

IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

THE UK COVID-19 INQUIRY

**WRITTEN OPENING SUBMISSIONS ON BEHALF OF
THE DEPARTMENT OF HEALTH AND SOCIAL CARE
FOR MODULE 2**

1. INTRODUCTION

1. The Department of Health and Social Care (“the Department”) would like to say at the outset of Module 2 that it expresses its deepest sympathies to all those who suffered and lost loved ones in the pandemic. The disruption caused by COVID-19 is ongoing and the Department recognises that its effects are still being felt.
2. The Department acknowledges the huge burden that Government guidance placed on individuals and families, particularly in respect of the restrictions that led to the isolation of loved ones who were unwell or dying. The public bore this burden with the utmost dignity and selflessness.
3. Further, the Department repeats its thanks to those who responded to the pandemic. This includes all those in hospitals, care homes and the community, members of the armed forces and the charity and volunteering sector, staff in the Department and everybody who observed the laws and guidance that Government brought in to suppress the virus, which saved lives and bought vital time for vaccines and treatments to be developed.
4. The Department would like to take the opportunity of this Opening Statement to set out what it considers to be the context through which the Inquiry should view the evidence in Module 2, before identifying some of the key challenges faced by the Department over this time period.

5. An important source of information that the Department would invite the Inquiry to consider as Module 2 progresses is the 'Technical report on the COVID-19 pandemic in the UK, *A technical report for future UK Chief Medical Officers, Government Chief Scientific Advisers, National Medical Directors and public health leaders in a pandemic*' ("the Technical Report"), published on 1 December 2022 and authored by, amongst others, the UK Chief Medical Officers, the Government Chief Scientific Adviser, the UK deputy CMOs most closely engaged with the COVID-19 response, the National Health Service England ("NHSE") Medical Director and the UK Health Security Agency ("UKHSA") Chief Executive.
6. The Technical Report is divided into chapters including understanding the pathogen and the disease, research, modelling, testing, tracing, non-pharmaceutical interventions, and pharmaceutical interventions. Each chapter sets out what the scientific questions were and how these were answered with reflections and advice for the future. It does not offer a definitive narrative of the policy decisions taken during the COVID-19 pandemic, rather reflections on the relevant science and public health issues that might be useful in the future; and the Department considers that it is a valuable resource for lessons to be learnt.

2. CONTEXT FOR MODULE 2

7. Module 2 concerns, "... *the UK's core political and administrative decision-making in relation to the Covid-19 pandemic between early January 2020 until February 2022,*"¹ with particular attention to be paid to the period between early January and late March 2020. The Department invites the Inquiry to bear in mind the following points, which it considers provides context for that decision-making.
8. First, there was inevitably very limited data about the virus between January 2020 – March 2020, given it was a new disease. The evidence was inevitably initially incomplete, limited, patchy and sometimes slow. In the early months of

¹ The Inquiry's Module 2 'Provisional Outline of Scope'.

the pandemic the available information was evolving on a daily basis but was still embryonic compared to our current base of knowledge. Decisions had to be taken on the basis of what was known at that time, and the available data. As the pandemic went on, information and data grew rapidly and this changed the decision-making environment.

9. The best available data for decision-making within the Department, in particular in March and April 2020, was that available from hospitals, i.e., how many patients were being admitted with COVID-19, how many beds in intensive care units were occupied and, sadly, how many people were dying. The purpose of the measures taken in responding was to minimise COVID-19 deaths and prevent the NHS from becoming overwhelmed, which would have led to avoidable deaths from both COVID-19 and other conditions and added suffering from normally treatable conditions.
10. The Department knew that the risk of health services being overwhelmed was a realistic possibility both from pandemic exercises and looking at what happened in other comparable countries, such as Italy, and sought to ensure that to the greatest extent possible patients who were likely to benefit from being admitted to hospital were able to receive appropriate treatment. As well as technical information about the virus, data was also limited on mitigations. It was extremely difficult at the time to know with confidence what the precise impacts of any measure (non-pharmaceutical or otherwise) would be. The Inquiry is necessarily conducting its exercise with the benefit of hindsight, but as recognised by the Royal Society in its August 2023 report, ‘COVID-19: examining the effectiveness of non-pharmaceutical interventions’:²

“...Were NPIs effective in reducing SARS-CoV-2 transmission and, if so, which NPIs and to what extent? ... Despite all the caveats about the difficulties of imperfectly designed observational studies described earlier, a rigorous review of the evidence collected during the pandemic from around the world, has taught us a great deal. There were clear signals from the evidence reviews that many of the NPIs were effective, especially when implemented in combinations. ... A great deal has been

² <https://royalsociety.org/-/media/policy/projects/impact-non-pharmaceutical-interventions-on-covid-19-transmission/the-royal-society-covid-19-examining-the-effectiveness-of-non-pharmaceutical-interventions-report.pdf>

learnt about the effectiveness or otherwise of NPIs – and there is also much more clarity about what is not yet known.”

11. The Department considers that it is important to recognise that, even with the benefit of hindsight, there is still much that is not yet known about the impact of measures taken during the pandemic, or to what degree the measures that were taken were effective. Government was also cooperating with the international scientific community to learn as much as possible as fast as possible on the nature of the virus, and the effectiveness of mitigations.
12. The following are example of just some of the unknowns at the start of 2020: how long was the incubation period? Did the virus transmit pre-symptomatically or asymptotically and how great was the importance of these? Was it possible to be re-infected? What would be the nature of any long-term health effects which may arise? Would vaccines/treatments become available and on what timescale? These uncertainties and unknowns led to greater complications as to which non-pharmaceutical intervention were necessary or would be particularly effective against the virus.
13. Second, the Department and Government were dealing with balancing risks and there were no ‘good’ options. The uncertainties outlined above imposed on Government the task of balancing the dangers of overreaction and underreaction at a time when decision-makers could not wait for better information. This is what happened between the end of February 2020 and the implementation of the first lockdown on 23 March 2020. The Government had to make decisions that it considered to be the ‘least-worst’ in certain situations, in the face of a novel virus.
14. The decision to discharge medically fit patients from hospitals into the community is an example of the choices that had to be taken by balancing numerous competing risks: the risk of otherwise medically fit people in hospital catching COVID-19; the increasing risk of the NHS running out of hospital bed capacity to treat COVID-19 patients; discharging patients into care homes without sufficient testing capacity to mitigate the risk of spreading infection; the

potential risk of impact on those in care homes being isolated away from family and loved ones; and the risk of a lack of capacity to deal with non-COVID-19 patients.

15. Throughout the pandemic, it was the aim of the Department to minimise death and serious illness. It was not for the Department to undertake the complex balancing exercise as to the impact on the economy and society of socially disruptive non-pharmaceutical interventions or other policies. Its role was to identify and advise upon the needs of the health and care services and to deliver a pandemic response in line with Government policy. It follows from this that the Department did not expect the advice it gave as to what measures or policies would have the greatest impact in respect of health outcomes to be followed every time; it was for the Prime Minister and his Cabinet to weigh up the various competing factors, e.g., macroeconomic impacts, to determine where the public interest lay.

16. Third, as the Department has previously outlined, in combatting a pandemic of this kind there are only ever four realistic weapons: (1) non-pharmaceutical interventions; (2) testing, tracing and isolation; (3) therapeutics; and (4) vaccines.³ The Department commenced work on the development of all four of these at the start of 2020. During the course of the pandemic, as other tools became available, the balance of use of each of the four changed over time.

17. In the absence of a scalable testing regime, at the start of this pandemic only the first option of non-pharmaceutical interventions was available, and therefore the questions were when to deploy such measures, and to what extent.

18. Taking no decision or delaying the imposition of non-pharmaceutical interventions was potentially just as damaging as taking action when there was not yet any need or they were unlikely to be effective. Whilst the idea of quarantine and social isolation at an individual level had been used for

³ See First Witness Statement of Sir Christopher Wormald Module 1, paragraph 22 and Third Witness Statement of Sir Christopher Wormald, Module 2, paragraph 153.

centuries, it was acknowledged during Module 1 that there had not been significant preparation for a response such as full societal and economic lockdown in law in advance of 2020. As noted in paragraph 11, even in retrospect the effects of individual non-pharmaceutical interventions are difficult to judge. In the face of this uncertainty, the Government had to make decisions and implement them. The growing information did mean that policies, advice and guidance had to change, sometimes quickly when a new piece of evidence emerged.

19. The Department initiated work on potential pharmaceutical interventions in Spring 2020 to maximise the chances that effective vaccines or treatments would become available as soon as possible and provide effective mitigations against the novel virus. It set up clinical trials at scale, covering both existing and new treatments; turned existing research contracts to tackle COVID-19; and engaged internationally. Whilst vaccines and therapeutics are not the focus of this Module, it is essential context for the decision-making environment.

20. It is not the case that a vaccine will always be available to combat pandemics in the future, nor was it inevitable in this pandemic. The development of an effective vaccine is inherently uncertain. As reflected in the Technical Report⁴ (emphasis added):

“Studies to develop a vaccine for COVID-19 started within weeks of the genotype being published. It was supported by clinical trial data within 9 months and available from midway through the second wave in the UK. The one general point it is worth making here is that the extraordinary speed of development and effectiveness of viral vector and RNA vaccines was a surprise to almost all scientists. On the positive side this demonstrates how fast a vaccine could be developed for the next pandemic, if it is achievable. There is a danger this falsely reassures some policymakers that a vaccine can be produced at this speed for the next pandemic. The last major pandemic was HIV where there is still no effective vaccine, despite decades of serious investment and scientific effort.”

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128099/Technical-report-on-the-COVID-19-pandemic-in-the-UK-PRINT.pdf – page 112.

Whilst ultimately vaccines were successfully developed in order to combat COVID-19, and at ground-breaking speed, decision-makers in Government could not count on those vaccines (or therapeutics) being developed or the timescale on which they would be produced until the initial trials came in. Other measures had to be implemented on this basis of uncertainty, while at the same time setting up the appropriate scientific research into pharmaceutical mitigations.

21. Fourth, protecting the vulnerable was always a central feature in the decision making of the Department and the Government. The understanding of which people were particularly vulnerable evolved over time. For example, it is recognised that the particular vulnerabilities of certain minority ethnic communities to the virus were not immediately understood – albeit that with the excellent work of Professor Kevin Fenton and others at Public Health England, the publication of ‘Beyond the data: Understanding the impact of COVID-19 on BAME groups’ clearly showed the need for additional support.
22. The aim of the Department was to minimise the spread of the virus overall and by doing that, protect the vulnerable. The understanding of which groups or pre-existing underlying drivers of ill health would have the greatest impact also evolved as pandemic developed. For example, the early assumption that old age would be a significant vulnerability was borne out in the growing evidence, while it was not until later that it was understood that living with obesity was a vulnerability. The changes in the Department’s understanding of vulnerabilities throughout the pandemic is illustrated to an extent by the changes to the Shielded Patient List.
23. The Department suggests that in addition to the four areas set out above, it was presented it with a series of specific and exceptional challenges in responding to the pandemic, including:
 - a. The relatively few number of tests initially available made it difficult to understand the spread of the virus in the community for the first few

months of the pandemic and the need to scale up testing, contact tracing and the production of vaccines and treatment were jobs that required a degree of central, national and in some cases supra national (i.e., between all four nations of the United Kingdom) co-ordination at a speed and scale which was challenging to every organisation and institution;

- b. The widespread requirement for personal protective equipment (“PPE”) was much greater than was anticipated for in an influenza pandemic. The SAGE reasonable worst-case scenario for the number of people infected requiring hospital treatment and the resulting requirement for PPE to protect those staff caring for those patients was much greater than planned for influenza. Further, the expectation of a higher requirement for aerosol generating procedures (such as mechanical ventilation) and that patients would spend longer in hospital all drove higher demand on the stockpile in a situation where it was the supplier of last resort at a time of global supply system failure; and
- c. The lack of manufacturing capacity in the UK for PPE, medical devices (including testing products) and goods meant it was not possible to import all the relevant components with the speed and scale required. Many countries closed their borders or refused to allow exports of equipment. The constraints of relying upon a global supply chain became evident almost immediately during the pandemic.

24. To meet the challenges presented by the pandemic, the Department had to and did very rapidly reorganise and expand its functions and develop and implement new policies. It also devised and implemented national programmes that had not been planned for and which required significant input into whole new institutions – such as a national tracing service, and a national vaccine roll out – that required the development of new logistical frameworks on a supra national basis and which required input from a number of agencies, including from the Department’s partner agencies like NHSE, Public Health England, UKHSA, the Medicines and the Healthcare products Regulatory Agency.

25. Initially the response within the Department was led by an incident team that monitored the novel virus in accordance with established practices, and to oversee the repatriation of British Nationals. The team quickly expanded as the scale of the threat became more apparent in early 2020. From 22 January 2020 onwards, the Permanent Secretary's central focus was the response to COVID-19, with a Second Permanent Secretary position being created to assist in the running of the Department's other functions. The Executive Team prepared for and implemented a scalable resourcing response and by April 2020 it was a whole Departmental response.⁵

26. In March 2020 the department had 1,754 full time equivalent (FTE) staff. Government figures for March 2021 showed 3,752 FTE staff in the Department. Of that number, 849 FTE were on a Test and Trace cost centre, so the core Department had 2,903 FTE. The share of the March 2021 FTE engaged on social care was 266.

27. On 3 March 2020 the Department published an Action Plan setting out the Government's response to COVID-19. The Coronavirus Bill was introduced to Parliament on 19 March 2020 and received Royal Assent on 23 March 2020. On 22 March 2020, the day before the Prime Minister spoke to the nation to confirm the national stay at home order, the Department implemented a 'Battle Plan'. The Battle Plan was initially split into six workstreams: (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 and these workstreams informed the Department's role in the decision-making process.

28. The Department adapted the Battle Plan throughout the pandemic as its understanding of the disease, and the response required, evolved.

⁵ Third Witness Statement of Sir Christopher Wormald, paragraph 46.

3. CONCLUDING REMARKS

29. From January 2020 and throughout the pandemic, up to and including today, the aim of the Department has been to minimise direct and indirect death and serious illness from the novel disease. To meet this aim, the Department had to help ensure that the NHS was not overwhelmed so that it could provide emergency and other care for non-emergency conditions. The Department also took actions to slow transmission; research potential medical interventions through treatment, medicines and vaccines; identify those most vulnerable; and expand NHS capacity and workforce. The Department's advice on these areas was weighed against other factors in the overall decision-making by government.

30. The issues faced by the UK in the spring of 2020 were not unique. Every country in the world had to respond to a novel disease, about which little was known. Whilst there was variability, many comparable countries also struggled with one or more issues such as healthcare capacity, testing volumes, PPE supply, and introducing new legal restrictions. Countries had different starting points in areas including age profile, the underlying health of the population, provision of health services, public health capacity, manufacturing base, research base and so on. The UK, like others, was operating in a global market for the supply of PPE, and later on for vaccines. It was also cooperating with the international scientific community to learn as much as possible as fast as possible on the nature of the virus, and the effectiveness of mitigations. Other countries are taking varied approaches to their own inquiries and learning, which the Department will consider.

31. The Department is incredibly grateful to all those who helped navigate and support the country's response: NHS staff, care workers, volunteers, the military and, of course, the general public.

32. The Department stands ready to assist the Inquiry in completing its functions.

26 September 2023