected by external factors e.g. education, early childhood development, employment, working conditions, income and cost of living.[37] As Professor Chris Whitty set out, ultimately the best way to limit the unequal impact of a pandemic once it has emerged, is to get on top of and tackle the disease.[38]

8. In addition to the key areas identified above, the Department wishes to set out its view in relation to some of the other topics which have emerged in evidence throughout module one which it is hoped will be of assistance to the Inquiry.

Preparing for an influenza pandemic

9. The Inquiry has heard evidence on whether the 2011 Pandemic Influenza Strategy ("**the 2011 Strategy**"), the National Risk Register, and the associated programmes of work were too focused on the prospect of an

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[34] Mark Lloyd, Chris Llewellyn and Allison Allen transcript 12.07.2023, pp.117-120. Michael Adamson transcript 17.07.2023, p.116, ll.8-25, p.117, ll.1-15. Melanie Field transcript 13.07.2023, pp.32 – 34. Marcus Bell transcript 13.07.2023, p.20, ll.7-24.
[35] Professor Chris Whitty second witness statement, p.40, §5.55.
[36] Sir Chris Wormald fourth witness statement, p.8, §35.
[37] Professor Michael Marmot and Professor Clare Bambra report, pp.8-9, §§14-22.
[38] Professor Chris Whitty transcript 22.06.2023, p.115, ll.11-25, p.1116, ll.1-3. Professor Chris Whitty second witness statement, p.49, §5.57.

influenza pandemic. It is the Department's respectful view that it was not unhelpful or unwise to have prepared for an influenza pandemic. To the contrary, the expert evidence suggests that such planning was, and continues to be, essential and necessary given influenza has a proven ability to cause repeated pandemics with substantial mortality and it remains the biggest single predictable health risk the UK faces.[39] With regards to the 2011 Strategy, some suggestion has been made that this was "out of date or unfit for purpose"; that is, in the Department's view, a mischaracterisation. Of course, it was not an appropriate plan for what happened, but that does not mean that the planning was entirely wasted or unhelpful. To the contrary, the evidence shows that parts of the document were very useful during COVID-19. For example, the Coronavirus Action Plan 2020 drew heavily on the 2011 Strategy,[40] NERVTAG was established as part of the commitment in the 2011 Strategy,[41] and the vast majority of local councils (87%) said they were able to adapt their influenza pandemic plans (which were based on the 2011 Strategy) well to respond to COVID-19.[42] Further, and in any event, the Department would not agree that an "update" or "refresh" of the 2011 Strategy prior to January 2020 would have made a significant difference to the UK's preparedness for COVID-19 given it would not have led to materially different plans, or as Professor Whitty put it, a significant change in the "philosophical approach."[43] Having said this, the Department accepts that there should be, as previously stated, a wider approach to pandemic preparedness covering all routes of transmission, and with building blocks of capabilities that can be scaled up to respond to any new and emerging threat. The Department accepts that both an overarching pandemic strategy and a new pandemic flu plan are needed; the Government will prepare and consult on such plans and provide them to the Inquiry in due course.

Containment, not just mitigation

10. The Department wishes to clarify that, in its view, the UK's planning prior to the COVID-19 pandemic did not focus solely upon *managing* widespread fatalities and illness. The Department recognises the importance of any future pandemic planning starting from first principles, and focusing on what can be done to contain a novel and emerging HCID to prevent it developing into a pandemic on the scale of the reasonable worst-case scenario ("**RWCS**"). Indeed, the Department's pandemic preparedness programme

[39] Professor Chris Whitty second witness statement, p.40, §5.16. Professor Chris Whitty transcript 22.06.2023 p.93, l.22. Dame Sally Davis transcript 20.06.2023, p.146, ll.13-15. Professor Mark Woolhouse transcript 05.07.2023, p.124, ll.15 – 17, p.125, ll.7-9. Claas Kirchhelle transcript 10.07.2023, p.101, ll.6-7.
[40] Clara Swinson witness statement, p.14, §30.
[41] Sir Christopher Wormald first witness statement, p.60, §321.
[42] Mark Lloyd transcript 12.07.2023, p.86, ll.11-15.
[43] Professor Chris Whitty transcript 22.06.2023, p.92, ll.9-10.

was designed to *mitigate* the impact of a pandemic, i.e. how to actively minimize deaths and serious illness. The Department's strategy was, and remains, that *from the start and throughout* any outbreak of a disease work is done to contain, mitigate, delay and research the disease. These actions are not consecutive; they are undertaken simultaneously and consistently throughout any pandemic response. The Department also wishes to highlight the evidence which shows that alongside prevention planning, preparing for the RWCS is also imperative. [44] Even if the goal is to prevent it from occurring, a plan is still needed for a disease that cannot be controlled and contained.[45]

Lockdowns

11. The Inquiry has heard evidence that there was no plan for "lockdown", defined as closing down large parts of society and the economy in order to minimise household mixing and transmission, in advance of 2020. This does not mean all NPIs were not anticipated; NPIs have been used in many cases for centuries such as self-isolation for those with symptoms, the closure of specific high-risk venues and quarantine at borders. However, the Department accepts that while pandemic plans set out a range of measures including some school closures, large population-scale measures used in the COVID-19 pandemic in law had not been considered.[46] Crucially, the Department wishes to highlight that the evidence shows that *no* Western country had planned for what became known as "lockdown". The consensus in the UK had been to keep society as open as possible whilst protecting the most vulnerable.[47] The reasons for this may well be multi-faceted including that lockdowns would not have been effective or proportionate in the two previous pandemics (2009 H1N1 or HIV).[48] Further, a national lockdown was and is a very radical thing to do and carries huge economic and social ramifications; it is therefore unsurprising that scientific advisory groups to government did not contemplate such major social intervention.[49] In light of the experience of COVID-19, the Department recognises that pandemic plans should set out a range of possible measures for Ministers to consider at the time. These would depend on the route of transmission, the transmissibility and the severity of the disease.

Learning lessons from other countries

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[44] Sir Chris Wormald first witness statement, p.45, §244.
[45] Professor Chris Whitty transcript 22.06.2023, p.102, ll.4-25.
[46] Katharine Hammond transcript 16.06.2023, p.164, ll.18-20, p.165, ll.5-7.
[47] UK Influenza Pandemic Preparedness Strategy 2011 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf, p.57, §7.4.
[48] Professor Chris Whitty transcript 22.06.2023, p.97 ll.24 – 25, p.98 ll.1 -24. Katharine Hammond transcript 16.06.2023, p.185, ll.18-21.
[49] Professor Chris Whitty transcript 22.06.2023, p.83, ll.5, 8-13.

12. The Inquiry has heard evidence of preparations made by other countries, such as South Korea, in advance of the COVID-19 pandemic which meant they were better prepared when COVID-19 hit and were able to limit its impact.[50] The Department accepts that had the UK government implemented larger scale public health infrastructure for testing and tracing, learning from the experience of these countries, prior to 2020 then our initial response to COVID-19 may well have been improved.[51] The Department would like to suggest two reasons why, in our view, this approach was not implemented. First, as highlighted by Professor Chris Whitty, much of the learning was the need for generic systemic improvements – predominantly greater investment in public health – rather than specific countermeasures.[52] For example, countries such as South Korea invested significantly in public health after their experience of MERS which enabled them to have systems in place to better respond to COVID-19.[53] It is the Department's view, that at no point in the period prior to COVID-19 would the UK have introduced similar new systems given the period of austerity the country faced;[54] public health professionals were focused on how to deliver the best levels of health protection available within reducing budgets rather than ways to increase government investment.

13. Second, while the Department accepts that it should look widely across the world for examples of best practice to inform pandemic planning, it is not the case that prior to the COVID-19 pandemic the Department was ignoring the advice of scientists in this regard. None of the scientific groups advising the government identified there was a major gap in plans for emerging HCID prior to the pandemic. There has been much discussion in evidence given to the Inquiry about "groupthink". This phrase has been used in reference to different aspects of pandemic preparations, including the focus in UK plans upon pandemic influenza, the lack of planning for a whole society lockdown, and the lack of consideration of HCIDs which had impacted other countries in the world.[55] However crucially, all witnesses have agreed that this was not unique to the UK; it affected, as Dame Sally Davies and others put it, the whole Western world.[56] Studies by the European Centre for Disease Prevention and Control (and EU organisations, the Organisation for Economic Co-operation and

[50] Professor David Heymann transcript 15.06.2023, pp.54-60.
[51] Professor Chris Whitty transcript 22.06.2023, p.104, ll.6-25.
[52] Professor Chris Whitty transcript 22.06.2023, p.105, ll.1-25, p.106, ll.1-8.
[53] Professor Chris Whitty transcript 22.06.2023, p.105, ll.3-18.
[54] David Cameron transcript 19.06.2023, pp.45-49.
[55] David Cameron transcript 16.09.2023, p.7, ll.19-25. Rosemary Gallagher transcript 26.06.2023, p.71, ll.18-20. Jeremy Hunt transcript 21.06.2023, p.150, ll.9-20.
[56] Sally Davis transcript 20.06.2023, p.146, ll.9-11. Professor Chris Whitty transcript 22.06.2023, p.84, ll.9-16. Clara Swinson transcript 19.06.2023, p.168, ll.8-11. George Osbourne transcript 20.06.2023, p.67, ll.20-21. Jeremy Hunt transcript 21.06.2023, p.160, ll.5-9. Dr Richard Horton transcript 13.07.2023, p.68 ll.9-19, p.68 l.24 to p.69 l.15. Dr Richard Horton transcript 13.07.2023, p.88, ll.20-25.

Development and other multinational bodies) confirm that the same judgements were made by others western countries who had not implemented systems to conduct testing at scale or ensure effective surveillance.[57]

Global health security

14. The Department has taken note of the evidence from some witnesses which suggests the UK's ranking on the Global Health Security Index prior to the COVID-19 pandemic led to a complacency about the sufficiency of UK health protections and turned out to be a poor predictor of actual outcomes.[58] The Department agrees that the UK needs to be alive and resistant to such complacency in the future. The Department has also reflected that the UK's ability to respond to the increasingly likely chance of "zoonotic spillover" and a consequential emerging HCID outbreak requires strong international co-operation and coordination. Good preparedness and response depends upon having the necessary surveillance in place, and early reporting and honest, rapid information sharing by all countries.[59] The Department has already sought to strengthen this element of pandemic preparedness: first, by engaging in negotiations, whilst maintaining the sovereignty of the UK parliament and control of any future domestic decisions on national public health measures, on possible reforms to the International Health Regulations and a possible international instrument by May 2024; second, by continuing its funding of the WHO through both core and voluntary contributions and its direct support to low and middle income countries; third, by attending the High Level Meeting on Pandemic Prevention, Preparedness and Response in September 2023 hosted by the United Nations; and fourth, by securing multilateral and bilateral agreements, including G7 and G20 health declarations and the 100 Day Mission.[60]

Exercises

15. The Department maintains that while exercises are no substitute for expertise or experience, they are helpful to test the resilience of systems in place.[61] In this regard, the Department recognises the benefit of exercises testing capabilities necessary for responding to a range of threats, rather than testing the response to a specific disease. The Department has reflected on the value of undertaking these exercises regularly, for example

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[57] See for example: The EU experience in the first phase of COVID-19: implications for measuring preparedness (europa.eu) and First lessons from government evaluations of COVID-19 responses: A synthesis (oecd.org).
[58] Professor Mark Woolhouse transcript 05.07.2023, p.108, l.18 – p.111, l.1.
[59] Professor Chris Whitty second witness statement, p.30, §3.69.
[60] Clara Swinson witness statement, pp.24-27, §§61-69. Sir Chris Wormald sixth witness statement, p.13, §§48-49.
[61] Dr Richard Horton transcript 13.07.2023, p.71, ll.18-20. Sir Chris Wormald sixth witness statement, p.9, §31.

every five years, but would stress the need to ensure the scope of such exercises was flexible to reflect evidence of new and emerging threats. In relation to exercises previously undertaken, the Department accepts that not all the recommendations from specific exercises were fully implemented but disagrees that had they all been implemented then the response to the COVID-19 pandemic would have been materially different. For example, it is respectfully submitted that some have misunderstood the nature and purpose of Exercise Alice which did not look at planning for a pandemic scale event but was instead designed to look at modest size scale outbreak of a HCID.[62] Further, Exercise Alice focused on a potential outbreak of MERS. MERS-CoV which causes MERS is a different virus to SARS-CoV-2 which caused COVID-19; typically, it does not transmit as easily and then mainly in healthcare settings, it has a much higher fatality rate, transmission is almost all from symptomatic people and it has much smaller outbreaks.[63] The extent to which the recommendations from Exercise Alice would therefore have been relevant to planning for COVID-19 is limited. In any event, some of the recommendations from Exercise Alice *were* implemented via the development of two HCID programmes by NHS England and Public Health England and have been further incorporated into ongoing planning work by the Department and the UKHSA.[64] It is also the case that the lessons learnt from the SARS, MERS and Ebola outbreaks shaped the development of HCID units in the UK and the improved training for healthcare staff. [65]

EU Exit

16. The Department recognises that some streams of pandemic planning were deprioritised as a result of preparations for a no-deal Brexit (known across government as Operation Yellowhammer).[66] It was inevitable that after the decision had been made by the British people to leave the European Union this would require an extensive and unprecedented degree of preparation. It is only with hindsight – and the knowledge that a no deal Brexit did not happen, but the COVID-19 pandemic did – that the reallocation of resources from pandemic planning to no-deal planning could be judged as a mistake. It must be remembered that at the time, preparations for a

[62] Professor Chris Whitty transcript 22.06.2023, p.86, ll.1-4. Sir Chris Wormald transcript 19.06.2023, p.137, ll.10-12. Sir Chris Wormald first witness statement, p.66, §352. Sir Chris Wormald seventh witness statement, p.24, §98. Professor Chris Whitty second witness statement, p.60, §6.51.
[63] Sir Chris Wormald first witness statement, p.66, §352.
[64] Emma Reed transcript 26.06.2023 p.36 ll.19-25, p.37 ll.1-5. Sir Chris Wormald first witness statement, p.67, §353. Sir Chris Wormald seventh witness statement, pp.24-25, §§99-100.
[65] Sir Chris Wormald first witness statement, pp.69-72, §§360-381.
[66] Sir Chris Wormald seventh witness statement, p.27, §108. Clara Swinson witness statement, p.18, §41.

possible no-deal Brexit had been communicated as the government's 'principal operational focus'.[67]

17. The Department therefore contends that it was not wrong, in the context of constrained resources and only a select number of personnel with emergency planning and response expertise, to have reallocated recourses from pandemic preparedness to Operation Yellowhammer. This is particularly so given the evidence from a number of witnesses was that the UK's response to COVID-19 would have been worse had the work during Operation Yellowhammer not been undertaken[68], and that preparations for EU exit were helpful in terms of acquisition of general skills for crisis management.[69] More specifically, Operation Yellowhammer led to the establishment of the Operational Response Centre within DHSC , a new Continuity of Supply programme to mitigate the impact of border disruption, and the National Supply Disruption Response function which played a significant role in PPE supply, as well as supporting the COVID-19 testing and vaccination programmes.[70] All of this contributed to improved resilience and capability, improved management of medical supply chains, and an improved understanding of how to deal with shortages, all of which was directly utilised and invaluable during the response to COVID-19.

Conclusion

18. The Department would like to thank the Inquiry team and all the witnesses who have given evidence so far. The Department wishes to reiterate that it has listened carefully to the evidence in module one, has reflected on lessons learned and is committed to implementing those lessons for the future. We remain dedicated to assisting the work of the Inquiry in upcoming modules.

28 July 2023
On behalf of DHSC

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[67] Clara Swinson witness statement, p.18, §40.
[68] Dr McMahon transcript 06.07.2023, p.71, ll.17-25. Clara Swinson witness statement, p.18, §41.
[69] Michael Gove transcript 13.07.2023, p.110, ll.10-18.
[70] Clara Swinson witness statement, pp.18-20, §§40-44. Chris Wormald first witness statement, pp.18-20, §94-99, pp.77-80, §§405-416. Chris Wormald sixth witness statement, pp.7-8, §§26-27.