Witness Name: Sir Christopher Stephen Wormald
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UK COVID-19 INQUIRY

THIRD 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 20 September 2022 made under Rule 9 of The Inquiry Rules 2006 (the Request) asking for a corporate statement on behalf of the Department of Health and Social Care (the Department) providing an overview of the structure of the Department and the role it played in the UK Government's response to the COVID-19 pandemic between 1 January 2020 and 24 February 2022.

3. As set out above, I am the Permanent Secretary of the Department, a post I have held since May 2016. Before joining the Department, I was the Permanent Secretary of the Department for Education (DfE) between 2012 and 2016, and a Director General within the Cabinet Office (CO) between 2009 and 2012.

4. By reference to the six topics set out in the Module 2 Provisional Outline of Scope I will address the matters of interest to the Inquiry as set out in the Request during the period 1 January 2020 to 31 July 2020. Where it is necessary to refer to events outside that

date range, I will make that clear and explain why I have referred to that event. Where a matter raised in the Request does not appear to fall within the Module 2 Provisional Outline of Scope I have sought to deal with it in a section at the end.

5. As this is a corporate statement on behalf of 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: CENTRAL GOVERNMENT STRUCTURES AND BODIES CONCERNED WITH THE UK RESPONSE TO THE PANDEMIC AND THEIR RELATIONSHIPS

Summary Overview

6. 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 s. 1 of the National Health Service Act 2006 (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. 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. PHE was replaced by the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities in October 2021. Under s. 2 of the Civil Contingencies Act 2004 (CCA), the Secretary of State has a duty to assess, plan and advise in respect of emergencies. The duties under the CCA are fulfilled through the

Department's role as Lead Government Department (LGD) for pandemic preparedness and emergency response, which is explained further below.

7. The Department does not directly fund or deliver adult social care and much of the funding for adult social care is raised locally. The Care Act 2014 places the duty to plan and secure adult social care services on 152 local authorities in England who commission services through a predominantly outsourced market of approximately 14,000 provider organisations. The Department is responsible for setting national policy and the legal framework, while the Department for Levelling Up, Housing and Communities (DLUHC) oversees local government funding and the financial framework.

8. In 2019/20, the Department's strategic priorities as set out in its Annual Report and Accounts (CW3/1 - INQ000106312) were:

    a. To keep people safe, leading global health and international relations including EU exit;
    b. To keep people healthy and independent in their communities, supporting the transformation of NHS primary, community and Mental Health services, and Local Authority public health and adult social care;
    c. To support the NHS to deliver high-quality, safe and sustainable hospital care and secure the right workforce;
    d. To stay at the cutting edge of research and innovation to maximise health and economic productivity;
    e. To ensure accountability of the health and care system to Parliament and the taxpayer, and create an efficient and effective department;
    f. To create value by promoting better awareness and adoption of good commercial practice across the Health Family, the Department's arms-length bodies (ALBs); and
    g. To improve health and social care by giving people the technology they need.

9. As the Department's 2019/20 Annual Report and Accounts did however recognise:

    "COVID-19 is the biggest challenge the country and our public sector have faced in a lifetime. DHSC is central to the Government's response and, as a result, the Department has adapted to these unprecedented times. Work on

COVID-19 is the single most important operational and policy focus for the whole Department and wider health and social care system."

10. The Department is supported by the Chief Medical Officer (CMO) who is the UK Government's principal medical adviser and the professional head of all directors of public health in local government and the medical profession in government. The CMO is an independent position at permanent secretary level in the Department and is a member of the Department's Executive Committee and Departmental Board. The CMO advises ministers across government on medical matters. He works closely with CMO colleagues in the devolved governments.

11. The Department is further supported by a Chief Scientific Adviser (CSA) who advises on scientific aspects of health and acts as the Chief Executive Officer of the National Institute for Health Research (NIHR). From the start of the pandemic to August 2021 the roles of CMO and CSA were held by the same person (Professor Sir Chris Whitty). From August 2021 the post of CSA has been held by Professor Lucy Chappell.

12. Clara Swinson, Director General (DG) for Global and Public Health (now Director General for Global Health and Health Protection), was responsible for leading health teams including emergency preparedness and health protection, international policy and EU Exit. Clara Swinson was the DG level Senior Responsible Owner (SRO) for the COVID-19 Battle Plan (on which further detail is provided below) in the Department. Throughout 2020, Ms Swinson's responsibility expanded to include social distancing strategy, oversight of the COVID-19 programme (and Battle Plan), COVID-19 vaccines deployment and the Therapeutics Taskforce.

13. Non-Executive Directors (NEDs) are appointed primarily to support, advise and provide an external source of challenge to the Department. They also make a significant contribution to Departmental business by working through Committees and with senior officials. NEDs are appointed for a fixed term of three years initially. In the period covered by this statement, the Departmental Board held positions for six Non-Executive Directors which are detailed in the Directors' Report within the DHSC Annual Report and Accounts 2019/20 (CW3/1).

Devolved Governments

14. Whilst health and social care policy is largely devolved to the Welsh and Scottish Governments and the Northern Ireland Executive, the Department has some reserved

policy areas with UK-wide responsibility, including our international relations. Public health is a devolved matter and this meant that certain arrangements to respond to the pandemic could be made separately by the Devolved Governments.

15. There had been official level engagement in place with Devolved Governments on health and social care issues, including a number of existing fora across areas such as supply of medicines and medical goods; EU and trade policy; Adult Social Care; and Emergency Preparedness, Resilience and Response (EPRR) teams. The need to work together to respond to the pandemic precipitated considerable cross-UK, collaborative working between the UK Government and the Devolved Governments. Numerous existing structures were utilised and additional structures were put in place throughout the pandemic to support policy co-ordination and decision making between the UK Government and the Devolved Governments at official and ministerial level, including formal UK Government Cabinet Committee structures like Cabinet Office Briefing Room (COBR) meetings, Ministerial Implementation Groups (MIGs) and Covid Operations Committees. Regular discussions also took place between the UK Government, Health and First Ministers of Scotland and Wales and the Northern Ireland Executive.

16. UK Health Ministers established regular, dedicated conversations on the health and social care Covid-19 response from 10 March 2020. These provided an important forum for the discussion of key issues and coordination on responses and communications in areas of devolved competence.

17. Each of the Devolved Governments has its own CMO, CSA and Deputy Chief Medical Officers (DCMOs). The UK CMOs meet regularly and there is collaboration and coordination between the CMOs and CSAs across the UK Government and the Devolved Governments, which supports coordinated scientific advice to the UK Government and the Devolved Governments.

18. The Department, the Devolved Governments and the UK's national public health organisations had also agreed to set a common framework on health protection (CW3/2 - INQ000106904) to ensure there continued to be a robust UK-wide regime on public health protection and health security. This framework was established in response to the UK's exit from the EU. An operating model and governance arrangements have since been implemented to strengthen strategic and operational

cooperation between the UK Government, the Devolved Governments and the national public health organisations of the UK.

Other Government Departments

19. The Department worked closely with a number of other government departments (OGDs) during the response to COVID-19, including the CO, the Department for Digital, Culture, Media and Sport (DCMS), the Foreign, Commonwealth and Development Office (FCDO) (previously the Foreign and Commonwealth Office (FCO) and the Department for International Development DfID) but referred to in this statement as FCDO at all times), DLUHC (previously the Ministry of Housing, Communities and Local Government (MHCLG) but referred to in this statement as DLUHC at all times); the Ministry of Defence (MoD); and the Department for Transport (DfT). I detail below where the Department worked with these OGDs as part of the response to COVID-19.

Arms-Length Bodies

20. In addition to the work the Department carries out, it also works through a number of ALBs[1] to deliver its strategic objectives. This is described in my First Witness Statement to the Inquiry dated 19 October 2022 at paragraphs 106 to 119, as follows:

> ***United Kingdom Health Security Agency***
> *106. UKHSA officially operationalised in October 2021, replacing the health protection responsibilities of PHE. It is an executive agency of DHSC with operational autonomy. UKHSA is our permanent standing capacity to prepare for, prevent and respond to threats to health. Its responsibilities are for England, across the UK on reserved health matters, and in partnership with lead agencies in Scotland, Wales and Northern Ireland on devolved issues where relevant.*
>
> *107. It provides national leadership on health security and health protection, and ensures a cohesive response across public health functions. UKHSA*

[1] ALBs are a specific category of central government public body that is administratively classified by the Cabinet Office. There are three types of ALB: executive agency; non-departmental public body; and non-ministerial department.

embeds effective clinical, scientific and operational functions in the public health system. I will say more on UKHSA and its predecessors in Section 4.

NHS England

108. NHSE leads and oversees the NHS. It is accountable to the Secretary of State and holds local commissioning organisations (Integrated Care Boards (ICBs) under the Health and Care Act 2022) and NHS providers, such as hospitals and trusts, to account. NHSE is an executive non-departmental public body of DHSC. It took on its statutory responsibilities on 1 April 2013. NHSE operationally merged with NHSI in 2018. NHSE is responsible for allocating budgets to ICBs (and formerly Clinical Commissioning Groups (CCGs), as discussed below at paragraph 111), holding them to account, as well as leading on commissioning specialised services and primary care. With the merger with NHSI under the Health and Care Act 2022, the organisation also became responsible for overseeing and holding NHS providers to account.

109. In the context of pandemic preparedness, NHSE's responsibilities included:

a. *Making arrangements for NHS providers to deliver certain health services to patients*
b. *Allocating funds to NHS CCGs, so they can arrange with providers for the remainder and the majority of NHS services to be provided to patients*
c. *Ensuring that both itself and NHS CCGs are properly prepared for dealing with emergencies (including a pandemic)*
d. *Monitoring NHS providers' compliance with the arrangements imposed upon them to ensure that they are properly prepared for emergencies*
e. *Maintaining the National Pandemic Flu Service (NPFS), which COBR can activate to enable requests for antivirals over the phone without visiting a General Practitioner (GP).*

110. Between 2009 and 2020, the Chief Executives of NHSE and its predecessor functions were Sir David Nicholson (2006-2014), and Sir Simon Stevens (2014-2021).

Clinical Commissioning Groups (CCGs)

111. NHS Clinical Commissioning Groups were clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. They were created following the Health and Social Care Act 2012 (HSCA 2012), and replaced Primary Care Trusts on 1 April 2013.

112. In the context of pandemic preparedness, they were responsible for:

a. *Governance of local planning*
b. *Ensuring that multi-agency plans are up to date*
c. *Command and control arrangements*
d. *Arranging with providers for the majority of NHS services to be provided to patients*
e. *Maintaining service contracts*

NHS providers

113. NHS providers (hospital, mental health, community and ambulance services) are responsible for:

a. *Providing NHS services to patients*
b. *Ensuring that plans are up to date*
c. *Undertaking regular training and exercising*
d. *Participating in relevant forums*
e. *Maintaining lists of vulnerable patients*

The Medicines & Healthcare products Regulatory Agency (MHRA)

114. The MHRA regulates medicines, medical devices and blood components for transfusion in the UK. It is an executive agency of DHSC.

115. The MHRA is responsible for:

a. *Ensuring that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy*
b. *Ensuring that the supply chain for medicines, medical devices and blood components is safe and secure*
c. *Promoting international standardisation and harmonisation to assure the effectiveness and safety of biological medicines*
d. *Helping to educate the public and healthcare professionals about the risks and benefits of medicines, medical devices and blood components, leading to safer and more effective use*

e. *Supporting innovation and research and development that's beneficial to public health*
f. *Influencing UK, EU and international regulatory frameworks so that they are risk-proportionate and effective at protecting public health.*

National Institute for Health Research (NIHR)

116. The NIHR is a part of DHSC. It is one of the nation's major funders of health and care research. Its mission is to improve the health and wealth of the nation through research. DHSC commissions independent research through the NIHR. The Science, Research and Evidence (SRE) Directorate senior management team provides executive leadership for the NIHR within DHSC. The DHSC CSA is the Chief Executive Officer (and until 2021 Head) of the NIHR.

117. The NIHR was established in 2006. Its remit was to "create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public".

118. Since that time, the NIHR has transformed research in and for the NHS and helped to shape the health research landscape more broadly, for example in public health and social care.

119. The NIHR is primarily funded by DHSC and as a research system it:

a. *Funds, supports and delivers high quality research*
b. *Engages and involves patients, carers and the public*
c. *Attracts, trains and supports researchers*
d. *Invests in the healthcare infrastructure and workforce*
e. *Partners with other public funders, charities and industry*
f. *Funds applied global health research and training"*

21. During the period 1 January 2020 to 31 July 2020, NHS England (NHSE) and NHS Improvement (NHSI) (together NHSE and NHSI are referred to as NHSEI reflecting that they operated under a single leadership model in the period covered by this statement) led on measures to manage hospital capacity and staffing under co-ordination from the Department and later wider Government. PHE provided technical leadership and input in assessing the public health risk to the UK during the pandemic.

Expert scientific and analysis advisory groups

22. Paragraphs 121-176 of my First Witness Statement to the Inquiry dated 19 October 2022 provides information on expert groups including New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and Scientific Pandemic Infections Group on Modelling (SPI-M). I have set them out below by way of background:

> ***Expert Groups***
>
> *121. The Department received advice from a variety of scientific groups. These included groups that advised the department on a range of health-threats, and groups to advise specifically on pandemic influenza. I set these out below. The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) is the primary expert advisory committee advising the Department on new and emerging respiratory viral pathogens. NERVTAG is one of several departmental expert advisory committees that advise policy officials on different aspects of infectious diseases and other threats. These include: the Advisory Committee on Dangerous Pathogens (ACDP), the Advisory Committee on the Safety of Blood, Tissues, and Organs (SaBTO), the Advisory Committee on Antimicrobial Prescribing, Resistance, and Healthcare Associated Infections (APRHAI), and the Joint Committee on Vaccines and Immunisations (JCVI). Of most relevance to the NRR pandemic and emerging infectious disease risks are NERVTAG, ACDP, and JCVI.*
>
> *New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)*
>
> *122. NERVTAG, a Scientific Advisory Committee with an independent Chair, was established in 2014. Its first meeting was held on 19 December 2014. Prior to this the independently chaired National Expert Panel on New and Emerging Infections (NEPNEI) and ACDP covered aspects of emerging respiratory infection threats. ACDP continues in its role (more below).*
>
> *123. The National Expert Panel on New and Emerging Infections (NEPNEI) was established in November 2003, meeting twice per year until November 2008 (CW/64 - INQ000022712). Its purpose was to provide independent expert advice to the CMO on the public health risk from new and emerging infections. Between 2008 and 2014, SPI provided similar advice (see paragraphs 144-147).*

124. Following the experience of the 2009 Swine Flu pandemic and the threats posed by other respiratory viruses including the outbreak of MERS in 2012, SPI (more on this group below) was disbanded in 2014 and a new threat-agnostic committee, NERVTAG was created holding its first meeting on 19 December 2014. NERVTAG continues to provide scientific risk assessments and advice over a wide range of subjects relevant to the threats posed by new and emerging respiratory viruses. The role of NERVTAG is to advise the CMO (and, through the CMO, ministers, DHSC and OGDs) by providing scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory virus threats and options for their management.

125. On its establishment, it was agreed that the group would draw on the expertise of scientists and health care professionals, including clinicians, microbiologists and public health practitioners, and colleagues in related disciplines. NERVTAG is supported by a scientific secretariat from UKHSA and is scientifically independent. The scope of NERVTAG includes new and emerging respiratory virus threats to human health including strains of influenza virus (regardless of origin), and other respiratory viruses with potential to cause epidemic or pandemic illness, or severe illness in a smaller number of cases.

126. All minutes of NERVTAG meetings from 2014 to 2020 are published online and exhibited at (CW/65 - INQ000022719) to (CW/76 - INQ000023119).

127.In respect of the Inquiry's specific question around meetings on 13 and 21 January 2020, I consider these are better addressed as part of Module 2.

128. The current chair is Professor Sir Peter Horby (from 2018 to the present day). Professor Sir Jonathan Van Tam was the previous chair (from 2014 to 2018).

<u>Groups advising on wider health threats:</u>

<u>Advisory Committee on Dangerous Pathogens (ACDP)</u>

129. The ACDP is a DHSC scientific advisory committee with an independent chair. Its work cuts across a number of organisations, including the Health and Safety Executive (HSE), UKHSA and Defra.

130. The Committee's purpose is to provide as requested independent scientific advice to HSE, and to ministers through DHSC, Defra, and their counterparts under devolution in Scotland, Wales and Northern Ireland, on all aspects of hazards and risks to workers and others from exposure to pathogens. Also, the Committee provides these organisations and the Food Standards Agency (FSA) as requested with independent scientific risk assessment advice on transmissible spongiform encephalopathies (TSEs).

131. The current chair of ACDP is Professor Thomas Evans (2016 to present). Previous chairs have been Professor Chris Whitty (2015 to 2016), Professor George Griffin (2004 to 2013, and again from 2014 to 2015), Professor Roland Salmon (who was interim chair in 2014).

132. The Group advises officials from across the UK. Its secretariat is provided by UKHSA.

The Human Animal Infections and Risk Surveillance (HAIRS) group

133. The HAIRS group is a multi-agency cross-government horizon scanning and risk assessment group. It aims to identify and risk assess emerging and potentially zoonotic infections which may pose a threat to UK public health. Since its establishment in early 2004, there has been a steady evolution and development of the risk assessment processes used by the group. Information on HAIRS is exhibited at (CW/77 - INQ000023135).

134. Members of the HAIRS group identify potential hazards (either zoonotic agents, syndromes, or emerging infections). These undergo an initial review whereby a brief overview of all currently available information on the identified hazard is compiled and provided to HAIRS group members to determine further actions. These include logging a hazard for awareness and ongoing monitoring, producing a risk review statement (where insufficient information is available for a formal risk assessment or a comprehensive risk assessment is not deemed necessary), or performing a formal risk assessment using existing zoonotic potential or emerging infections probability and impact algorithms, more information on this can be found in the HAIRS risk assessment process (CW/78 - INQ000023028).

135. The HAIRS group routinely reviews and updates HAIRS risk assessments and statements which are published online (CW/79 - INQ000023129).

136. The current chair of HAIRS is Dr Helen Roberts; HAIRS was previously chaired by Dr Dilys Morgan from 2004 to 2019.

137. HAIRS membership span agencies across all four UK nations and the UK Crown Dependencies. Its secretariat is provided by UKHSA.

UK Zoonoses, Animal Diseases and Infections (UKZADI) Group

138. The UKZADI Group is an executive group from across the agricultural and public health departments that provides tactical and strategic oversight of zoonotic threats and incidents, by providing oversight, coordination and assurance of activity on emerging and zoonotic infectious diseases. UKZADI advises, as appropriate, the CMO and Chief Veterinary Officer (CVO), Departments of Health across the UK, Department for Agricultural and Rural Development Northern Ireland (DARDNI) and the FSA on important trends and observations which impact on animal and public health, including where necessary preventative and remedial action.

139. The role of UKZADI is also to provide a strategic overview to ensure overall co-ordination of public health action at the UK, national and local level with regard to existing and emerging zoonotic infections and trends in antimicrobial resistance.

140. The group makes recommendations to departments and agencies on current and future priorities, including co-ordination of surveillance, laboratory capabilities and response to incidents of zoonotic disease; consults with and receives advice, including risk assessments and identification of threats and other emerging issues, from expert groups and agrees what changes need to be considered in light of this information; and co-ordinates timely advice to ministers where needed and engages effectively with, and supports, cross-government high-level governance groups with an interest in public health.

141. Membership of UKZADI includes representatives from the FSA, DHSC, Defra, the Animal and Plant Health Agency (APHA), UKHSA and the Veterinary Medicines Directorate (VMD), in addition to at least two representatives from each of Scotland, Wales and Northern Ireland covering public health and veterinary health.

142. UKZADI is co-chaired by relevant Deputy Directors from DHSC, Defra, and the FSA, who take turns to chair the group. The current chair is the DHSC Deputy Director for Health Protection and Health Security.

143. UKZADI advises all four UK nations.

Influenza specific groups

Scientific Advisory Group (SAG)/ Scientific Pandemic Influenza Advisory Committee (SPI)

144. In 2005, as part of the UK's pandemic influenza preparation, DH established a Scientific Advisory Group (SAG) on Pandemic Influenza, to advise on the scientific evidence base for health-related pandemic influenza policies. The Scientific Pandemic Influenza Advisory Committee (SPI) was an enhanced group, covering a wider range of scientific disciplines, that replaced SAG in 2008 (CW/80 - INQ000022688).

145. NERVTAG replaced the former SPI and extended the role, to cover not only pandemic influenza, but any new, emerging (or re-emerging) respiratory virus threat to the UK.

146. The modelling subgroup of the SAG on Pandemic Influenza first met in September 2005 (see (CW/80) above). This was the predecessor of Scientific Pandemic Infections Group on Modelling (SPI-M).

147. SAG was chaired by Dr David Harper. SPI was chaired by Professor Sir Gordon Duff. The remits of the groups were UK-wide.

The Scientific Pandemic Infections Group on Modelling (SPI-M)

148. Up to 2022, this group was called the Scientific Pandemic Influenza Group on Modelling (SPI-M). I have set out more information below on its name change, and change of remit.

149. 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.

150. In non-emergency periods, SPI-M provides expert advice to DHSC and the wider UK Government based on infectious disease analysis, modelling and epidemiology. DHSC has sponsorship of SPI-M and determines its programme of work (CW/81 - INQ000023133).

151. Advice provided by SPI-M represents a consensus view of the group, with the co-chairs responsible for reporting the scientific advice to DHSC and ensuring the scientific integrity of the group's discussion and outputs. SPI-M participants are typically drawn from the academic community and public health agencies, and contribute as experts in the field of epidemiological modelling and statistics, with relevant experience to contribute to the consensus position of the committee.

152. Prior to the COVID-19 pandemic, the work of the committee focused on pandemic influenza and included (CW/82 - INQ000023025):

a. Reviewing the available modelling evidence, and where appropriate the implications for policy.

b. Advising on the possible progression and severity of a future pandemic.

c. Providing expert challenge to epidemiological models informing procurements or those which might be used to respond to a future pandemic.

153. Further information on advice from SPI-M is given in Section 3.

154. SPI-M does not provide advice on endemic infectious diseases, such as seasonal influenza, or vaccination. Analysis of endemic diseases is led by UKHSA. Advice on the effectiveness, safety and deployment of vaccines is provided by the JCVI.

155. While SPI-M previously focused on pandemic influenza, it was formally agreed in 2018 that the group may provide advice on other areas of infectious disease modelling and epidemiology where appropriate (as detailed at (CW/82) above). This was later reflected in a formal revision of the group's name. The change in remit reflected operation of the group in practice, given formation of an "Ebola modelling group" which drew on the SPI-M membership and secretariat to support the government's response to the West African Ebola outbreak in 2014-2016. More on this can be found in Section 3.

156. Typically, SPI-M met three times a year. The last meeting of SPI-M prior to the COVID-19 pandemic was in July 2019.

157. During an emergency, the Scientific Pandemic Infections Group on Modelling, Operational sub-group (SPI-M-O) may be stood up to support the government's response. SPI-M-O is a separate group to SPI-M. Participants may be partly or mostly drawn from SPI-M, but with additional contributors to reflect the specific emergency and expertise required.

158. The current chairs of SPI-M are Professor Graham Medley (academic chair; 2017 onwards) and Dr Thomas Waite (executive chair; 2022). Previous chairs include Peter Grove (2005 – 2017) and Paul Allen (2017-2020) from DHSC.

159. SPI-M advises the UK Government. The secretariat for both SPI-M and SPI-M-O is provided by DHSC.

Scientific Pandemic Insights Group on Behaviours (SPI-B)

160. The Scientific Pandemic Insights Group on Behaviours (SPI-B) provides behavioural science advice aimed at anticipating and helping people adhere to interventions that are recommended by medical or epidemiological experts.

161. SPI-B advises the Scientific Advisory Group on Emergencies (SAGE). More on SAGE can be found below.

162. SPI-B for COVID-19 was stood up in February 2020. The chairs for this are therefore out of scope of Module 1.

The Moral and Ethical Advisory Group (MEAG)

163. MEAG was set up in October 2019 as a successor to the Committee for Ethical Aspects of Pandemic Influenza (CEAPI) to provide advice to policy teams. Its establishment followed the recommendations of Exercise Cygnus (2016), which found that the public reaction to a reasonable worst case pandemic influenza scenario needed to be better understood. MEAG is a group of experts and advisers who advise government on moral, ethical and faith considerations to support the development of policies and response plans both in advance of, and during, a pandemic.

164. The current chairs of MEAG are Professor Sir Jonathan Montgomery and Jasvir Singh.

165. MEAG advises the UK Government. Its secretariat is provided by DHSC.

Other groups to note:

Joint Committee on Vaccination and Immunisation (JCVI)

166. The JCVI's role is to advise UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. It considers and identifies factors for the successful and effective implementation of immunisation strategies and identifies knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered.

167. The JCVI is an independent Departmental Expert Committee (DEC). The JCVI is sponsored by the Routine Vaccines and Immunisations Team in DHSC and its secretariat is provided by UKHSA.

168. The JCVI provides advice and recommendations for all UK health departments based on consideration of scientific and other evidence.

169. JCVI recommendations are presented to the Secretary of State who, if a number of requirements are met, is, in accordance with the Health Protection (Vaccination) Regulations 2009, legally bound to implement those recommendations "so far as is reasonably practicable". These requirements include that the JCVI recommendation "must be based on an assessment which demonstrates cost-effectiveness".

170. For a number of reasons, including where no cost effectiveness analysis has been undertaken, the JCVI will publish advice, which the Secretary of State is not legally bound to implement.

171. The current chair of the JCVI is Professor Sir Andrew Pollard (2013-present). JCVI was previously chaired by Professor Sir Andrew Hall (2006-2013). A specific sub-group for COVID-19 was set up, chaired by Professor Wei Shen Lim. Professor Sir Andrew Pollard recused himself from this group due to a potential conflict of interest as a result of Professor Pollard's role as Director of the Oxford Vaccine Group, which was developing a COVID-19 vaccine.

172. JCVI provides advice to all four UK nations. Its secretariat is provided by UKHSA.

Scientific Advisory Group on Emergencies (SAGE)

173. SAGE is responsible for providing COBR meetings with coherent, coordinated advice and to interpret complex or uncertain scientific evidence in non-technical language. Typically, SAGE meets in advance of COBR and the Government Chief Scientific Adviser (GCSA), who chairs it, subsequently represents SAGE at COBR. Where the issue is principally a health emergency, the CMO co-chairs SAGE. SAGE provides COBR with science advice at the UK level.

174. The secretariat for the Group is usually provided by CO or the GO-Science, but other departments may provide a secretariat if there is a clear Lead Government Department.

175. COVID-19 is not the first time SAGE has been activated - there have been eight previous emergencies, since its conception, when the government has sought expert scientific advice through the SAGE mechanism. Expert participants at SAGE are determined by the scientific expertise needed in that particular situation.

176. SAGE was last activated in response to the potential breach of Toddbrook Reservoir in Whaley Bridge in August 2019. A precautionary SAGE (known as Pre-SAGE) was activated to advise on the Zika virus outbreak in 2016. In 2015, SAGE was activated to advise on the Nepal earthquake, and in 2014 it was called in response to the Ebola outbreak in West Africa. It was also activated during the nerve-agent poisonings in Salisbury. SAGE also advised on winter flooding in the UK in 2013, the Japan nuclear incident in 2011, the volcanic ash emergency in 2010 and the Swine Flu pandemic in 2009"

23. Many of the relevant expert advisory groups fed directly into the work of the Scientific Advisory Group for Emergencies (SAGE) from 28 January 2020 onwards. I understand that the corporate statement being prepared on behalf of the Government Office for Science (GO-Science) and SAGE will address the detail of advice provided to the Prime Minister (PM)/No. 10/CO and its committees on the spread of the COVID-19 virus and the emergence of the COVID-19 variants.

24. Outside the work of SAGE and its sub-groups, the Joint Committee on Vaccination and Immunisation (JCVI) advises UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. It considers and identifies factors for the successful and effective implementation of immunisation strategies and identifies knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered. The JCVI is a Standing Advisory Committee established under section 250 of the Act by the NHS (Standing Advisory Committees) Order 1981. That Order specified that the JCVI is constituted for the

purpose of advising on 'the provision of vaccination and immunisation services being facilities for the prevention of illness.'

25. As an executive agency of the Department, the MHRA is responsible for regulating all medicines, medical devices and blood components for transfusion in the UK. Once the MHRA has thoroughly reviewed data on quality, safety and effectiveness for any vaccine, it seeks advice from the Government's independent advisory body, the Commission on Human Medicines. The Commission critically assesses the data before advising the UK government on the safety, quality and effectiveness of any potential vaccine.

26. The Joint Biosecurity Centre (JBC) was first formed in May 2020 and later established as a directorate of NHS Test and Trace, accountable to Parliament through the Secretary of State. The JBC was established to provide a UK-wide analytical function and to undertake shared priority projects to deliver insights across the UK. It delivered evidence-based, objective analysis, assessment and advice to inform local and national decision making in response to COVID-19 outbreaks. This included:
    a) Helping to inform action on testing, contact tracing and local outbreak management in England;
    b) Informing an assessment of the risks to UK public health from inbound international travel; and
    c) Advising on the COVID-19 alert level.

27. The UK Government's approach to the JBC was non-legislative and it delivered its UK-wide functions on devolved issues through Agency Agreements with the Devolved Governments.

International

28. The UK attended the World Health Organisation (WHO) Executive Board in February 2020 (CW3/3 - INQ000106099) and the virtual Seventy-Third World Health Assembly (WHA) in May 2020 (CW3/4 - INQ000106866), at which the WHA agreed the COVID-19 Response Resolution (CW3/5 - INQ000107092).

29. Throughout the Department also bilaterally engaged with other countries to exchange information on their COVID-19 response. This engagement included bilaterally, and with the WHO, WHO EURO, the G7, the G20, the Global Health Security Initiative and the European Commission.

Context of DHSC's response and decision making

30. Before turning to consider how the Department's response to the COVID-19 pandemic was structured, I will set out some context about the circumstances in which decisions were taken in this period.

31. Firstly, the Department, alongside the rest of Government, was reacting to a global pandemic of unprecedented scale in recent times and dealing with a novel virus about which, in the early months of 2020, there was little scientific understanding and about which many aspects were unknown, including, for example, the rates of reinfection, severity or about any long-term health impacts after infection. The Department and the Government was also initially reliant upon unverified reports from China (CW3/6 - INQ000106038 and CW3/7 - INQ000106039). The scientific community's understanding of the virus developed and matured rapidly over the course of 2020.

32. Additionally scientific knowledge frequently developed by changes in degree of certainty rather than one-off breakthroughs of changes of direction. For example knowledge about the role of asymptomatic infection accrued gradually during the first 4 months of 2020 and beyond. Policy makers however needed to establish point in time positions – for example on the appropriate use of PPE – and capture it in operational guidance based on scientific advice that would continue to develop. Policy makers had to balance the need to be up-to-date with the latest science against providing a level of policy certainty so that delivery could be planned and implemented. This distinction between the nature of how the scientific understanding developed and the need for policy decisions to be taken at specific moments in time and then implemented over weeks and months is key to understanding the dynamic between science and policy and operational decisions over the period. Policy was always kept under review in such a fast-moving environment.

33. There was also a large degree of uncertainty and lack of data about the impacts of decisions on health (in respect of both COVID-19 transmission and on non-COVID-19 care and population health), on society and on the economy. At the outset, the Department's and the Government's understanding of the impact of the disease was informed by data on numbers of hospitalisations, Intensive Care Unit (ICU) bed capacity and deaths. As testing expanded, the data on infection rates became more reliable and therefore more important.

34. In this context, highly impactful decisions had to be considered, taken and, on occasion, reconsidered at an unusually rapid pace based on scientific understanding and the data available at that particular point in time. The Department's and the Government's understanding at any point in time should be understood by reference to the published studies and documents that were then available. Decisions could often not be delayed until more and better data had become available as decisions not to act could be as impactful as those to take action.

35. There were no easy options; the Government was faced with circumstances in which every policy decision would have some sort of a negative impact as well as the intended positive one of reducing the impact of the pandemic. Ultimately in taking a policy decision the Government had to consider the scientific advice that it received, based on the understanding of the course of the disease at the time, and in arriving at the eventual public policy decision weighed often impossible to quantify benefits against disbenefits of the potential health, economic and societal impact.

36. While Government policy evolved over the period as is described in this statement, the objectives remained focused on those set out in the 3 March 2020 Action Plan (CW3/8 - INQ000057508 and CW3/9 - INQ000106145), which is covered in more detail below: first to seek to prevent the virus from taking hold in the UK if it was containable; then to delay its spread; to minimise deaths and serious illness, particularly by protecting the most vulnerable; to prevent the NHS being overwhelmed; to research possible vaccines and treatments; and do the above while, to the extent possible, minimising the wider health, economic and social costs of tackling the virus. The key data which drove Government decision making were infection rates (when available via testing), hospitalisation rates from COVID-19, ICU admissions and deaths. In the early stages of the pandemic, non-pharmaceutical interventions (NPIs) were the only effective mitigations available to Government. In following this policy the Government implicitly rejected two alternative approaches advocated by some: either to let the virus circulate unchecked in an attempt to protect only the most vulnerable; or to pursue a so-called 'zero COVID' policy. In doing this UK Government policy was in line with that followed by the vast majority of European countries, which accepted that COVID-19 would be circulating in the community but due to Government and societal actions was circulating at a relatively low level which reduced the risks of death and serious illness and protected health services from being overwhelmed. In later stages of the pandemic, the development of testing, vaccines and therapeutics allowed alternative strategies to be developed and deployed. This was possible due to action taken in the

early stages of the pandemic to establish clinical trials and prepare for purchase and deployment of effective treatments and vaccines.

37. As well as minimising deaths and serious illness, a key driver of Government decision making throughout the period was avoiding the NHS becoming overwhelmed with COVID-19 patients to the extent that other lifesaving services such as Ambulances, A and E, general hospital beds and HDU/ICU beds became unavailable for both Covid-19 and non-COVID-19 patients, causing patient harm and loss of life. This was reported to have happened at times in Wuhan, Lombardy, Hong Kong and New York and would of course impact particularly on the elderly and most vulnerable as heavy users of NHS services. Government action to achieve this objective was both to reduce demand via non-pharmaceutical interventions (including social distancing and lockdowns) and delaying non-urgent treatments, and to increase the available NHS capacity via increased staffing, increased provision of oxygen and additional ventilators, and additional beds (through stand-alone Nightingale hospitals, use of private sector provision and discharge of medically fit patients). Keeping the demand from COVID-19 below the level of NHS capacity was a key component of decisions to both introduce and then relax lockdowns. It was also one of the reasons for the importance of the 'delay' phase of the 3 March 2020 plan (CW3/8 and CW3/9) as the further any COVID-19 wave was from Winter, when NHS capacity is often limited, the less pressure the NHS would be under. Further details of decisions around NHS capacity are covered in paragraphs 154-157.

Emergency Response

38. Prior to the pandemic, 'human disease' was identified on the Government owned National Risk Register of Civil Emergencies (2017 edition) (NRR) (CW3/10 - INQ000107099) led by the CO. The Department was identified by the Civil Contingencies Secretariat (CCS) as the 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 a 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 classified as a chronic risk). The Emerging Infectious Disease risk incorporates the risk of a High Consequence Infectious Disease (HCID) outbreak or incursion.

39. Under the CCA the Secretary of State is designated as a Category 1 responder and the Department maintains an Emergency Preparedness, Resilience and Response (EPRR) team called the Operational Response Centre (ORC) to help fulfil this role.

40. The Department has standing incident response plans developed in line with standard EPRR requirements. The ORC has the responsibility of providing system-wide leadership for emergency preparedness and response. This means the ORC's role (when not responding to an incident) is to prepare the Department and the health and social care system for potential disruptions that could pose a risk to the public's health, or to the effective operation of the health and social care system. The ORC also provides the Department's out-of-hours emergency response function with on-call officers including a Senior Civil Servant providing 24/7 coverage.

41. The ORC staff regularly engage with emergency preparedness and response functions across OGDs. This includes CCS within the CO and DLUHC's Resilience and Emergencies Department (RED). Representatives of the ORC work with RED Resilience Advisors to engage with local government and Local Resilience Forums (LRFs), which have an obligation to deliver planning and response in relation to health-related emergencies under the CCA.

42. Since December 2018, the ORC has had in place a surge capability called the Voluntary Emergency Response Team (VERT). This was a cohort of over 100 trained volunteers within the Department that can be called from their business-as-usual role for deployment in circumstances where the ORC's capacity is exceeded when responding to incidents. The VERT structure was initially developed in readiness to support preparations for the UK's exit from the EU to allow a quick release of staff to critical areas requiring rapid response.

43. A COVID Incident Management Team (the ORC COVID IMT) was established on 19 January 2020 to formalise and expand the capability to respond to COVID-19. Staff were deployed from the Department's VERT in support. Shift working was introduced for ORC staff in February 2020 to meet the work demands with 07:00-22:00 covered seven days a week and designated on call officers covering night shifts. At its height in April 2020, the ORC had over 150 staff drawn from across the Department as well as on loan from OGDs and ALBs.

44. Secondees from OGDs and ALBs (including DfT, CCS, MoD, DLUHC, PHE and NHSEI were embedded in the Department to facilitate communication and reporting

across government. Similarly, the Department had staff embedded in the FCDO to assist with the repatriation efforts and to promote communication flows across the two departments.

45. Throughout the pandemic, ORC staff facilitated the flow of information from the health and social care system into the CO, including reporting on death management within the NHS and to provide assurance on NHS mortuary capacity and the effective management of COVID-19 related excess deaths. The ORC's emergency response function remained agile and was designed to respond and react to emerging information, informing wider departmental knowledge.

46. As the Department's understanding of COVID-19 developed, so too did its response. The Department transitioned between three phases of operation:

    a. Phase 1: the ORC solely managing the national incident response on behalf of the Department where there were a small number of COVID-19 cases in the UK but increasing numbers worldwide;
    b. Phase 2: the ORC providing coordination across a number of workstreams operating across the Department as case rates increased in the UK and Europe; and
    c. Phase 3: a whole Departmental response to address significant UK cases and pressures on the health and social care system.

47. The Department's Executive Committee met on 6 February 2020 and discussed the three aforementioned Departmental phases for managing the response (CW3/11 - INQ000106136). The Executive Commitee noted that the first phase applied and that it was anticipated that the Department might move to second phase within two to three months. In practice, this happened at a faster pace. The Department moved to the second phase in mid-February 2020 and to the third phase on 4 March 2020. At the meeting on 6 February 2020, the Executive Committee also considered the issue of business continuity (including the development of a 'Gold list' of staff required to keep activities at a minimum acceptable level) during the pandemic in the event that Departmental staff sickness peaked at 20% (as a plausible planning assumption), with a further 10% of staff resources centrally deployed in responding to the pandemic and a further 30% of staff diverted onto COVID-19 related activities within their existing teams.

48. On 10 February 2020 a new policy directorate, the Reasonable Worst Case Scenario (RWCS) Team, was established within the Global and Public Health Group to develop COVID-19 policy in conjunction with others in the Department, its ALBs, CO and OGDs. On 4 March 2020, the RWCS Oversight Board, chaired by Clara Swinson, was set up to co-ordinate and assure the Department's COVID-19 response, supporting and aligning where possible with cross-government response and assurance.

49. The shift towards a whole Department response under the phased approach is reflected not only by the establishment of the RWCS Team and the RWCS Oversight Board but also by the appointment of a Second Permanent Secretary, David Williams, from 6 March 2020. David Williams' role as Second Permanent Secretary was created to recognise the significant expansion in the Department's workload and the need to increase the resilience of senior staffing. Initially the plan was that I would lead on COVID-19 and the Second Permanent Secretary would lead on business as usual. As COVID-19 became the overwhelming focus of Departmental activity, the Second Permanent Secretary acted as my deputy on all issues, and we agreed on a case-by-case basis which of us would oversee a specific workstreams at Permanent Secretary level. For example, as well as the Second Permanent Secretary's oversight of all financial matters, David Williams led on Supply and Testing and I led the other strands (NHS Resilience, Technology, Social Distancing, Shielding, Cross-Cutting).

50. As set out above, the Department is always the LGD in respect of the threat from pandemics and emerging HCID, and it continuously monitors such threats with a proportionate degree of resource deployed at any time based on an assessment of the threat posed. The Department's concerns about the scale of threat from COVID-19 increased over the course of January 2020.

51. The Department maintained its usual role as LGD until 2 March 2020 when the Prime Minister began to chair the COBR meetings, which had been chaired by the Secretary of State since 24 January 2020, in response to the pandemic. At this stage it became clear that the response to the pandemic required a whole government approach. Therefore, whilst it was confirmed in the Coronavirus (COVID-19) Action Plan published on 3 March 2020 (the Action Plan) (CW3/8 and CW3/9), as set out in paragraph 53 below, that the Department remained the LGD, in reality the issue became a cross-Government one with key decisions and overall policy responsibility being taken over by the CO/No. 10. In May 2020, CO created a COVID-19 Taskforce

to oversee matters. Throughout the pandemic the Department remained the principal department on health and social care issues arising from the pandemic.

52. At the 2 March 2020 COBR meeting, a CO paper (CW3/12 - INQ000106141) outlined that the use of the CCA as a means of responding to the COVID-19 pandemic was considered. It was recommended that the policies the Government would need to put in place would require use of the powers set out in the Public Health (Control of Disease) Act 1984 (the 1984 Act) and to supplement this with new primary legislation, which was subsequently provided through the Coronavirus Act 2020 (the CVA) (addressed in more detail in section 6 below). Thus whilst the Department nominally remained the LGD and continued to operate in accordance with its established procedures under EPRR, no powers under the CCA were exercised by it.

Coronavirus (COVID-19) Action Plan, published 3 March 2020

53. The Action Plan (CW3/8 and CW3/9), as referred to in paragraph 36 was developed under the leadership of the Department following a request from the Secretary of State, recorded on 10 February 2020 (CW3/13 - INQ000106107). The decision making structures in the Action Plan relied on CO/No. 10 structures, including Ministerial Cabinet meetings. The Action Plan was jointly agreed between the UK Government and the Devolved Governments.

54. The Action Plan set out:

    a. What the Government knew about the virus COVID-19 and the disease it caused;
    b. How the Government had planned for an infectious disease outbreak such as that caused by COVID-19;
    c. The actions that the Government had taken in response to the COVID-19 outbreak so far;
    d. What the Government was planning to do next, depending on the course of the outbreak; and
    e. What role the public could play in supporting the Government's response, both in the immediate term and the future.

55. The Action Plan set out that the UK's response at the time of publication was based on the Contain phase and that the decision to step up the response from Contain to the Delay and Mitigate phases would be taken following advice from the UK's CMOs,

taking into account the degree of sustained transmission and evidence of the effectiveness of measures taken in other countries to reduce spread. The Action Plan outlined that the measures which most protected those most at risk of becoming seriously affected by the disease would be balanced against impact on society in the Delay phase, with a focus on helping those most at risk to access the right treatment in the Mitigate phase. The Research phase would run throughout and be used to achieve a better understanding of the virus, and of the actions that would lessen its effect on the UK population; to promote innovative elements of the response, including diagnostics, drugs and vaccines; and to use the evidence to inform the development of the most effective models of care.

56. It is important to recognise that the different phases – Contain, Delay, Mitigate – do not set a formula or set route of escalation in the approach taken by Government, but rather should be understood as a useful and succinct description of the types of action available to meet distinct objectives for the general approach that was being taken at the time in outbreak management. The different phases overlap. For example, there were policy decisions that were taken during the Contain phase aimed at effecting the Delay phase. The Delay phase allows time for research and improving understanding of managing the virus through the development of vaccines and therapeutics.

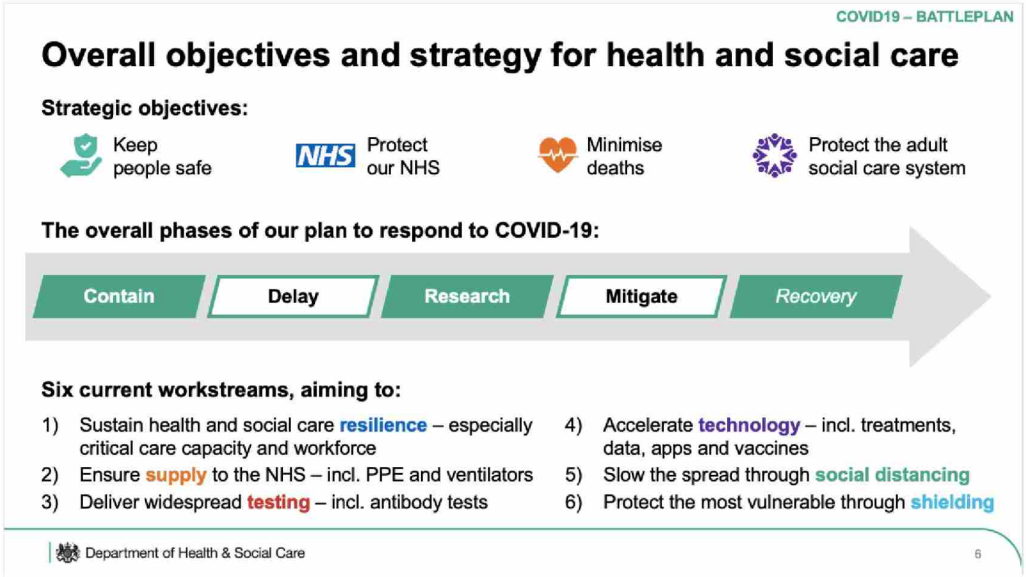
COVID-19 Battle Plan

57. Whilst the Action Plan represented the outward-facing information provided to the public, internally the Department prepared a 'Battle Plan'. The initial three-month Battle Plan was commissioned by the Prime Minister at a meeting on 20 March 2020 (CW3/14 - INQ000049742 and CW3/15 - INQ000049743) and was intended to organise the work of the Department (working with the CMO, the Government Chief Scientific Adviser (GCSA) and the Chancellor of the Duchy of Lancaster (CDL) and across Government) to lead the health and care response to COVID-19. This drew on work already underway in the Department to identify and organise key workstreams. The Battle Plan was scrutinised by the Health Ministerial Implementation Group (HMIG) and the Prime Minister and agreed on 22 March 2020 (CW3/16 - INQ000106279 to CW3/20 - INQ000106289).

58. Work under 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)

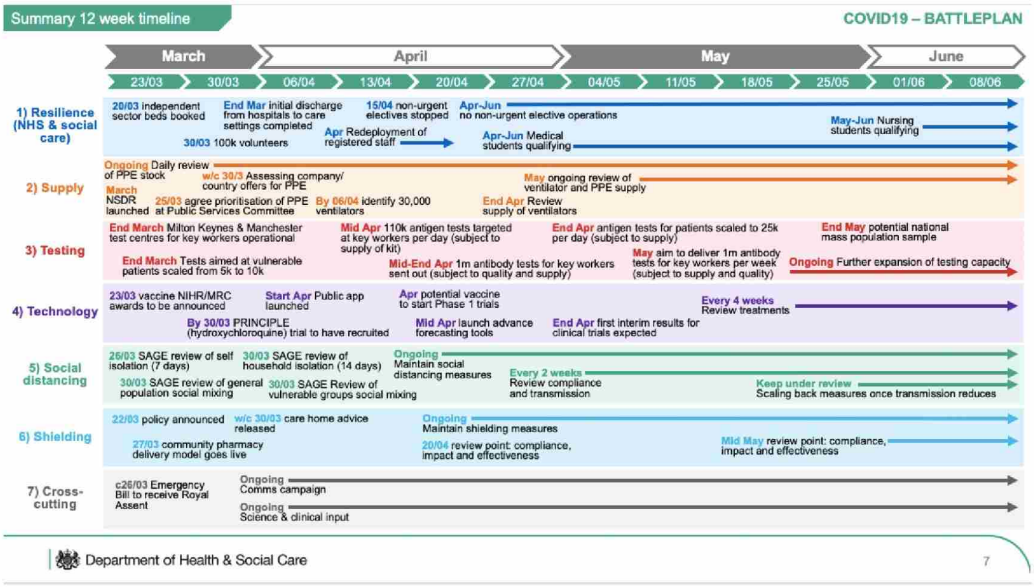
social distancing to slow the rate of transition; and (6) shielding to protect the most vulnerable. These six workstreams informed the Department's decision making role, as covered in more detail in section 4 below. Under each workstream a number of key performance indicators were identified and an SRO was assigned to each workstream. Progress on the workstreams was reported to the Department's Oversight Board by SROs or their deputies, on a weekly basis. The Oversight Board was later renamed the COVID-19 Oversight Board and met weekly until the end of June 2021, after which the frequency of meetings was agreed by the Board to reflect the level of assurance needed during particular phases of the pandemic. The Oversight Board's Terms of Reference were updated in October 2020 but its purpose was fundamentally unchanged (CW3/21 - INQ000106149 to CW3/40 - INQ000106564).

60. As set out in the diagram below, the Battle Plan also set out the broad phases of the proposed response to COVID-19, reflecting those in the Action Plan: (1) Contain, (2) Delay, (3) Research, (4) Mitigate and (5) Recovery (CW3/41 - INQ000106286 to CW3/45 - INQ000106298).



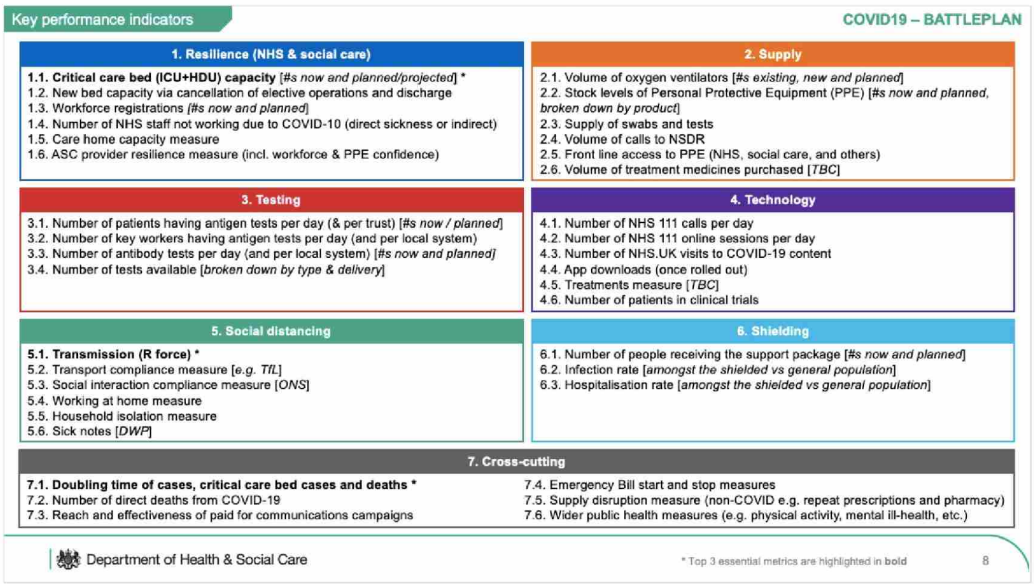
(Battle Plan, v.1.1)

61. The aims of each of the workstreams for the initial three-month period are set out in the image below:



62. As the 12-week timeline makes clear, underpinning the six identified workstreams was a seventh 'cross-cutting' workstream, which recognised the need for input from the communications and science and clinical teams.

63. A number of key performance indicators (KPIs) were developed for each workstream to accompany the Battle Plan, which are set out in the image below:

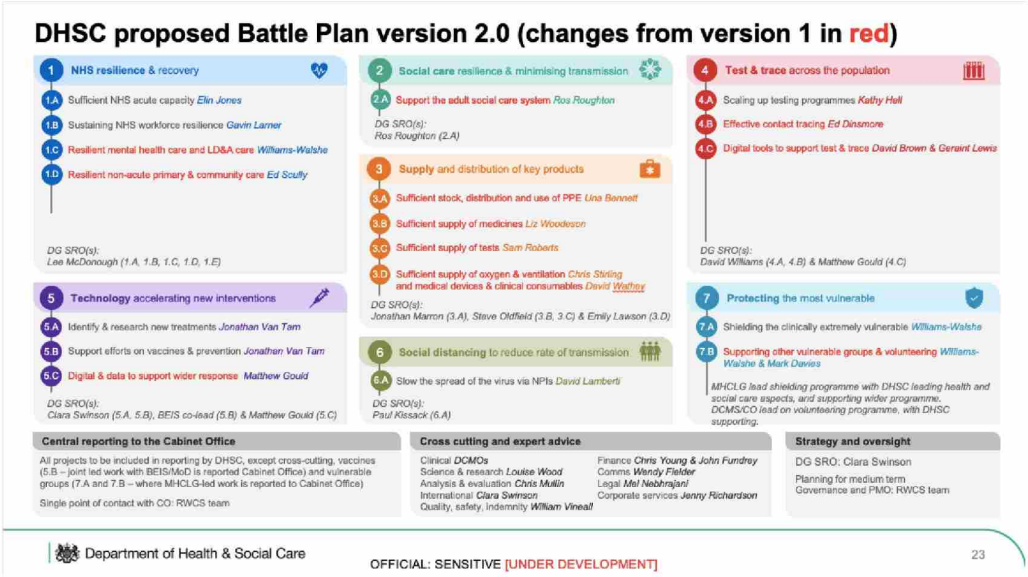


64. The Battle Plan continued to be developed in terms of number of workstreams and detailed priorities and KPIs for each, but it remained broadly consistent, covering

similar areas and encompassing work by the Department's policy teams and some of the ALBs, particularly NHSEI and PHE. A version of the Battle Plan was considered but rejected for publication externally (CW3/46 - INQ000107088). A testing strategy was published on 4 April 2020 (CW3/47 - INQ000106325) and other elements of the plan were published at different times as part of the overall Government response coordinated by the CO/No. 10.

65. The Department developed the Battle Plan over time. Two further versions were produced during the period this statement covers: version 2.0 (11 May 2020) (CW3/48 - INQ000107087 to CW3/51 - INQ000106506) and version 3.0 (21 July 2020) (CW3/52 - INQ000106542 to CW3/54 - INQ000106544).

66. Version 2.0 amended the workstreams to: (1) NHS resilience and recovery; (2) social care resilience and minimising transmission; (3) supply and distribution of key products; (4) test and trace across the population; (5) technology accelerating new interventions; (6) social distancing to reduce rate of transmission; and (7) protecting the most vulnerable. The image below sets out the workstreams with the changes from version 1 of the Battle Plan shown in red.

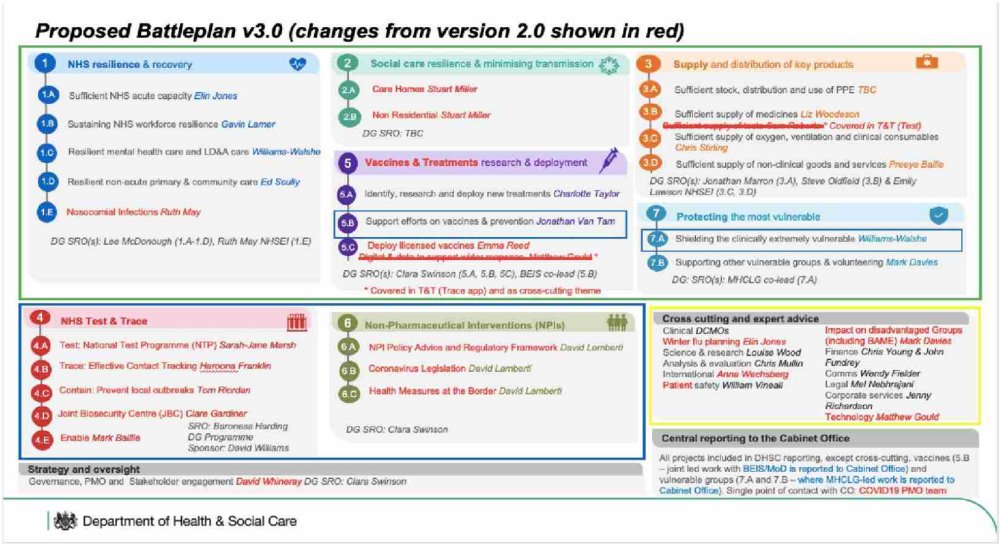


(Battle Plan, v.2)

67. As the image above demonstrates, the Department put in place SROs for each of the workstreams with reporting lines to the CO/No. 10 and identified those responsible for

the important cross cutting issues (finance, communications, legal, etc.) and expert advice.

68. Version 3.0 further amended the workstreams to: (1) NHS resilience and recovery; (2) social care resilience and minimising transmission; (3) supply and distribution of key products; (4) NHS Test and Trace; (5) vaccines and treatments research and deployment; (6) NPIs; and (7) protecting the most vulnerable. The image below sets out the workstreams with the changes from version 2 of the Battle Plan shown in red.



(Battle Plan, v.3)

69. The Department also used the Battle Plan to report on progress for its projects under the CO/No. 10 centrally managed COVID-19 portfolio and for inputting to external publications by the CO/No. 10 at key stages of the pandemic, for example a Winter Plan in Autumn 2020 (CW3/55 - INQ000106867) and the Roadmap in early 2021 (CW3/56 - INQ000106869).

70. The aims of the Battle Plan were to have a single overview of the Department's COVID-19 response and key actions, to track progress and to enable key interdependencies to be managed, to facilitate coordination, and to ensure that planning reflected agreed RWCS and assumptions. The Department ensured, as far as possible, that its work under the Battle Plan workstreams aligned with the projects it was accountable for in accordance with the CO/No. 10's COVID-19 Taskforce.

71. The Department also developed its governance over time in response to COVID-19 and particularly in the period with which this statement concerns at the start of the

pandemic. For the first 23 days of 2020, as the Department continued to monitor and learn about the virus in the early stages, the response was largely comprised of internal and ad hoc cross-Government meetings. These meetings account for the period up until the first COBR meeting, which was chaired by the Secretary of State on 24 January 2020.

72. Following the Government's activation of the COBR system, the response centred around its meetings, first chaired by the Secretary of State (on 24 and 29 January 2020 and 5, 12, 18 and 26 February 2020) and then by the Prime Minister, and where necessary the Secretary of State, from 2 March 2020 onwards (CW3/57 - INQ000106061 to CW3/63 - INQ000106144). Alongside the establishment of COBR, the Government's response to COVID-19 shifted to whole of Government decision making process owing to the scale of the incident, with the CO/No. 10 COBR function assuming responsibility for major Government decisions including where the meetings were chaired by the Department's Secretary of State. From the point that the Prime Minister chaired COBR on 2 March 2020 it would be accurate to characterise all major decisions made as part of the Government's response to COVID-19 as having been taken on a whole of Government basis.

73. The various legal restrictions, as set out in Section 6, were the product of the collective decision-making process outlined above. In general, Ministers would collectively decide on the policy for restrictions, with advice co-ordinated by the CO. Those collectively made policy decisions would then be developed into draft regulations. Once the regulations were drafted, a signing submission accompanying the draft regulations was sent to the Secretary of State, who would determine whether to make the regulations and thus give legal effect to the policy decision(s). The decision whether to make a particular set of regulations was always being made in the context of the prior policy decision, but was in itself always a separate decision and subject to the usual decision-making processes. Whilst the Secretary of State for the Department generally made the regulations, under the 1984 Act any Secretary of State could have signed them, which is explained further below, and regulations were laid before Parliament. Most of the regulations were made using the emergency procedure in section 45R of the 1984 Act (the 'made affirmative' procedure). I have provided more detail on this in section 6.

74. During the period of the COBR meetings chaired by the Secretary of State up to 2 March 2020, the Department was aware that its understanding of the virus was still

extremely limited and guided by advice being provided by SAGE which was based on incomplete data (CW3/64 - INQ000106049 to CW3/74 - INQ000106129).

75. From 17 March 2020, COBR meetings were supplemented by regular, often daily, COVID-19 meetings chaired by the Prime Minister, with the Deputy Prime Minister deputising when the Prime Minister was unavailable. Four new Ministerial Implementation Groups (MIGs) were established to support COBR, including: a healthcare committee, HMIG, chaired by the Secretary of State focusing on the preparedness of the NHS (CW3/75 - INQ000106236 and CW3/76 - INQ000106237). The CO provided the secretariat for the MIGs.

76. The MIG system continued until 29 May 2020 when it was replaced with two Cabinet Committees, COVID-Operations (COVID-O) and COVID-Strategy (COVID-S) (CW3/77 - INQ000106454 and CW3/78 - INQ000106455). The COVID-O and COVID-S model of collective decision making remained in place until March 2022 and February 2021 respectively.

77. Within the Department a Gold structure was implemented on 11 June 2020 to provide oversight of the local containment aspects of the Test and Trace programme, and escalated issues requiring national decisions (CW3/80 - INQ000106468). Weekly Gold meetings (also known as Local Action Committee meetings) were chaired by the Secretary of State and covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; and proposed issues to raise with the Cabinet Office and Prime Minister on a weekly basis (CW3/80, CW3/81 - INQ000106471 and CW3/82 - INQ000106469). Final decisions were taken by Ministers following recommendations to COVID(O) and COVID (S). These meetings remained in place throughout the period with which the Inquiry is concerned.

SECTION 2: INITIAL UNDERSTANDING AND RESPONSE TO THE SPREAD OF COVID-19

78. The tools available in a pandemic are a mixture of testing, pharmaceutical interventions (vaccines and treatments) and non-pharmaceutical interventions. In this initial stage, the government was largely reliant on NPIs to control the virus; it was also scaling up testing and setting up the groundwork for research into

pharmaceutical interventions and potential deployment. Within this context, there are three time periods within this statement:

a. From January 2020 to 23 March 2020, NPIs were being developed and tightened, including the Prime Minister's address to the nation on 23 March 2020 (CW3/83 - INQ000106288);
b. From March 2020, the NPIs were largely stable with consistent communications, advice and legal restrictions;
c. From 17 May 2020 to 4 July 2020, the government loosened the NPIs in stages. Further relaxations and tightenings will be covered in subsequent paragraphs.

79. On 31 December 2019, PHE identified a notification from the Program for Monitoring Emerging Diseases (ProMED) (CW3/84 - INQ000106037) about an outbreak of viral pneumonia in Wuhan, China. PHE provided written updates to the Department's Emergency Preparedness and Health Protection directorate, and the CMO, on 2 and 8 January 2020 (CW3/85 - INQ000106035, CW3/86 - INQ000106036, CW3/6 - INQ000106038 and CW3/7 - INQ000106039).

80. For context, PHE performed this monitoring role continuously and the identification of an emerging virus is not in itself unusual. Between July and October 2022, the Mpox (previously known as monkeypox) epidemic was occurring in Europe, the USA and elsewhere; a respiratory outbreak in the Argentine Republic (Argentina) with high mortality which concerned the WHO but turned out to be Legionella; an Ebola Sudan type (for which we have no rapid vaccine) in the Republic of Uganda (Uganda); a hantavirus outbreak in Panama City (Panama); Marburg virus detected in the Republic of Ghana (Ghana); plague cases reported in the Democratic Republic of Congo (DRC); vaccine-derived polio detected in London and New York sewers; and cholera in the Republic of Haiti (Haiti).

81. On 9 January 2020, ORC staff made a submission to Ministers about the outbreak of viral pneumonia in China (CW3/87 - INQ000106041). It stated that the WHO had reported that there was no evidence of significant human to human transmission and no healthcare worker infections, but further information from China about the affected patients and potential source of infection was expected. The submission noted that PHE continued to lead on the public health response.

82. The WHO announced on 9 January 2020 that a novel coronavirus had been identified from samples obtained from the Wuhan outbreak (CW3/88 - INQ000106040).

83. At the request of the Department following advice from the CMO, NERVTAG met on 13 January 2020 (CW/75 - INQ000023107) and held a subsequent teleconference to update members and to consider a risk assessment of the emergence of the novel coronavirus (CW3/90 - INQ000106042).

84. On 20 January 2020, the first Departmental Wuhan Novel Coronavirus Officials Meeting took place and was chaired by the Permanent Secretary (me), with attendance from the CMO, DCMO (Professor Sir Jonathan Van-Tam), the Director of Emergency Preparedness and Health Protection and with colleagues from PHE and NHSEI. The meeting covered updates on the current surveillance picture, the Department's proposed response, trigger points for escalation, screening and the actions taken by other countries (CW3/91 - INQ000106056, CW3/92 - INQ000106057 and CW3/93 - INQ000106058).

85. At that time, the lead role for the oversight and provision of data relevant to the COVID-19 response sat with different partners in the health and social care system. PHE was responsible for providing data on disease surveillance (including confirmed domestic and international cases) and data on the early stages of the testing programme (number of tests carried out and number of positive and negative test results). At later points, NHSEI provided operational data on bed occupancy/availability, the number of ventilated beds available/occupied, hospital capacity, staffing numbers and deaths.

86. In these early stages, data quality and returns provided to the Department by NHSEI were challenging and difficult to use, particularly due to low or non-availability of testing data (for example in respect of regional and national hospital admission rates) which in turn meant that informed policy making was difficult for officials and ministers.

87. The Department established and chaired Daily National Sector calls from 21 January 2020 to co-ordinate the health and social care system response and maintain a common situational awareness of the national and international impacts of COVID-19 CW3/94 - INQ000106045 to CW3/101 - INQ000106376). These continued until summer 2020. The agenda covered the current reported cases and testing, repatriation, case definitions, port health measures, clinical management, the picture across all four nations, and policy/operational decisions, and was attended by

Departmental officials including communications officials, NHSEI, PHE and the Devolved Governments. The calls were informed by the SitRep from the previous evening and were used to address key live issues and to inform the subsequent SitRep.

88. On 22 January 2020, a Precautionary SAGE meeting on COVID-19 took place with actions for the Department to consider how NHS primary care facilities might respond to an increase of cases and potential cases (jointly with the CMO and PHE) and to work to ensure consistent messaging on travel advice to/from Wuhan (jointly with the CMO and the FCDO) (CW3/102 - INQ000106047). The initial understanding of COVID-19 was set out in the meeting, including that there was evidence of person-to-person transmission and an apparent incubation period of within 5 to 10 days with 14 days a sensible outer limit.

89. Further on 22 January 2020, the Department made a joint announcement with PHE about COVID-19 (CW3/103 - INQ000106048), setting out that the situation in Wuhan had been carefully monitored and that proportionate, precautionary measures would be put in place. The ORC escalated a PHE-proposed package of port health measures to the Department's Ministers, who agreed to the proposals, with a number of port health measures put in place in line with the case definition at the time (CW3/104 - INQ000106896 to CW3/107 - INQ000106050). Measures applied from 12:00 on 22 January 2020 including Enhanced Monitoring Arrangements (EMAs) for all direct flights from China to London Heathrow. Inflight messages were broadcast to passengers encouraging them to report illness. Leaflets with public health guidance were issued to passengers explaining what to do in the event they had or developed symptoms. Passengers could provide early warning of illness or formal declaration of their health via General Airline Declaration. A PHE Port Health Team was based at Heathrow Airport and local health protection teams met each direct flight aircraft. There were posters and leaflets available in the airport published in English and six other languages. The approach to the port health measures reflects the case definition at the time (i.e. there was a focus on symptomatic transmission with guidance aimed at passengers travelling from at risk regions who may have had exposure). Port health policies evolved but continued to align with the case definition that applied.

90. Following a series of informal updates to DHSC Ministers and Senior Officials from 9 January, on 23 January 2020, Daily Situation Reports (SitReps) (CW3/108 - INQ000106052 to CW3/114 - INQ000106512) were formalised by the ORC. These

provided the situational awareness and these continued until 29 June 2020 when they became weekly. The Department commissioned NHSEI and PHE for updates on their data sets for this and the wider Government SitRep, to provide a common situational picture. The SitRep at this stage included data on the number of tests carried out in England, Scotland, Wales and Northern Ireland, the number of confirmed cases internationally and an update on the NHS and port health measures. The SitRep was distributed across Government, the Devolved Governments, NHSEI and PHE.

91. On 25 January 2020, ORC representatives established a data-sharing protocol with the Devolved Governments (CW3/115 - INQ000106062). This ensured data consistency across the UK. At this point the data covered numbers of people being tested, numbers of tests completed and number of cases confirmed. As the pandemic progressed this expanded to include number of deaths. This data was used to inform the daily SitRep and later, the daily publication.

92. As the pandemic evolved, the SitRep evolved accordingly. The Department sought further data on, for example, bed occupancy, cancelled operations, availability of ventilators and workforce absence rates. Data on Adult Social Care in England was also included with information on outbreaks, deaths, capacity, workforce, Personal Protective Equipment (PPE) and testing. The SitReps began to include broader summaries of national issues and incidents, as well as more detail on tests and the number of deaths in the UK.

93. On 23 January 2020, the Secretary of State made a statement in the House of Commons about the outbreak of COVID-19 in China and the UK's response to protect the British public (CW3/116 - INQ000106051). The statement indicated that the CMO had revised the then current risk to the UK population, based on the evidence then available, from "very low" to "low" with the port health measures described above referenced. The Secretary of State indicated that the response would be kept under review in light of emerging scientific evidence. Before the second reading of the NHS Funding Bill on 27 January 2020, the Secretary of State provided a further update to the House of Commons on the ongoing situation in Wuhan (CW3/117 - INQ000106066). He indicated that anyone returning to the UK from Wuhan in the last 14 days would be asked to self-isolate. PHE officials would trace those who had arrived in the UK from Wuhan. He stated that the UK had developed an accurate test for COVID-19 with PHE working on scaling up testing capacity.

94. On 27 January 2020, the First Case Protocol was approved by the Director of Emergency Response and Health Protection (CW3/118 - INQ000106072 and CW3/119 - INQ000106073) to ensure that there were clearly set processes for the management of potential domestic COVID-19 cases, including the steps to be taken to manage the patient. This had been cleared by NHSEI, PHE and the Devolved Governments. It was presented at COBR (Officials) (COBR(O) on 29 January 2020 (CW3/118, CW3/120 - INQ000106068 and CW3/121 - INQ000106071).

95. Also on 27 January 2020 at a daily Secretary of State-led update meeting with CMO, DCMO (Professor Sir Jonathan Van-Tam), Departmental and PHE officials, options around vaccine development were discussed (CW3/122 - INQ000106067). The Secretary of State asked that the Department pursue every option possible on vaccines and testing.

96. On 28 January 2020 SAGE, following the first COBR meeting and the official establishment of SAGE under the COBR structure, met for the second time in response to COVID-19 with the Department providing an update on the number of declared cases, deaths and geographic spread (CW3/123 - INQ000057492). The current understanding of COVID-19 was set out, including that current evidence suggested a single point zoonotic outbreak being sustained by human-to-human transmission with a reproductive number (R-number) estimated between 2 and 3, with a doubling rate estimated at three to four days. The R-number is the average number of secondary infections produced by a single infected person. The Department was advised in the SAGE meeting to use the existing planning assumptions for an influenza pandemic to develop a RWCS for COVID-19 in the UK.

97. On 29 January 2020, Airport Public Health EMAs were extended to include all direct flights from mainland China to London Gatwick and Manchester; this applied to eight airlines (CW3/124 - INQ000106076). Printed public information was distributed at London Gatwick, Manchester and London Heathrow airports and at all UK Eurostar terminals, Dover and key ferry ports. This signposted passengers to appropriate assistance in the event that they were unwell or in the event that they subsequently become unwell/symptomatic.

98. On 30 January 2020, the WHO Director General, Dr Tedros Ghebreyesus declared the novel coronavirus outbreak a public health emergency of international concern (PHEIC) (CW3/125 - INQ000106079).

99. From 30 January 2020, ORC staff regularly joined the (LRF) Chairs call to share intelligence on COVID-19 (CW3/126 - INQ000106082 and CW3/127 - INQ000106081). These discussions focused on the domestic and international position, to share intelligence on delivery of local response and to update on plans for repatriations. NHS Trusts representatives form part of the LRF membership.

100. On 30 January 2020, the Department published a statement from the four CMOs raising the risk level for the UK population from "low" to "moderate" (CW3/128 - INQ000106080).

101. On 31 January 2020, the Department published a statement from the CMO confirming that two patients in England (members of the same family) had tested positive for COVID-19 and were receiving specialist NHS care (CW3/129 - INQ000106083).

102. Additionally on 31 January 2020, the Secretary of State received a submission which asked for agreement to launch a rapid research call, based on the assessment and recommendation of the CMO (CW3/130 - INQ000057497). The research call would encompass active intervention development, namely vaccines and therapeutics with prioritisation of those with rapid clinical development and diagnosis and understanding on COVID-19. The rapid call was launched in February 2020 (CW3/131 - INQ000106090) and projects were commissioned in March 2020. The funded projects were expected to lead to a benefit in UK and international public health within 18 months.

103. Also on 31 January 2020, 83 UK nationals and 27 non-UK nationals returned to the UK as part of the first repatriation flight from Wuhan (CW3/132 - INQ000106074, CW3/133 - INQ000106075 and CW3/134 - INQ000106554). The ORC worked closely with NHSEI to coordinate the reception for these repatriated nationals. This included working with MoD to coordinate airfields for the flight to land in the UK as well as the coordination of patient transport between the airfield and the supported isolation location at Arrowe Park. Individuals were allowed to travel on the plane back to the UK on the condition that they signed a form of contract/agreement that they would enter into voluntary self-isolation in accommodation provided by the Government. The period of self-isolation was for 14 days. For anyone not complying with the agreement, the local authority would be able to apply for a Part 2A order under the 1984 Act to quarantine them; however, this was not necessary as there was full compliance. The

1984 Act and regulations made under it provide a legislative framework for health protection in England and Wales. Part 2A of the 1984 Act, as inserted by the Health and Social Care Act 2008 (the 2008 Act), provides a legal basis to protect the public from threats arising from infectious disease or contamination from chemicals or radiation, and includes powers to impose restrictions or requirements on people, and in relation to things and premises, for use in rare circumstances where voluntary cooperation cannot be obtained.

104. On 2 February 2020, the Department launched a UK-wide public information campaign to advise the public on how to slow the spread of COVID-19 and reduce the impact on NHS services (CW3/135 - INQ000106087). This is covered further in section 5 below.

105. On 3 February 2020, the Secretary of State announced £20 million in new funding to the Coalition for Epidemic Preparedness Innovations (CEPI) for coronaviruses and other infectious diseases (CW3/136 - INQ000106086).

106. On 3 February 2020, the DCMO and I attended a meeting chaired by the Cabinet Secretary to discuss the impacts of COVID-19 (CW3/137 - INQ000106088, CW3/138 - INQ000106089 and CW3/139 - INQ000106094).

107. On 4 February 2020, the Department had its regular performance meeting with the Prime Minister (CW3/140 - INQ000106092). This meeting was also used to brief the Prime Minister on COVID-19. This was, to my knowledge, the first meeting in which the Prime Minister was briefed by the CMO on the then-current knowledge about the virus. The CMO advised that the RWCS for the virus was 100,000 – 300,000 excess deaths.

108. On 8 February 2020, EMAs at London Heathrow Airport were extended to cover direct flights from Thailand, Hong Kong, Japan, the Republic of Korea, Singapore, Taiwan and Malaysia, with a further extension on 10 February 2020 to cover flights from Singapore to Manchester (CW3/141 - INQ000106106).

109. At the COBR meeting on 18 February 2020, the need for a full response to an outbreak of COVID-19 was discussed, including the development of additional UK legislation (CW3/142 - INQ000106115 to CW3/145 - INQ000106118). The Department was asked, as part of its RWCS planning, to lead the development of policy across

Whitehall and the Devolved Governments, with a view to bringing forward new primary legislation to introduce measures that would further assist in tackling the pandemic. This work led to the drafting of the Bill that became the CVA.

110. On 20 February 2020, the First Death Protocol was produced and signed off by the Director of Emergency Response and Health Protection (CW3/146 - INQ000106121, CW3/147 - INQ000106122, and CW3/148 - INQ000106124). This was cleared by NHSEI, PHE and the Devolved Governments. This set out the procedures that would be followed in the event of the death of a resident in the UK from COVID-19 as well as the death of British Nationals (BNs) overseas, including procedures and escalation routes for government

111. On 22 February 2020, the Government conducted the first of many cruise ship repatriations from the cruise ship the Diamond Princess (CW3/149 - INQ000106063, CW3/150 - INQ000106064 and CW3/151 - INQ000106065). FCDO were leads for the Government-wide repatriation programme. The ORC led on the health and wellbeing of those BNs on arrival to the UK. This included coordination of the reception for the repatriated BNs, including their screening, arrangements for incoming flights including coordination with the MoD, identifying and establishing isolation arrangements and accommodation for BNs upon arrival in the UK and transport to accommodation. Other cruise ship repatriations took place up until the end of April 2020. The ORC continued to coordinate the health needs for these arrivals. In total, direct or supported charters were organised for over 1,500 people to return to the UK. Once the last cruise ship arrived in the UK at the end of April 2020, the Government repatriation programme concluded.

112. As of 5 March 2020, people entering the UK from locked down regions in Italy were asked to self-isolate for 14 days (CW3/152 - INQ000106153). This guidance was based on the recommendations of the UK CMOs (CW3/153 - INQ000106151). These regions in Italy were identified because of the volume of air travel from affected areas, understanding of other travel routes and number of reported cases. This list was kept under review. For areas with direct flights to the UK, PHE carried out enhanced monitoring. This involved communications to passengers on how to report any symptoms that they developed either during their flight, at the time of arrival, or after leaving the airport. The ORC engaged with PHE as necessary to aid reporting.

113. During the period covered by this statement, a number of NPIs were considered with a view to reducing the transmission risk that arose from people's everyday interactions with each other.

114. In considering whether, or when, each of these NPIs should be introduced, the Department and the Government as a whole was continually balancing the available evidence about the evolving risks, impacts and benefits of introducing particular measures, aiming to introduce each one as necessity and proportionality dictated. These measures or restrictions were amended or removed when it was decided that they were no longer necessary to prevent, protect against, control or provide a public health response to the incidence or spread of infection in England of COVID-19.

115. At an officials meeting on 5 March 2020 (CW3/154 - INQ000106157 to CW3/158 - INQ000106156) the Department was commissioned to provide a paper on the details of three NPIs that had been discussed by SAGE: home isolation for seven days for symptomatic cases; whole household isolation for 14 days where anyone living in that household had been found to be symptomatic; and enhanced measures for elderly or vulnerable groups for a period of up to 13 weeks. The Department submitted this paper on 6 March 2020 (CW3/154 and CW3/155 - INQ000106158).

116. On 8 March 2020, the Secretary of State received initial advice on the three proposed NPIs (CW3/159 - INQ000106160), setting out the impact of introducing these measures, and the requirements to support health and social care services. The COBR(Ministerial) (COBR(M)) meeting of 9 March 2020 discussed interventions to delay a peak of infections as well as communications about moving to the Delay phase (CW3/160 - INQ000106163 to CW3/164 - INQ000106167). Following this meeting CO set up a cross-government team including the Cabinet Secretariat, the Department, SAGE, CCS and Comms to develop and articulate the policies for the three proposed interventions, including developing definitions of the measures and how they would be communicated, and updated advice on triggers. This was presented as a paper to COBR(O) on 10 March 2020 (CW3/165 - INQ000106168 to CW3/168 - INQ000106171) . In addition, on 10 March 2020 NHS modelling capacity under different scenarios was sent to Secretary of State's office (CW3/169 - INQ000106180 and CW3/170 - INQ000106181).

117. The COBR(O) discussed and finalised policy, advice on timings and phasing, and communications ahead of COBR. Following this the cross-government cell further

developed the paper, along with plans to implement measures. This was then submitted for the COBR(M) on 12 March 2020 (CW3/171 - INQ000106172 to CW3/178 - INQ000106200). **and CW3/167, CW3/29 and CW3/168).**

118. On 10 March 2020, the Secretary of State received advice from officials on proposed clauses for the CVA and about the timetable for the proposed bill (CW3/179 - INQ000106176 to CW3/181 - INQ000106178). The Secretary of State received briefing from CO and chaired the COBR meeting on 11 March, the purpose of which was to reach collective agreement about the draft content of the CVA (CW3/182 - INQ000106183 and CW3/183 - INQ000106192).

119. On 11 March 2020 the WHO declared that the spread of COVID-19 was a pandemic (CW3/184 - INQ000106182).

120. The Secretary of State received briefing from officials on 12 March 2020 to support him for COBR(M) (CW3/185 - INQ000106196 to CW3/188 - INQ000106202) on the same day on the proposals for NPIs and the preparations were underway to introduce the measures. At the COBR(M) meeting it was collectively agreed that Government guidance should be changed from 13 March 2020 so that anyone with symptoms compatible with COVID-19 should stay at home for at least seven days. In addition, people aged over 70 and those with serious medical conditions were advised against going on cruises; and the Government also advised against international school trips. This was announced by the PM at the COVID-19 press conference on 12 March 2020 (CW3/189 - INQ000106195), which also outlined that the Government was moving to the Delay phase of its COVID-19 Response.

121. The Department provided three papers to CO/No. 10 on 15 March 2020, which included one about a 14 day stay-at-home policy for household contacts; provided an outline of the social distancing measures that could be enacted to delay and mitigate the impact of the spread of Covid-19 in the UK; and set out how this approach would work in practice, including expected compliance issues, lead times for implementing, and actions Government would need to take to deliver these measures (CW3/190 - INQ000106206 to CW3/206 - INQ000106222).

122. On 15 March 2020, the Prime Minister chaired a meeting with CDL, the Secretary of State, CMO, GCSA, the Cabinet Secretary and me to agree to a package of proposed announcements to be put to COBR(M) on 16 March 2020 (CW3/195 -

INQ000106211 to CW3/206 - INQ000106222). These included announcing and launching the household stay-at-home policy from Monday 16 March 2020; and announcing a package of voluntary social distancing advice for the general public (CW3/207 - INQ000049640). In addition, it set out that the Government would advise that more vulnerable groups (e.g. those aged 70 years or over, pregnant women and those with particular health conditions) should follow these social distancing measures more rigorously.

123. On 18 March 2020, the Prime Minister announced that schools would close from 20 March 2020, except for children of key workers and vulnerable children (CW3/208 - INQ000106250).

124. On 20 March 2020, the CO advised the Prime Minister about new policy to support social distancing. Following a COBR meeting which included Devolved Governments, a decision was taken to require the closure of businesses selling food or drink on the premises, and to close other businesses such as cinemas and theatres (CW3/209 - INQ000106261 to CW3/213 - INQ000106265). The Secretary of State received advice and a signing submission from DLUHC on 21 March 2020 (**CW3/214 - INQ000106273, and CW216 - INQ000106275 to CW3/218 - INQ000106277**), and made the Health Protection (Coronavirus, Business Closure) Regulations 2020 on the same day.

125. The package of social distancing advice had been in place for one week when the Prime Minister addressed the nation on 23 March 2020, setting out the requirement for people to stay at home from 26 March 2020 (CW3/83 - INQ000106288).

126. On the morning of 23 March 2020, the Prime Minister held two strategy meetings with officials where he was briefed on policy recommendations to support further social distancing measures, including the closure of retail and public premises and to require that people should stay at home except for very limited purposes (which included shopping for necessities) (CW3/219 - INQ000106290 and CW3/220 - INQ000106291). These policy recommendations were agreed at COBR, which included Devolved Governments (CW3/221 - INQ000106293). Following this decision, the Prime Minister addressed the nation and announced these new restrictions (CW3/83). This is what is commonly known as the 'first lockdown', which saw restrictions being put in place on a statutory basis through the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, which came into effect on 26 March 2020. The regulations required the closure of some businesses and placed

restrictions on others, prohibited anyone from leaving the place they were living without reasonable excuse and banned public gatherings of more than two people. DLUHC led on providing advice and products to the Secretary of State for these regulations (CW3/222 - INQ000106457 to CW3/224 - INQ000106307).

127. On 7 April 2020, the Department provided a paper to the HMIG providing an update on the work to identify health impacts of social distancing policy (CW3/225 - INQ000106327 and CW3/226 - INQ000106337).

128. On 15 April 2020, the Department provided a further paper to HMIG to provide a further update on potential health impacts of social distancing (CW3/227 - INQ000106348 to **CW3/229 - INQ000106350**).

129. On 20 April 2020, the Prime Minister, the CDL, the Chancellor of the Exchequer, and the Secretary of State commissioned officials to provide advice on which measures could potentially be relaxed (CW3/301 - INQ000106362). The Chancellor-led Economic and Business group (EBRIG(M)) met on 23 April 2020 to discuss a Department for Business, Energy and Industrial Strategy (BEIS) paper on safer workspaces (CW3/303 - INQ000106364 to CW3/309 - INQ000106370) . The Department provided a briefing (CW3/310 - INQ000106363) to the Minister of State for Health, Edward Argar, who attended the meeting on behalf of the Department, to discuss the appropriate balance between maximising economic activity and at the same time managing transmission risk.

130. As part of Government's consideration for relaxing measures, amendments were considered at Cabinet on 7 May 2020 (CW3/311 - INQ000106400 to CW3/313 - INQ000106402) and at COBR on 10 May 2020 (CW3/314 - INQ000106406 to CW3/317 - INQ000106409). Following agreement at those meetings the Secretary of State received advice (CW3/318 - INQ000106410 to CW3/320 - INQ000106412) and then the PM announced the agreed plan on the same day (CW3/321 - INQ000106405). This outlined a proposed three step approach, with the move to step 1 from 13 May 2020 and a provisional timeline for when NPI measures could be relaxed, subject to five specific tests being met.

131. The tests set out in the government publication 'Our Plan to Rebuild' were: (1) making sure the NHS could cope and continued to have sufficient capacity; (2) a 'sustained and consistent' fall in daily deaths; (3) data showing the rate of infection to

be decreasing to 'manageable' levels'; (4) ensuring that supply of tests and PPE were able to meet future demand; and (5) avoiding a second peak that would risk overwhelming the NHS. The CO in its central function co-ordinated advice to Ministers on whether these tests were being met and whether the plan was able to move ahead. The Government also published its new system of COVID-19 alert levels (CW3/321).

132. The Secretary of State received advice on 12 May 2020 to make regulations to support move to step 1 (**CW3/322 - INQ000106413 to CW3/324 - INQ000106415, and CW3/326 - INQ000106417 to CW3/332 -**

133. On 15 May 2020, a submission was sent to the Secretary of State regarding the review of shielding policy (CW3/333 - INQ000106430 and CW3/334 - INQ000106431). This followed a commitment by Government to review shielding policy drawing on the latest clinical evidence from NERVTAG/SAGE about those at a heightened risk from COVID-19. The submission provided the Secretary of State with background on the shielding categories and noted the anticipated NERVTAG/SAGE advice that was due to follow within the next week and upon which a decision would likely be recommended. The Secretary of State noted the submission on 21 May 2020 (CW3/335 - INQ000106443).

134. CO discussed measures for step 2 of 'Our Plan to Rebuild' on 25 May 2020 (CW3/336 - INQ000106444 and CW3/337 - INQ000106445). Departmental officials provided briefing outlining what they expected to be covered. This included amending plans for step 2 to a more limited reopening of retail on 1 June 2020 and further reopening on 15 June 2020. In addition, the position for social contact was to not introduce support bubbles at this time and to relax gathering limits outside, including private gardens, to a maximum of 6 people.

135. The Secretary of State received advice on 27 May 2020 (CW3/338 - INQ000050709 to CW3/340 - INQ000106446) that outlined officials' understanding of proposed amendments being considered to come into effect for 1 June 2020 as part of step 2. This included moving from the requirement for people to stay at home unless they had a reasonable excuse and replace this with restrictions on what people can do, including gathering size and staying away overnight from home.

136. The Secretary of State received further advice on 28 May 2020 (CW3/341 - INQ000106447 and CW3/342 - INQ000106456) to sign regulations to implement the decision to enable people to be part of a gathering of up to 6 people in total, unless an exemption applied, from 1 June 2020.

137. On 10 June 2020, the Secretary of State was provided with a submission on the policy options on relaxing shielding following the provision of new clinical advice from the then DCMO, Dr Jenny Harries (CW3/343 - INQ000050886 to CW3/346 - INQ000106470). As the guidance on shielding was expiring at the end of June 2020, and with a commitment having been given to provide an update in the week of 15 June 2020, the submission noted the need to agree a future policy for the cohort of c.2.2m Clinically Extremely Vulnerable (CEV) people. The Secretary of State decided to make a further change to advice for those shielding to advise they could now meet outdoors in groups of up to six people, while maintaining strict social distancing, from 22 June 2020, and that shielding measures be fully eased, bringing guidance for this group in line with that of the clinically vulnerable cohort, from 13 July 2020.

138. On 12 June 2020 the Secretary of State was sent an updated submission on the future support packages required as the shielding policy was relaxed (CW3/347 - INQ000106480 and CW3/348 - INQ000106481). Whilst DLUHC had responsibility for the majority of the support package, the Department had responsibility for the medicine delivery service and for the NHS Volunteer Responders programme and the '9 Actions' that the NHS was taking as part of the wider changes to support clinically vulnerable people. In respect of medicine delivery service, the submission set out four options for the Secretary of State to consider, with the submission recommending Option D (continuing the service as it was for the next few months).

139. On 15 June 2020, the mandatory wearing of face coverings on public transport came into force through the Health Protection (Coronavirus, Wearing of Face Coverings on Public Transport) (England) Regulations 2020 (CW3/349 - INQ000106461). This had been recommended to the Secretary of State in a submission dated 11 June 2020 (CW3/350 - INQ000106472 to CW3/356 - INQ000106478) and agreed by him on 12 June 2020 (CW3/357 - INQ000106479).

140. The Secretary of State was briefed by officials on 19 June 2020 for a COVID-O on the same day which discussed how to ensure that businesses could reopen safely (CW3/358 - INQ000106487 to CW3/361 - INQ000106490). The briefing outlined the progress being made on developing the guidance. In addition, officials advised that effective enforcement of restrictions would be beneficial in terms of reducing transmission risk.

141. The Department provided a briefing for the Secretary of State for the 22 June 2020 COVID-S (CW3/362 - INQ000106492 and CW3/363 - INQ000106493) which considered whether the five tests that had been set out in 'Our Plan to Rebuild' were being met to a degree that warranted a move to step 3 of that plan; and, if so, what sectors could reopen at this point, and what social distancing restrictions would remain in place. The briefing outlined that the public health case was that this could be a high risk set of changes, but not a needlessly high one. Following this meeting and further advice to the Secretary of State on 23 June 2020 (**CW3/364 - INQ000106494 to CW3/368 - INQ000106498, and CW3/370 - INQ000106500**), the Prime Minister announced that step 3 reopening would go ahead on 4 July 2020 (CW3/371 - INQ000106501).

142. On 29 June 2020, ahead of the relaxation of social distancing measures planned for 4 July 2020, the Secretary of State sought advice on the potential benefits of mandating the wearing of face masks in other indoor settings (to expand on the requirement to wear one on public transport) (CW3/372 - INQ000106511). The advice was provided in the form of a submission to the Secretary of State dated 1 July 2020 (CW3/373 - INQ000106517 and CW3/374 - INQ000106518) and it noted evidence that there may be some benefit in wearing a face covering in enclosed crowded spaces and provided three options for consideration.

143. The Secretary of State received a briefing on 16 July 2020 (CW3/375 - INQ000106526 and CW3/376 - INQ000106527), which outlined that a COVID-S meeting would be seeking agreement to publish the next chapter of 'Our Plan to Rebuild' on 17 July 2020, alongside a statement by the Prime Minister. Departmental officials provided briefing for the COVID-S that advised that the overall tone and level of ambition in this next chapter of the roadmap set out in 'Our Plan to Rebuild' could be underplaying the scale of the risk of a second wave. The Prime Minister announced on 17 July 2020 (CW3/377 - INQ000106536) that from 25 July 2020 gymnasiums and other indoor sports facilities were to be allowed to re-open and that, if COVID-19 prevalence remained at or below current levels, the Government would consider whether to allow further re-openings from 1 August 2020 for: bowling alleys, indoor skating rinks, casinos, exhibition halls and conference centres.

144. On 17 July 2020, the Secretary of State was advised that, given some evidence about the virus having the potential for transmission beyond 7 days after symptoms start, the four UK CMOs had agreed that it would be advisable to increase the self-isolation period (for symptomatic individuals with a positive test result) from 7 to 10

days (CW3/378 - INQ000106537 and CW3/379 - INQ000106538). The Department provided a paper for a COVID-S on 22 July 2020 where the change was agreed (CW3/380 - INQ000106541). Following discussions with the Devolved Governments on whether to include other amendments to isolation guidance, the change was announced by the UK CMOs on 30 July 2020 (CW3/381 - INQ000106546).

145. Following a COVID-S on 22 July 2020 , the Secretary of State made regulations the same day which permitted the reopening of indoor swimming pools (including indoor facilities at water parks), indoor fitness and dance studios, and indoor gymnasiums and sports courts from 25 July 2020. The need for the remaining restrictions in the regulations was reviewed by the Secretary of State on 30 July 2020 and, due to the rising rates of transmission, it was announced by the Prime Minister on 31 July 2020 (CW3/382 - INQ000106551) that the restrictions remained necessary, and therefore the planned relaxations for 1 August 2020 was delayed.

146. On 30 July 2020, COVID-O met (CW3/383 - INQ000106550 to CW3/385 - INQ000106553) to consider whether and how to reintroduce shielding should this be required, either, if incidence levels of COVID-19 remained the same at that date throughout the winter, with a series of localised outbreaks and local restrictions/lockdowns or if a significant wave of the virus similar to the levels in March-May required national action. The Secretary of State was sent a submission regarding this meeting on 23 July 2020 (CW3/386 - INQ000106547 and CW3/387 - INQ000106548) in which the Department recommended that the decision making authority on introducing and pausing shielding, at both a local and national level, be retained as a Ministerial decision. The Secretary of State responded to the submission and agreed that decisions on resumption of shielding (whether at local or national level) should be made at national level and the collective decision was taken at the 30 July 2020 meeting to pause shielding guidance as planned from 1 August (CW3/388 - INQ000106545).

SECTION 3: ACCESS TO AND USE IN DECISION MAKING OF MEDICAL AND SCIENTIFIC EXPERTISE, DATA AND MODELLING

147. I understand that GO-Science and SAGE will address the detail of advice provided to the Prime Minister/No. 10/the CO and its committees on the spread of the COVID-19 virus and the emergence of the COVID-19 variants. In this section I will

therefore concentrate on those areas where the Department accessed medical and scientific expertise, data and modelling other than that to be covered by SAGE, namely: advice from NERVTAG prior to when SAGE first met and started providing the whole of Government scientific assessment, and advice received from the JCVI.

148. As a general observation, the Department has access to a great deal of medical and scientific expertise, data and modelling as required.

149. In the early stage of the pandemic there were two elements to the case definition to identify those most likely to have COVID-19. These were symptoms, an understanding of which was developed by PHE as the pandemic progressed, and geography, which was used only at the start of the pandemic. In March 2020 the geographical element was removed once there was substantial domestic transmission. The symptoms aspect was kept under review by experts throughout the pandemic. Symptoms were selected to balance maximising coverage of those most likely to have COVID-19, while not covering a great number of people who did not. More information on case definitions, including how they evolved, is provided in Chapter 1 and Chapter 7 of the independent 'Technical report on the COVID-19 pandemic in the UK' (the Technical Report) (CW2/1 - INQ000087225).

150. In addition to the medical and scientific expertise, data and modelling received from NERVTAG prior to 28 January 2020 and from JCVI throughout the pandemic, it is also worth setting out how the Department responded to the issue of asymptomatic transmission of COVID-19. The information on asymptomatic infection, asymptomatic transmission and immunity post-infection evolved over the time with which this statement is concerned as laid out in Chapter 1 of the Technical Report (CW2/1 - INQ000087225).

151. The Department's evolving understanding of asymptomatic transmission and its changes in approach as new scientific evidence came to light provides an example of how the Government's pandemic response, which necessitated balancing health, economic and societal factors, had to evolve as scientific understanding did. What was measurable in respect of each of the factors changed as the pandemic, and the Department's understanding of it, evolved and in the initial stages the evidence and data relating to all of the factors was limited. Once the fact of significant asymptomatic transmission became known, this could be added to the known information on other health matters like NHS capacity, deaths, care homes policy and PPE policy, and fed

into the decision making process on NPIs. In the initial stage of the pandemic economic and societal impact could not be quantified and the balancing act was necessarily imprecise as a result but the introduction of NPIs was always treated as a measure not to be taken lightly.

152. The CMO provided advice from March 2020 setting out that excess mortality would come from a number of direct and indirect causes. More information on excess mortality is provided in Chapter 8 of the Technical Report on the COVID-19 pandemic in the UK (CW2/1 - INQ000087225).

SECTION 4: POLICY APPROACHES

153. As stated previously, broadly speaking there are four counter-measures for responding to a pandemic: (1) NPIs, (2) testing and isolation, (3) pharmaceutical interventions (treatments) and (4) pharmaceutical interventions (vaccines). It is perhaps self-evident that in the early stage of responding to the COVID-19 pandemic the Government could only rely on NPIs and isolation initially with the other counter-measures being developed subsequently. I have described the Government's approach in relation to NPIs above, I now turn to other aspects of the response during the time period covered in this statement.

NHS Capacity

154. As noted in paragraph 37, avoiding the NHS becoming overwhelmed and maintaining its ability to treat patients with COVID-19 and non-COVID-19 conditions, to prevent avoidable deaths, together with and slowing the spread of the disease was critical to the Department's and the Government's policy approaches before and during the pandemic. In this section I address the wider Government decision making on NHS capcity. When the Prime Minister announced the first national lockdown on 23 March 2020 (CW3/83), he explained that the NHS would be unable to cope if too many people became seriously unwell at one time. Modelling on NHS bed capacity was a critical input to the decision-making processes on NPIs. The modelling highlighted clear risks that without intervention, demand would significantly exceed available beds.

155. Throughout this period, action was taken to ensure that the NHS did not become overwhelmed. This was achieved by managing demand at a societal level through NPIs (i.e. slowing the spread of the disease) and through health system

initiatives to maximise capacity in order to respond to the pressures created by the pandemic. By 17 March 2020, the Chief Executive of NHSEI had instructed the NHS to free up 30,000 hospital beds by 15 April 2020 (CW3/389 - INQ000106453). This included activity to postpone non-urgent elective activity for a period of at least three months, urgently discharge patients who were medically fit to leave and block-buying independent sector capacity.

156. NHSEI led the operational response to the pandemic, supported by the Department, including regular ministerial meetings to discuss pressures and the progress of interventions. NHS capacity was a core strand of the COVID-19 Battle Plan. During this period the Government ensured that funding was made available to support the pandemic response. The Spring Budget in 2020 (CW3/390 - INQ000106194) included a £5bn COVID-19 response fund for the NHS and other public services. In April 2020 the Government issued an update on the coronavirus emergency fund noting that £6.6bn of £14.5bn expenditure approved had gone to health services (CW3/391 - INQ000106346).

157. In addition to increasing capacity, it was important to reduce demand for hospital beds by retaining the public's access to NHS services at a local level. In Primary Care, the increased use of digital applications, the prime example being online appointments, allowed patients continued access to General Practitioners (GPs) and measures were taken to ensure practices and surgeries endured through the various stages of the pandemic.

Ventilators and the Ventilator Challenge (part of the Supply workstream, paragraphs 280-285)

158. In response to the immediate need for more mechanical ventilators, the Government developed a cross-departmental approach across the following three workstreams:

a. increased purchasing of existing ventilators available to the NHS (this was led by the Department/NHSEI under the National Covid Oxygen, Ventilation, Medical Devices & Clinical Consumables (O2VMD&CC) Programme) (CW3/392 - INQ000106555);
b. ramping up the manufacture of existing ventilator designs (led by CO); and
c. partnering designers with large manufacturers to rapidly develop and manufacture new simplified ventilator designs (led by CO).

159. Workstreams b. and c. detailed above became known as the 'Ventilator Challenge' (CW3/392 - INQ000106555 to CW3/395 - INQ000106519). The Department and the CO ran their programmes separately, but worked towards the same overall targets and exchanged data on their progress in acquiring ventilators daily.

160. In March 2020, the NHS had around 7,400 mechanical ventilators. Modelling based on the trajectory of other European countries forecast the need for significant and extremely rapid increases in the UK ventilator capacity and the Government adopted a formal target to secure up to 30,000 ventilators by 30 June 2020. The Ventilator Challenge began on Friday 13 March 2020 with CO inviting a number of organisations to take part in the project, followed by a "call to arms" to industry bodies by the Prime Minister on 16 March 2020. By 30 April 2020, the total number of ventilators available to the NHS had increased to 11,500 and by 30 June 2020 it stood at around 24,000 (of which around 12,000 had been built via the Ventilator Challenge). The Department and CO met the 30,000 target in early August 2020.

161. During this period, the anticipated demand for ventilators in the NHS did not materialise and, although the 30,000 target was not met until August 2020, the Department and NHSEI are not aware of any UK patient being unable to access a ventilator when needed.

Nightingale Hospitals (part of the NHS Capacity workstream, paragraphs 154-157)

162. The Department worked with NHS to provide the legal oversight for the establishment of the Nightingale hospitals and then to ensure sufficient resourcing during the pandemic. The first NHS Nightingale hospital opened at the ExCel Centre in East London on 3 April 2020 (CW3/396 - INQ000106324). The Nightingale hospitals were established in the early days of the pandemic and the facilities provided resilience during uncertain times by ensuring that the NHS had capacity to support patients across England if needed and saw the use of both NHS staff and members of the armed forces to help staff them.

163. The Nightingale hospitals were specifically designed to provide extra national surge capacity to help ensure that all those who needed care were able to access it. At the beginning of the pandemic, the NHS's focus was on ensuring that extra support was available for critical care or ventilated care. The Nightingale hospitals were

therefore set up to provide overflow support for the most critical patients requiring ventilated care, rather than being designed to provide routine NHS care. Given the number of people in hospital with COVID-19 during the various waves, it would not have been practical, in terms of number of patients, to place all COVID-19 patients in a Nightingale hospital, nor would it have been clinically appropriate or desirable.

Electives (part of the NHS Capacity workstream, paragraphs 154-157)

164. In the first wave, COVID-19 hospital activity peaked at almost 19,000 beds occupied by patients with COVID-19. This resulted in per working day elective inpatient activity falling to around 17% of the expected levels based on activity the previous year, and outpatient activity falling to around 50%.

165. Work to step up elective operations and to increase the numbers of people accessing healthcare took place as early as April 2020. On 29 April 2020, the Chief Executive of the NHS wrote to NHS providers asking them to work across local systems and with regional teams to judge whether there was capacity to re-commence at least some routine non-urgent elective care (CW3/397 - INQ000050226). The 'Help us Help You' campaign aimed to build public awareness that the NHS had adapted its services and could still see patients safely (CW3/398 - INQ000106371). The campaign looked to address barriers that were deterring patients from accessing services.

Independent Sector

166. The independent healthcare sector was one source of additional hospital capacity which could be accessed at very short notice. Therefore, in March 2020, NHS England put in place national commissioning arrangements with 26 independent providers to secure 100% of their facilities, resources and staff to aid the NHS response to COVID-19 on an at-cost basis.

Staffing

167. The Department adopted measures and enacted plans to increase the workforce through encouraging former staff to return to the NHS, allowing medical students in their final year of training to take up roles more swiftly and putting measures in place to enable overseas nurses to continue to come to the UK safely during the pandemic.

Emergency Register

168. In response to the COVID-19 pandemic, the Government enabled some healthcare professional regulators to establish temporary emergency registers:

a. The General Medical Council (GMC) granted temporary registration to doctors in good standing who had left the register in the last six years;
b. The Nursing and Midwifery Council (NMC) opened a temporary register to nurses and midwives who had left the register in the last five years and overseas nurses already working in the UK who were part-way through the NMC's application process;
c. The General Pharmaceutical Council (GPhC) and Pharmaceutical Society of Northern Ireland (PSNI) granted temporary registration to pharmacy professionals in good standing who had left the register in the last three years; and
d. The Health and Care Professions Council (HCPC) granted temporary registration to former registrants who had left the register in the last three years and third year students on UK approved programmes who had completed all of their clinical practice placements.

Volunteers

169. NHS Volunteer Responders (NHSVR) programme was launched in March 2020 (CW3/399 - INQ000106294 and CW3/400 - INQ000106308) to support the NHS and people who were shielding or self-isolating. Volunteers provided help with fetching prescriptions, shopping, welfare calls, plus delivery of equipment for the NHS and patient transport. When the services launched around 750,000 volunteers stepped forward to provide help and support.

Discharge

170. To free up bed capacity NHSEI asked hospitals to urgently discharge all inpatients who were medically fit to leave (CW3/389). To support this, the number of patient reviews were increased and any that met the clinical criteria were deemed suitable for discharge from hospital. The Government made funding available for discharge packages and to support the supply and resilience of out-of-hospital care. The NHS worked with local authority partners to ensure that additional capacity was appropriately commissioned. It was estimated this measure may potentially free up to 15,000 acute beds that were occupied by patients awaiting discharge. Further funding

to cover the costs of this additional increase in demand was available across the social care sector.

171. Decision making regarding the discharge of patients to care homes in the first wave has been the subject of considerable comment and debate with regard to its role in spreading COVID to care home residents. The Department's understanding of the evidence in this area is set out in chapter 8.2 of the CMOs' Technical Report (CW2/1). This notes that 'outbreaks in care homes were closely correlated with community prevalence throughout the pandemic, and there is genetic evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community'. While comparisons are difficult, the correlation with community rates appears also to match the international evidence (CW3/401 - INQ000107084).

Adult Social Care (ASC)

172. As described in paragraph 7 above, the Government has a different relationship with ASC than it does with the NHS; the Department does not directly fund or deliver adult social care and much of the funding for adult social care is raised locally. Over the course of the pandemic, the Government significantly expanded its role in adult social care beyond its statutory requirements. In particular, the Department provided clinical and operational guidance, provided free PPE, testing, collected significantly more data and provided further funding. The following paragraphs set out the key activity and events within ASC in which the Department played a significant role.

ASC: Stakeholder Engagement

173. At the beginning of February 2020, the Department established weekly meetings with stakeholders who represented the ASC sector, including care home representatives. On 6 March 2020, the Department formed a senior leaders' group called the '*National Adult Social Care and COVID-19 Group*, to oversee the development and implementation of DHSC's response to COVID-19 in ASC. Representatives included the NHS, Care Quality Commission (CQC), Local Government Association, PHE, as well as Carers UK, the Care Provider Alliance and the Association of Directors Adult Social Services (ADASS).

Guidance

174. On 19 March 2020, the Government published COVID-19: the ethical framework for ASC (CW3/402 - INQ000106252) , developed in conjunction with the Chief Social Worker (CSW), to support local response planning and decision-making during the pandemic.

175. As a part of the Coronavirus Act 2020, the government introduced relaxations to the Care Act 2014 (which took effect on 31 March 2020). These relaxations were intended as a tool to help local authorities continue to meet the most urgent and acute needs in the face of COVID-19 by relaxing some duties on local authorities, allowing them to prioritise care and support more effectively.

176. The Department was also involved in the production of the following guidance:

a. On 13 March 2020: PHE guidance, *residential care provision* was published (CW3/403 - INQ000106251)
b. During March and April 2020, DHSC produced guidance for local authorities, care homes and hospitals, on how to plan and operate effectively during the pandemic and how to maintain key duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
c. On 2 April 2020: DHSC produced the *Coronavirus (COVID-19): admission and care of people in care homes* guidance (CW3/405 - INQ000106486) .
d. On 9 April 2020: PHE published guidance for *Stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings* (CW3/406 - INQ000106344).
e. On 15 April 2020: DHSC published '*Coronavirus (COVID-19): Adult Social Care Action Plan'* (CW3/407 - INQ000106354).
f. On 15 May 2020: DHSC published the '*Care Home Support Package'* (CW3/408 - INQ000106440).
g. On 22 May 2020; DHSC produced: Provision of home care (CW3/409 - INQ000106906).
h. On 19 June 2020: DHSC published guidance on the *admission and care of residents during COVID-19 in a Care Home* (CW3/405).

177. In June 2020, the PPE 'Task and Finish' group was set-up for key ASC stakeholders, offering a forum to discuss PPE issues (CW3/410 - INQ000106340 to CW3/412 - INQ000106326). On 8 June 2020, the Secretary of State announced the

'Social Care Sector Covid-19 Support Taskforce' (CW3/413 - INQ000106467 and CW3/414 - INQ000106465), chaired by Sir David Pearson, to oversee the implementation of two packages of support: the Social Care Action Plan (CW3/407) and the Care Homes Support Package (CW3/408). The Adult Safeguarding Forum was also created which brought together key sector partners to share good practice and learning, and address issues as and when they arose.

Funding

178. The Government announced significant funding packages to help local authorities respond to the immediate impacts and pressures of COVID-19. On 19 March 2020, the Government announced £1.6bn of funding (CW3/415 - INQ000106253) and this was further boosted by funding of £1.594bn on 18 April 2020 (CW3/416 - INQ000106361). In addition to this, on 15 May 2020, the first £600 million Infection Control Fund (ICF) was launched (CW3/417 - INQ000106429), alongside the Care Home Support Package (CW3/408).

Testing and PPE in ASC Settings

179. In March 2020 the Government began supporting an emergency supply of PPE to the ASC sector including :

a. setting up the National Supply Disruption Response hotline for health and care providers to urgently access PPE which they were unable to obtain through their usual channels;
b. distributing 300 fluid repellent facemasks to each CQC registered care home and home care provider; and
c. supplying PPE to designated wholesalers for onward sale to the sector, totalling 258 million items of PPE between April 2020 and February 2022.

180. On 10 April 2020, the Department produced a PPE plan for ASC (CW3/418 - INQ000050008). This was supported by the establishment of a PPE portal to support care providers on 5 June 2020 (CW3/419 - INQ000106462).

181. In May 2020, a testing pilot began in care homes (CW3/420 - INQ000106428 and CW3/421 - INQ000107098) and on 7 June 2020, care home testing expanded to cover all care homes including all care home staff and residents. On 6 July 2020,

regular weekly PCR testing for staff was introduced, and monthly testing for residents in older age care homes was set up.

Adult Social Care Data Collection and Monitoring

182. The adult social care Capacity Tracker (CT) was originally developed by NHS England and the Better Care Fund to enable the system to better manage hospital discharges by identifying available capacity in care homes.

183. In March 2020, following a number of conversations with stakeholders (provider groups, LGA, ADASS etc), the CT was identified as the most suitable tool for COVID-19 data collection from care providers.

184. Guidance on 2 April 2020 (CW2/1) set out the CT as the tool to be adopted as part of COVID-19 emergency (level 4) response which were initially around PPE, COVID-19 and business continuity workforce, admission status. Its re-purposing was announced via the government's 'Action Plan' (15 April 2020) (CW3/407) and joint letter (17 April 2020) from DHSC and NHSEI together with CQC and the Care Provider Alliance (CW3/422 - INQ000106359).

185. To support the Infection Control Fund (ICF) published on 9 June 2020 (CW3/423 - INQ000106466), questions tracking the sector's compliance with the infection control measures were added to the CT.

186. Regular completion of CT was a key condition of providers receiving funds. Initial questions for ICF were launched ahead of this on 13 May 2020.

187. Care providers were required to notify the CQC about deaths of their residents from COVID-19, whether confirmed or suspected, from 10 April 2020 (CW3/407).

188. DHSC has relied on the CQC deaths data to monitor deaths in care homes over the course of the pandemic, as this data was timelier than deaths registrations data, which were used as the basis of ONS deaths statistics. COVID-19 deaths prior to 10 April 2020 were not recorded.

189. From April 2020, DHSC produced a daily SitRep (CW3/112 - INQ000106352 to CW3/114 - INQ000106512) that brought together data from CT on PPE, workforce

pressures, bed availability/capacity, from CQC on deaths and service notifications and from PHE on COVID-19 outbreaks. This was developed over the course of the pandemic to both exploit new data sources and to monitor new priorities – infection control data and information from NHS Test & Trace, for example.

190. CT data covered both care homes and domiciliary care providers.

191. Further information regarding ASC will be provided in the Department's second and third corporate statements for Module 2. In addition to this, the Department will produce a supplentary statement for Module 2 specifically focussing on ASC.

192. In addition, I refer the Inquiry to Chapter 8.2 of the Technical Report on the COVID-19 pandemic in the UK' (CW2/1).

Data

193. As set out above in paragraphs 90 to 92 in the early stages of the pandemic, the Department produced daily SitReps with input from PHE and NHSEI in particular (CW3/108 - INQ000106052 to CW3/114 - INQ000106512). These were used in the Department and were distributed across Government, and were used to set out the current available situation in the UK and internationally, and to inform policy decisions. The SitReps evolved with work to improve completeness, incorporate more datasets and improve consistency across the UK.

194. From the early stages, the Department also recognised the importance of transparency in public communications and in making data available for local and national organisations. The Secretary of State updated Parliament regularly and the Department published the available and consistent data as quickly as possible. At first, this covered numbers on testing, positive and negative cases and deaths. This data was supplemented by many new data collections which were added over time. By March 2020 public information was a major cross-government effort led by the CO and led to the COVID-19 Dashboard on gov.uk, which is covered in more detail below. Guidance for the public was also published centrally as restrictions were tightened and eased. More detailed technical analysis continued to be published by PHE and others.

195. Chapter 4 of the Technical Report on the COVID-19 pandemic in the UK (CW2/1), outlines what data were needed and where they were sourced from

throughout the pandemic. It also sets out how transparency was supported through tools such as the COVID-19 Dashboard, and the importance of such transparency in engaging the public with public health interventions as well informing policy decisions.

Shielding

196. The concept of shielding to identify, protect and support those most at risk of serious outcomes from COVID-19 was discussed at SAGE on 5 March 2020 (CW3/424 - INQ000106152). The criteria for those who would be advised to shield was agreed at that meeting following consideration of which conditions should be included and how to identify them by the UK CMOs and other senior clinicians. This led to the development of the Shielded Patients List (SPL) of which the first iteration was published on 20 March 2020 (CW3/425 - INQ000106464 and CW3/426 - INQ000106311). After this point the advice was for people meeting the clinical criteria to follow the guidance on protecting people defined on medical grounds as CEV, which was jointly published by the Department and PHE on 21 March 2020 (CW3/427 - INQ000106266).

197. On 22 March 2020 the Secretary of State for Housing, Communities and Local Government announced that CEV people were advised to stay at home, at which point the shielding programme started (CW3/529A - INQ000106278). As more was learnt about those who were particularly vulnerable to COVID-19, the UK Clinical Panel for Shielded Patients gave further consideration to other groups that should be added to the SPL and made recommendations to the UK CMOs. By mid-May 2020, the SPL had reached circa. 2.2 million people.

198. On 22 June 2020, the Secretary of State announced the relaxation of shielding guidance for the CEV individuals across England from 6 July 2020 due to the continued reduction of infection rates (CW3/428 - INQ000106491 to CW3/431 - INQ000107100). However, the guidance remained unchanged for a small number of local areas where the infection rate remained high, and this position was regularly reviewed.

Personal Protective Equipment Pre Pandemic

199. PPE in healthcare includes a variety of different items ranging from the widely used (e.g. gloves and aprons) to more specialist items (e.g. FFP3 respirators). Health and care providers sourced PPE from a wide variety of sources. NHS Supply Chain

provided an estimated 63% of the NHS Trust requirement. Social care, and primary care procured mainly from wholesalers. It was largely sourced from overseas and there was very limited UK production.

200. As part of the Pandemic Influenza Preparedness Programme (PIPP), around 323m items of PPE were stockpiled for pandemic response. The Department took recommendations from NERVTAG as the relevant expert body on the relevant stockpile items, and funding and procurement was agreed through the Spending Review process. Funding and procurement for stockpile was provided by DHSC and PHE arranged storage and maintenance. The stockpile included: including masks, aprons, gloves, respirators, eyewear, and respirators. The approach to stockpiles pre-pandemic is set out in paragraphs 245-253 of my First Witness Statement to the Inquiry dated 19 October 2022 which state:

> ***"Availability and supplies of clinical countermeasures***
> *245. A core part of the Department's pandemic preparedness programme and strategy for responding to an influenza pandemic was ensuring the UK had rapid access to clinical countermeasures that could be deployed as part of the response. Through the oversight of DHSC, the UK Government maintained a centralised stockpile of relevant products together with contracts agreed in advance for the provision of further stock, the development of a pandemic specific vaccine, or the delivery of dedicated operational functions (for example, the National Pandemic Flu Service).*
>
> *246. Management of stockpiles has been the responsibility of PHE since its creation in 2013, and is now the responsibility of UKHSA.*
>
> *247. The end-to-end process that resulted in a pandemic preparedness stockpile comprised the following stages:*
>
> a. *Identifying the products to be held, based on expert and scientific advice (e.g. from NERVTAG, ACDP, JCVI). For example, NERVTAG advised on the Personal Protective Equipment (PPE) product mix (**CW/380**) and the specific antivirals and antibiotics to be held to treat pandemic influenza patients.*
> b. *Modelling the volumes of products to be held, based on the RWCS planning assumptions for a 15-week pandemic wave. For PPE, this was*

to ensure enough PPE was available for the expected influx of patients requiring assessment or treatment for influenza (and related infections). Note the requirements did not include supplies for business as usual (BAU) services as these were not part of the central stockpiling programme.

c. *Policy advice and financial approvals, including on the balance of just-in-case (JIC) and just-in-time (JIT) contracts and funding secured through government spending reviews, led by DHSC. More detail on the economic analysis is provided below in this Section.*
d. *Procurement of the product, led by PHE.*
e. *Storage and management of the stockpiles, also led by PHE.*

248. Decisions about volume and type of products stockpiled were derived from modelling based on the RWCS for an influenza pandemic, with a majority percentage held in centralised stockpiles on a JIC basis, with separate JIT contracts in place to provide the remainder. A larger quantity was held on a JIC basis to facilitate rapid distribution in times of need and because of potential risks to supply chains in the event of a global pandemic.

249. The Pandemic Flu CCMB met on 9 October 2019 (CW/381 - INQ000023078) to (CW/383 - INQ000023079). This was their last meeting before the COVID-19 pandemic. The CCMB was scheduled to re-convene in March 2020 for their next meeting. The PHE-chaired CCMB provided governance and oversight of the necessary maintenance and management of the clinical countermeasure UK stockpiles and the agreements required to ensure that the UK was well prepared to respond effectively to a pandemic.

250. The levels within the pandemic stockpiles were reviewed as part of this meeting and the official stock levels were calculated at this point to contain approximately 323 million PPE items (including masks, aprons, gloves, respirators, eyewear, and respirators), approximately 43 million pharmaceutical items including antivirals and antibiotics, and a total approximation of 726 million clinical countermeasure consumables (including items such as boxes, syringes, paper towels, and cannulas).

251. These numbers only account for JIC stockpiles, and do not account for orders of PPE and pharmaceuticals placed and delivered prior to January 2020.

Furthermore, planned deliveries of antivirals and antibiotics for 2019/20 were in most cases either completed or brought forward for delivery before 31 October 2019 to prevent any potential EU Exit disruption

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252. In October 2019, the CCMB also held an advanced purchase agreement (APA) contract to enable procurement of a Pandemic Specific Vaccine (PSV) for influenza. This provided the UK with reserved production capacity for more than enough PSV doses for the entire UK population and to be available within 4-6 months of an influenza pandemic outbreak.

253. In addition to specific products, the pandemic preparedness programme included a contract for an antiviral distribution service called the National Pandemic Flu Service (NPFS). The NPFS was designed to supplement the response provided by primary care during an influenza pandemic. If the pressures meant that it was no longer practical for all those with symptoms to be individually assessed by a doctor or other health care professionals, patients could triage themselves via an online and telephony service in order to access antiviral medicines."

201. The PIPP stock did not contain gowns. NERVTAG had made an initial recommendation to include gowns in the stockpile for specific situations, including Aerosol Generating Procedures (AGPs), in June 2019 (CW/73 - INQ000023057) and confirmed the specification (sterile non/sterile) for the market analysis in November 2019. The market analysis was being finalised prior to commencing the procurement exercise which was planned for early 2020. Gowns were subsequently procured as part of the wider PPE procurement effort.

Personal Protective Equipment: COVID-19

202. The emergency of COVID-19 resulted in unparalleled increases in global demand for PPE, and significant disruption to supply chains. Securing sufficient PPE and ensuring it was available to front line staff when they needed it was a major element of the Government's response to the pandemic.

203. On 10 January 2020, Infection Prevention Control (IPC) Guidance for the care of suspected or known COVID-19 patients was first published (CW3/433 - INQ000106903). COVID-19 was initially categorised as a HCID, which meant that any

suspected cases would be managed as inpatients in a small number of fully equipped specialist centres around the country. HCIDs are acute infectious diseases, typically with a high case fatality rate requiring an enhanced individual, population and system response to ensure they are managed effectively, efficiently and safely. As a result, a higher level of PPE was required, including FFP3 respirators, fluid repellent disposable gowns, gloves with long, tight-fitting cuffs, disposable surgical caps and eye protection to be worn.

204. On 30 January 2020, NHSEI Incident response requested the convening of a Supply Chain Cell to assess existing supply and possible interventions which would need to be made. On 31 January 2020, the PIPP stockpile was made available for release to supplement the usual supply chains. Action was also taken to increase the procurement of PPE. On 9 February 2020, the Department instructed NHS Supply Chain to purchase additional volumes of PPE, both through existing suppliers and on the open market, and on 14 February 2020, NHS Supply Chain were given delegated authority to conduct additional significant spending on the open market for PPE items of most concern (CW3/434 - INQ000106111). At the end of February 2020, the UK Embassy in Beijing was mobilised to support the identification of, and dialogue with, prospective new suppliers for PPE.

205. In supporting the supply chain, the department released its PIPP stock to the NHS and to wholesalers. On 18 March 2020, the decision was taken to provide 300 Type IIR facemasks to each CQC registered care home and home care providers (25,245 providers) (CW3/435 - INQ000106256). An additional 23 million items of PPE were released to designated wholesalers for onward sale to social care providers. We made arrangements with seven wholesalers, Careshop, Blueleaf, Delivernet, Countrywide Healthcare, Nexon Group, Wightman and Parrish and Gompels to supply PPE to CQC registered providers in the social care sector. For primary care providers in the community, we organised emergency drops of PPE by 10 April 2020. These were delivered to individual GP surgeries, community pharmacies, dentists, urgent dental centres and hospices across England. We also released PPE to wholesalers for onward sale to these providers. In total, 22 million items of PPE were made available in these ways.

206. On 16 March 2020, the Department stood up the National Supply Distribution Response (NSDR) hotline, so that providers of health and social care had a number

to call if they had an immediate and urgent need for PPE within 72 hours (CW3/436 - INQ000107089 and CW3/437 - INQ000107090).

207. On 18 March 2020, the Secretary of State agreed to request the use of the military to support PPE distribution (CW3/438 - INQ000106259). This is an example of the 'MACA' resource as detailed in paragraph 303.

208. On 19 March 2020, having assessed further evolving information, including fatality rates, the UK public health agencies declassified COVID-19 as an HCID (CW3/439 - INQ000106267). Accordingly, IPC guidance changed to tailored guidance reflecting different care settings, whether the patient was known or likely to have COVID-19, and what clinical procedures were being undertaken. The guidance continued to develop as our understanding of the virus improved (CW3/440 - INQ000106126 to CW3/443 - INQ000106130).

209. On 21 March 2020, the Department agreed to establish a parallel supply chain to increase our capacity and capability to procure, ship and deliver PPE. Procurement experts from across government augmented the existing experts from NHS Supply Chain. NHS Supply Chain continued to work with their existing suppliers to secure additional supply. New opportunities were explored through a "China Buy" workstream with the Beijing Embassy, a broad effort to secure new supplies which led to the open procurement launched on 10 April, and a UK make workstream focused on building up UK manufacturing capability. NHS Supply Chain, Clipper Logistics and members of the armed forces developed the logistics pathways to provide PPE to the frontline. The logistics efforts supported daily deliveries to NHS providers, support to the LRFs, and established an online portal for social care, primary care and others to secure PPE. Members of the armed forces worked with DHSC and NHSE colleagues to establish a coordination cell to direct the procurement efforts, make allocation decisions and manage the logistics.

210. On 23 March 2020, the Department appointed McKinsey to develop a single model for demand (CW3/444 - INQ000106355 and CW3/445 - INQ000106356). This work was completed on 12 April, pulling together planning assumptions, analysis and decisions about assumptions into one single tool. To estimate demand for PPE the model estimated the number of anticipated patient contacts and the PPE required for each on the basis of the IPC guidance. The model covered demand in the NHS and Social Care. Following the IPC guidance changes on 2 April 2020 (CW3/440 to

CW3/443), the model was updated to include all patient contacts not just those for confirmed or suspected covid patients. This had a very significant effect on the modelled demand for PPE. It also added a further modelling challenge as the model now needed estimates of total patients treated in the NHS and not just the estimates of covid patients. The model was updated on a daily basis from mid-May 2020 to produce a 90-day forward projection of supply and demand for different categories of PPE. The model was continuously refined during that period, for example to reflect changes in IPC guidance. By late summer the Department had a consolidated view of the 'run-rate' demand for PPE each month.

211. Healthcare Ministerial Implementation Groups which met on 2, 7, 9 and 17 April discussed PPE as well as other Covid-19 issues (CW3/446 - INQ000106317 and CW3/447 - INQ000106341). The initial meeting focused on: the approach to collating and managing demand across the UK; prioritising and distributing existing supplies; publishing updated PPE guidance; and a joined-up public sector approach to procurement.

212. Health Ministers from the four nations met on 31 March, with subsequent meetings at official level on 7, 14 and 17 April, to coordinate efforts and ensure mutual aid between the nations. In April, a Four Nations protocol was developed that shared PPE stocks across the four nations of the UK on the basis of population (CW3/448 - INQ000106392 to CW3/450 - INQ000106398) . The principles underlying the protocol were:

a. UK Government procured PPE would be shared on a population basis between each of the UK four nations;
b. Each nation will continue to be ultimately responsible for and pursue PPE to meet its own population needs;
c. There will be transparent sharing of stock and supply information by the four nations to enable UK Government procured PPE to be shared on an equitable basis;
d. Mutual aid will operate alongside the protocol; and
e. The scope of the protocol is Health and Social Care only.

213. On 2 April 2020, a significant change was made to the guidance such that the use of PPE was advised for all episodes of care rather than known or suspected

COVID patients (CW3/440 to CW3/443). The updated guidance reflected the fact that coronavirus was now widespread in the community, meaning clinicians were more likely to see patients with the virus. It recommended enhanced protection across Hospital, Social Care and Primary Care settings, including aprons, gloves, surgical masks and eye protection in most clinical scenarios. Staff performing AGPs were also directed to use gowns, FFP3 filtering respirators and face shielding visors. This was significant change driving demand for PPE across a wide range of settings.

214. On 3 April 2020, the Department, working with DLUHC, confirmed that it would set up an emergency PPE supply route to a network of 37 Local Resilience Forums to meet urgent local demand for PPE, working closely with them to understand their needs across a number of settings. These stocks were primarily be used by LRFs for health and care settings. This PPE was also used for wider public services where LRFs identified need and in line with the priority criteria set out in the clinical guidance published by the Department and PHE on 2 April 2020 (including care homes and home care, hospices, children's homes, General Practitioners and funeral directors). On 6 April was the first drop to LRFs. Over 30 million items including aprons, gloves, type IIR masks, eye protection, FFP3 masks, cleaning equipment and clinical waste bags were issued.

215. On 10 April 2020, the department published its first PPE plan 'Covid 19: Personal Protective Equipment (PPE) plan' (CW3/451 - INQ000106347), which set the approach to three critical issues: PPE guidance; delivery of PPE to front line staff and future supply of PPE. Alongside the plan the Government issued a public call to action to support the scale of PPE now required to protect frontline staff (CW3/452 - INQ000106345). An open procurement approach received 24,000 offers of help and support received within a 14-week period from over 15,000 suppliers. A small proportion of offers – approximately 430 of the 24,000 – were initially processed through a 'high priority referral' route. All offers went through the same financial and quality assurance due diligence processes. Contracts were authorised by the DHSC Finance team.

216. On 17 April 2020, in the light of the challenges in the continued supply of PPE (specifically the risk of a stock-out of gowns), infection prevention control clinicians in PHE and the NHS created the "Acute Shortage Guidance" (**CW3/453 - INQ000106360,** **CW3/454 - INQ000107091,** **CW3/456 - INQ000106357,** **CW3/457 - INQ000106358**) providing guidance on alternatives, reuse and sessional, rather than single, PPE use. MHRA issued the guidance via a Central

Alerting System (CAS) alert. The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This guidance was withdrawn in September 2020 when there were no longer acute shortages.

217. On 19 April 2020, the appointment of Lord Deighton by the then Secretary of State for Health, Matt Hancock was announced, initially to spearhead 'UK Make' by ramping up manufacturing of PPE from UK-based companies, then subsequently to lead the PPE taskforce, supporting the Government's efforts to secure sufficient critical PPE and ensure this gets to where it is needed, including driving forward coordination of the end-to-end process design.

218. An online ordering system (the 'PPE Portal') was established from 20 April 2020. It initially focused on primary care and smaller adult social care providers to establish further access to PPE before growing to include any eligible health and social care setting in England (over 58,000 settings, predominantly non-acute services). It was delivered through the Department partnering with eBay, Clipper Logistics, Royal Mail, the NHS, Volo and Unipart, designed initially to be an emergency 'top-up' system of PPE for COVID-19 needs before increasing in scale to meet eligible providers' modelled requirements for COVID-19 PPE (e.g. masks, eye protection, gloves, aprons, gowns etc.) and associated stock (e.g., hand hygiene products). By the end of June 2020, the majority of eligible GPs and smaller adult social care providers (both domiciliary and residential) were able to register on this ordering portal. Throughout the summer of 2020, further sectors were onboarded (including dentists, orthodontists, pharmacies, optometrists and larger adult social care providers) and an increased range of product offerings were made available. In July 2021 LAs and LRFs were invited to register for the PPE Portal.

219. Guidance introduced universal face masks and face coverings in health and social care settings on 15 June 2020 (CW3/458 - INQ000106399). This was expected to increase the requirements for type IIR mask use.

220. As information about the virus and the PPE requirement improved, the PPE programme introduced the Sales and Operational Planning (S&OP) process in early June. This is a comprehensive and robust process for estimating future demand for PPE based upon a range of considerations including past distribution, assessments of

baseline demand, projections of trends and direct customer data. As soon as the Department was confident it had secured PPE supply for the health and care system to cover the immediate two-week period and the following 90-day period it gave the instruction to stop buying. The dates of these instruction by item are shown in the table below.

PPE ITEM	INSTRUCTION TO STOP BUYING
All Critical PPE	
Eye Protection	16 June 2020
Hand Hygiene	18 June 2020
Type IIR facemasks	24 June 2020
Clinical Waste Bags	26 June 2020
Aprons	26 June 2020
Gloves	26 June 2020
Gowns	29 June 2020
FFP3 Facemasks	30 June 2020

Testing

221. At the start of January 2020 there was no test for the novel pathogen, COVID-19, and no dedicated infrastructure for delivering any testing at scale. In January and February 2020, the UK Advisory Committee on Dangerous Pathogens (ACDP) designated that COVID-19 testing could only be conducted in secure laboratories that met certain standards, which is important to note as it explains the limitations placed upon our testing capacity at the time. Testing is one of the four available tools in tackling a new virus. The UK developed a test quickly and was able to share this knowledge with the rest of the world. Given the UK's diagnostics infrastructure, it was more challenging to scale up diagnostic capacity to the level required. However, by the end of the period that this statement is concerned with, very significant technical development and scale-up of testing capacity had been achieved. There was capacity for over 200,000 PCR tests and 120,000 antibody tests to be conducted a day. All symptomatic people could access tests through a variety of channels, in person and at home; and several separate priority testing schemes e.g. for hospitals and care homes were being supported. NHS Test and

Trace had been launched to provide contact tracing and support for isolation to people testing positive and their contacts. More information is provided on this in Chapter 6 and Chapter 7 of the Technical Report (CW2/1).

222. Initial guidance was given by the WHO on 10 January 2020 recognising that the causative agent of the virus had not been verified and the gene sequence of COVID-19 had not yet been published (CW3/459 - INQ000106556). On 17 January 2020 the WHO published further guidance recommending that a polymerase chain reaction (PCR) test should be developed (CW3/460 - INQ000106044).

223. The SAGE minutes for 28 January 2020 record that a specific test was expected to be ready by the end of that week with limited capacity of 400-500 tests per day with guidance being rolled out to laboratories across the UK (CW3/123 - INQ000057492). At this stage the accuracy of the test was unknown because of the lack of knowledge about the disease. At the start of February 2020 UK testing for COVID-19 had started at a PHE testing laboratory in London. Our testing capacity increased over the course of the month, as the test developed by PHE, was rolled out to a further 12 laboratories across the UK.

224. In mid-March, testing capacity had reached c5000 per day, but was being exceeded by demand. The prioritisation set out by PHE was as follows:

a. Group 1 (test first): Patients requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome (ARDS) or influenza like illness (ILI) or an alternative indication of severe illness;
b. Group 2: All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI;
c. Group 3: Clusters of disease in residential or care settings, e.g. long-term care facilities, prisons or boarding schools;
d. Group 4: Community patients meeting the case definition (over 60 years or risk factors for severe disease) and not requiring admission to hospital with prioritisation given to age;
e. Group 5: Community patients meeting the case definition (under 60 years with no risk factors for complication) and not requiring admission to hospital; and
f. Group 6 (test last): Contacts of cases.

225. Having increased capacity to 10,000 tests on 23 March and 15,000 on 1 April, on 2 April 2020 the Government announced a wider testing strategy based on the

establishment of five testing 'pillars' (CW3/461 - INQ000106460). The five pillars of the strategy were:

a. Pillar 1: Scaling up NHS swab testing (utilising PHE and NHS laboratories);
b. Pillar 2: Mass-swab testing for critical key workers in the NHS, social care and other sectors (working in partnership with universities, research institutes and companies to create a mass testing infrastructure in the UK through the creation of a network of new laboratory and testing sites across the UK);
c. Pillar 3: Mass-antibody testing to help determine if people have immunity to COVID-19;
d. Pillar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments; and
e. Pillar 5: Spearheading a Diagnostic National Effort to build a mass-testing capacity at a completely new scale.

226. The strategy set out an ambition to reach 100,000 tests across the 5 pillars by 30 April 2020. A further ambition was set to achieve capacity for 200,000 tests by 31 May 2020. The increased capacity of testing enabled health and care staff to continue working, led to a much greater understanding of how and where the virus was spreading, and helped enable some NPIs to be scaled back. As covered in paragraph 36, testing capacity was one element in the five tests that were used to decide whether to proceed in loosening the NPIs.

227. The following table sets out how testing capacity was prioritised as capacity increased throughout the period

Date	Daily testing capacity [29]	Groups added to eligibility
14 March 2020	Approximately 3,000	Testing of patients requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI), or an alternative indication of severe illness has been provided e.g. severe pneumonia or ARDS. All other patients requiring admission to hospital for management of pneumonia, ARDS or ILI. Clusters of disease in residential or care settings e.g. long-term care facility, prisons, boarding schools. Where clusters arose, following 5 positive tests, any new symptomatic cases were assumed to be positive without conducting testing.
27 March 2020	10,949	NHS staff with symptoms and their symptomatic families
12 April 2020	27,947	Symptomatic NHS non-frontline staff and their symptomatic household members.
15 April 2020	38,766	People being discharged from hospital to a care home, whether or not symptomatic. Testing of all symptomatic care home residents (expansion from first 5 members of a cluster). Testing of all symptomatic staff in care homes and symptomatic members of their household (expansion from first 5 members of a cluster).
24 April 2020	49,862	Symptomatic essential workers and their symptomatic family members.
27 April 2020	73,400	All emergency admissions to hospital.

28 April 2020	77,365	Asymptomatic staff and residents of CQC registered care homes whose primary demographic is residents over 65 or those with dementia. Anyone symptomatic over 65, as well as symptomatic members of their households. Symptomatic workers who were unable to work from home.
18 May 2020	127,697	Anyone symptomatic across the population.
30 May 2020	205,634	Antibody testing launched for health and social care staff in England.
07 June 2020	186,455	Asymptomatic staff and residents of all remaining CQC registered care homes for adults
10 June 2020	229,704	Asymptomatic people in high contact professions, like taxi drivers.
06 July 2020	349,109	Regular retesting of care home staff (weekly) and residents (monthly)
13 July 2020	339,755	Outbreak testing guidance amended to include rapid response testing.

228. Throughout the increase in testing capacity, adult social care was a particular priority. With testing capacity having reached over 35,000, on 15 April 2020, the Adult Social Care Plan set the requirement for all patients to be tested prior to discharge to a care home (CW3/462 - INQ000107086). The guidance made it clear that:

a. All individuals must be tested, and should receive their result, prior to discharge from hospital to a care home. Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be;
b. For people who were asymptomatic and discharged into a care home, these individuals would have been tested prior to admission to the care home. Again, where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be;

c. Where the pre-admission test was negative, the guidance still recommended isolation for 14 days;
d. For individuals coming from the community, move to these residents being tested prior to admission; and
e. If the appropriate isolated care is not available with a local care provider, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period.

229. It was announced on 28 April 2020 that the Department intended to ensure whole-home testing of all staff and residents in care homes for older people (those over 65) (CW3/463 - INQ000106391 and CW3/464 - INQ000106463). On 7 June, it was announced that this had been achieved for all care homes for older people and those with dementia.

230. As set out in Chapter 8.2 of the Technical Report on the COVID-19 pandemic in the UK (CW2/1), epidemiological and genetic evidence from across the UK suggests that although some care home outbreaks of COVID-19 were introduced or intensified by discharges from hospital into care homes, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes. Prior to testing being widely available, the risk of keeping care home residents in hospital at a time of rapidly increasing nosocomial infection risk needed to be balanced with the risk that they might already have acquired COVID-19 and introduce it to the care home.

231. On 7 May 2020, Baroness Dido Harding was appointed Executive Chair of NHS Test and Trace reporting directly to the Prime Minister and Cabinet Secretary, to lead the Government's testing and tracing effort (CW3/465 - INQ000107093). The NHS Test and Trace service was launched on 28 May 2020 to help identify, contain and control COVID-19 so as to reduce the spread of the virus and with the aim of saving lives (CW3/466 - INQ000107094). Anyone who tested positive for COVID-19 was contacted by the NHS Test and Trace and asked to share information about their recent interactions. Where close contacts (those either in direct contact with or within 2 metres of that person for more than 15 minutes) were identified, those close contacts were required to stay at home for 14 days (even if they had no symptoms) so as to stop unknowingly spreading the virus. The creation of NHS Test and Trace represented the Government's decision to rapidly expand the UK's testing and tracing capacity and to enable the loosening of restrictions. Baroness Harding was

directly responsible to the Prime Minister and Cabinet Secretary (this would later transfer to the Department on 3 December 2020). Ministerial accountability for testing and NHS Test and Trace remained at all times with the Secretary of State for Health and Social Care. Baroness Harding was able to shape NHS Test and Trace as required bringing in external experts along with utilising resource from across Government. This saw members of staff from the Department, along with military personnel, being seconded into NHS Test and Trace and members of her team operating from the Department's offices in London, broadening an approach which began prior to the formation of NHS Test and Trace. As part of this, as an additional Accounting Officer for the Department, David Williams oversaw the financial management and governance of the Test and Trace programme; although day to day financial management and planning activity was undertaken by staff seconded into the Test and Trace team.

SECTION 5: PUBLIC HEALTH COMMUNICATIONS

232. In the early stages of the pandemic the Department led on all Government communications about COVID-19, working closely with PHE and NHSEI as well as the CO/No.10. The Department's communications team was responsible for the communication of government health and social care advice, policy and implementation of decisions made by departmental Ministers. This included data published in the Department's public daily tweet which began on 25 January 2020 and recorded the number of positive cases (CW3/467 - INQ000107097). The data referenced within the daily tweet was refined over time to include deaths and testing rates.

233. In March 2020, the Government COVID-19 response moved from a health sector led to a whole of Government response. The Government created the COVID-19 Taskforce based at the CO which included a COVID-19 hub communications team whose role was to coordinate a whole of Government communications response and deliver joined up communication campaigns across channels to increase awareness and behaviour change and counter misinformation.

234. The COVID-19 hub worked closely with the Department, PHE, NHSEI and No.10. A large number of personnel in the hub were communications professionals seconded from the Department and PHE. The Department's communications team continued to support Ministers, CMO and officials as well as leading on health-related

media requests, briefing new developments in the COVID-19 response and contributing to the wider cross-Government and health system COVID-19 campaign. When COVID-19 moved to a whole of Government response, the Department's communications teams provided briefing to support all Government departments and the daily Downing Street press conferences (CW3/468 - INQ000106257).

235. The Department's communications team and the COVID-19 hub led all communications for NHS Test and Trace until a separate NHS Test and Trace communications team was established. This took place outside of the scope of this statement in September 2020, but worked within the COVID-19 hub and Departmental structure outlined above.

236. BEIS managed the communications for the Vaccine Taskforce (VTF) in the first months of the pandemic. As the vaccination programme moved from planning and procurement to implementation and delivery in October and November 2020 the Department led all COVID-19 vaccine communications, working closely with the COVID-19 hub, BEIS, NHSEI, MHRA and PHE (which led all communications for the JCVI).

237. The overall approach to countering disinformation was not directly to rebut, but instead to deliver large quantities of positive information from a range of voices with audience credibility to provide easy access to factual information and address misperceptions and misinformation. Although out of scope for the timeline of this statement, an illustrative example of this approach was to build knowledge and understanding of COVID-19 vaccines and reassure people of the safety and efficacy of those vaccines by addressing specific concerns, such as, the short time taken to develop COVID-19 vaccines and the use of new vaccine technology such as messenger ribonucleic acid (mRNA). This approach was built into all campaigns which were centrally commissioned, coordinated and delivered by CO's COVID-19 hub communications team, working closely with the Department's and NHSEI's communication teams (CW3/469 - INQ000106084, CW3/470 - INQ000106323 and CW3/471 - INQ000106238).

238. The approach to countering disinformation on social media was to promote positive information rather than engage with disinformation. DCMOs and online influencers were mobilised, including media medics, scientists, experts and NHS staff to create a range of content communicating clear facts and the latest advice about how

to get a vaccine, vaccine efficacy and side effects. Content was created to suit all Departmental channels and the full range of platform followers.

239. External Affairs teams worked with a range of influential and trusted organisations to disseminate factual information and advice to the wider public and target audiences, particularly those who were more vulnerable. Regular stakeholder forums and Q & A sessions were held featuring Departmental, NHSEI and PHE spokespeople, clinicians and Ministers to improve understanding of the development of the COVID-19 vaccine so that organisations could in turn reassure their communities and members of its safety and efficacy.

240. The media relations team deployed expert spokespeople across a broad range of media outlets, including clinicians from the Department, PHE and NHSEI, as well as government ministers. This included coordinating with No. 10 and CO to field clinical experts such as the CMO and DCMOs for daily Downing Street press conferences that were broadcast live and reached millions of people across the UK. At the same time, the Department's ministers were regularly updating Parliament by responding to Parliamentary Questions and making oral statements. Spokespeople and experts were also interviewed on a range of broadcast programmes in formats that included direct questions from viewers – such as Q&A on the BBC News Channel. Other communication via news media included newspaper op-eds, ministerial quotes to accompany press notices, and ministerial broadcast clips with vital public health messaging across a wide number of outlets. Reactive media handling included provision of factual spokesperson statements to answer journalist queries. Public health messaging was designed with input from regular polling and focus group research to address themes and issues raised in social media engagement.

241. The effectiveness of communications was measured through a range of evaluation tools. Research to monitor effectiveness was centrally commissioned, coordinated and delivered by the COVID-19 hub communications team in the CO. Data was routinely shared between CO, the Department, PHE and NHSEI to allow teams to adjust communications activity accordingly.

242. Key data included a weekly campaign evaluation tracker (c. 2,000 UK adults, nationally representative) a daily public sentiment tracker (c. 2,500 UK adults, nationally representative) a weekly coronavirus health behaviours tracker (c. 2,000 UK adults, nationally representative) a vaccines tracker measuring attitudes, behaviours

and campaign evaluation (c. 2,000 UK adults and/or specific audience groups) and weekly bespoke qualitative research to assist campaign and policy development, testing, understanding behaviours and actions.

243. The effectiveness of social media content was assessed in daily evaluations that measured content performance, including sentiment analysis, to inform future content creation and refinement. Weekly content evaluation was delivered as part of a wider communications evaluation tracker. Specific evaluation, including social media listening of the impact of key announcements took place to support priority audience communications e.g. communications to ethnic minority communities.

244. The effectiveness of media relations activity was measured by media evaluation and monitoring. Evaluations assessed many aspects of media coverage (print and broadcast), including the number of reactive statements carried, prominence of the Department and government statements; and the number of appropriate rebuttals to inaccurate claims. Rolling monitoring of coverage was undertaken to ensure relevant government messaging was carried and if follow-up briefings were required. Daily internal media coverage updates were produced in the morning, afternoon and evening.

245. Behavioural insight and expertise was provided by CO's in-house behavioural science consultancy and through specialist agencies such as Decode. Learnings were routinely shared for use by teams.

246. Social media content teams applied CO behavioural insights within the social media engagement and content strategies. Comments were monitored across the Department's social media channels to allow any confusion to be addressed and clarified. Media relations teams applied the latest behavioural insights public opinion research data to statements, interview briefings and overall public health messaging.

247. The timeline of campaigns and high-level messaging from 1 January 2020 – 31 July 2020 is as follows. Between January and March 2020, the Department delivered three rapid campaigns; a Public Information Alert, including specific Chinese diaspora messaging; Handwashing; and Household isolation. These were followed by CO coordinated campaigns Stay Home, Save Lives and Key Worker testing as virus rates increased.

248. From April 2020 – July 2020 the CO led on the following campaigns: Stay Alert, Symptoms and self-isolation changes, the Isle of Wight pilot for the NHS Covid-19 App, Testing: Let's Keep Life Moving and Local lockdowns.

SECTION 6: LEGISLATION AND REGULATIONS AND THEIR PROPORTIONALITY AND ENFORCEMENT

249. The decision-making processes that led to the development of the key legislation and regulations set out below are covered in section 1 of this statement, with further information on NPIs detailed in section 2. The paragraphs above in which I have endeavoured to 'set the scene' as to the difficulties faced by the Department (and wider Government) at the time – as to there being no easy decisions – should be borne in mind when considering the necessity and proportionality of the legislative measures the Government implemented in response to managing COVID-19.

250. Some of the regulations in the early stage of the pandemic detailed below were prepared by officials in DLUHC; the Secretary of State provided the final approval of those regulations upon their advice.

251. Following the initial involvement of DLUHC, the Department took over responsibility for preparing submissions and advice for the remainder of the legislation and regulations detailed below in chronological order. I have sought to reference the supporting ministerial submissions and other documents (including assessments in accordance with the public sector equality duty) prepared for each such decision.

252. In the particular case of social restrictions, the decision-making process essentially therefore involved two separate stages. The first was a decision made collectively across Government to introduce restrictions, the nature of those restrictions, and timings and other related matters (including, for example, the time period for reviewing the necessity of those restrictions). The second decision was then about enacting that policy decision, by making the specific set of regulations (under section 45C of the 1984 Act) to give the policy its legal form. The second decision is therefore separate from the policy decision, but gives practical effect to it.

253. The Public Heath (Control of Disease) Act 1984 (the 1984 Act) gives the Government powers in the event of a serious public health emergency. In particular,

section 45C provides powers to make regulations for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales. Section 45Q stipulates that regulations made under section 45C are subject to the affirmative procedure, which requires draft regulations to be laid and approved by each House of Parliament before they are made. Section 45R however allows the use of an emergency procedure under which regulations can be made using a "made affirmative" procedure, which means regulations are made and laid before each House of Parliament has approved them and would lapse after 28 days if not debated and approved subsequently. Due to the fast-moving, urgent and unpredictable nature of COVID-19, most of the regulations were made using the emergency procedure in section 45R. To use the emergency procedure, the Secretary of State needed to be of the opinion that, by reason of urgency, it was necessary to make the regulation without a draft having been laid before and approved by a resolution of each House of Parliament. Such regulations were subsequently debated and approved by each House of Parliament and were therefore subject to Parliamentary scrutiny, with the exception of a few instances where regulations were revoked before the approval motion was scheduled for debate.

254. It is important to recognise that the regulations detailed below, whilst made by the Secretary of State under powers set out in Part 2A (Public Health Protection) of the 1984 Act, could have been signed by any appropriate Minister, i.e. the power to make the regulations under Part 2A of the 1984 Act is non-specific and is a power exercisable by a Secretary of State or a minister thereunder delegated principles, rather than by the Secretary of State for the Department per se.

The Health Protection (Coronavirus) Regulations 2020

255. The Health Protection (Coronavirus) Regulations 2020 were made at 06:50 on 10 February 2020 and came into force immediately after they were made. They were made under the powers set out in sections 45B, 45C, 45F and 45P of the 1984 Act. In accordance with section 45R of the 1984 Act, they were made without a draft having been laid before and approved by a resolution of each House of Parliament (CW3/472 to CW3/476).

256. The underlying policy of the Health Protection (Coronavirus) Regulations 2020 was developed rapidly by the Department's ORC in order to provide public health

protection in response to the rapid repatriation of entitled people from Wuhan. The regulations enabled the Secretary of State or a registered public health consultant to impose a requirement to detain a person for screening or isolation purposes where they had reasonable grounds to believe the person was, or may be, infected with COVID-19 and might infect others. The regulations also provided powers for a police constable to detain an individual under certain circumstances and enforce those restrictions. Such restrictions could only be imposed where it was considered proportionate to do so as per reg. 5(2). The Health Protection (Coronavirus) Regulations 2020 created an offence for failure to comply with the various restrictions and requirements.

257. The Health Protection (Coronavirus) Regulations 2020 were considered an effective means of preventing the further transmission of COVID-19 as based on the information available at the time but were subsequently revoked by the CVA as it subsumed their intention.

The Health Protection (Notification) (Amendment) Regulations 2020

258. The Health Protection (Notification) (Amendment) Regulations 2020 were made at 18:15 on 5 March 2020 and came into force immediately after they were made. These regulations had the effect of making COVID-19 a 'Notifiable Disease' for the purposes of Schedule 1 of the Health Protection (Notification) Regulations 2010 and 'SARS-CoV 2' a 'Causative Agent' in Schedule 2 of the same (CW3/477 - INQ000106146 to CW3/479 - INQ000106148).

The Health Protection (Coronavirus, Business Closure) (England) Regulations 2020

259. The Health Protection (Coronavirus, Business Closure) (England) Regulations 2020 were made at 14:00 on 21 March 2020 and came into force at the same time.

260. The regulations required the closure of businesses selling food or drink for consumption on the premises, and businesses listed in the Schedule, to protect against the risks to public health arising from COVID-19 (CW3/218 - INQ000106277). The Secretary of State was required to review the need for these restrictions every 28 days and to issue a direction terminating them if they were deemed unnecessary in controlling the spread of COVID-19.

261. The regulations provided powers to a person, designated by the Secretary of State, to enforce a closure or restriction imposed in these regulations . Environmental Health, Trading Standards and police officers monitored compliance with these regulations.

262. These regulations were subsequently revoked by the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 on 26 March 2020.

Coronavirus Act 2020

263. The Department was confirmed as the lead on the development of the CVA in February 2020. The Secretary of State was first briefed on the draft Coronavirus Bill on 7 February 2020 (CW3/481 - INQ000049352 to CW3/483 - INQ000106098), with the Department co-ordinating the development of the Bill with active input from relevant OGDs and regular consultation with the Devolved Governments where appropriate. This included the legislative drafting and the parliamentary and governmental handing of the CVA, which received Royal Assent on 25 March 2020. The CVA provided additional powers thought necessary for the UK Government and the Devolved Governments to respond effectively to the pandemic. (**CW3/484 - INQ000106223 to CW3/486 - INQ000106225, and CW3/488 - INQ000106227 to CW3/494 - INQ000106233)**

264. The Department used the existing draft Pandemic Influenza (Emergency) Bill that had been prepared following Exercise Cygnus as a starting point for preparing the CVA. For further information about the draft Pandemic Influenza (Emergency) Bill see paragraphs 304-305 and 330 of my First Witness Statement to the Inquiry dated 19 October 2022 which are set out below:

> *"304. The draft Pandemic Flu Bill (CW/347 - INQ000023118) contained temporary provisions of an emergency nature to help manage the effects of a severe pandemic flu virus in the UK. It contained provisions designed to either amend existing legislative provisions or introduce new statutory powers, to help manage and mitigate the impacts of a severe pandemic – such as a reduced workforce, increased pressure on health services, and death management processes. The purpose behind the draft Pandemic Flu Bill was broadly to streamline systems, increase capacity in the healthcare system, and mitigate infection.*

305. The IHR is an international instrument which is legally binding on all WHO Member States, including the UK. The IHR came into force in 2007. The IHR sets out Member States' rights and obligations for handling public health events and emergencies that have the potential to cross international borders. The IHR require the UK to establish and maintain core capacities for surveillance and response, including at points of entry, in order to detect, assess, notify and respond to any potential public health events of international concern. Key IHR core capacities implemented by the UK since 2007 include: the appointment of a National Focal Point team responsible for rapid communications with the WHO on public health events occurring in the UK and abroad; reliable and timely laboratory testing and; a sensitive surveillance system which supports early warning and assessment during the early stages of a public health event.

……..

Draft Pandemic Flu Bill 2017-2019

330. One of the key achievements of the PFRB was the preparation of a draft Pandemic Flu Bill. Between 2017 and 2019, the draft Pandemic Flu Bill was developed by DHSC with support from CO and OGDs. The draft Bill was intended to provide legislative flexibilities to support the response to a severe pandemic. The draft Bill was held internally to be taken through Parliament only if required. I have provided more detail on the draft Pandemic Flu Bill in paragraph 304."

265. The overarching objective of the CVA was to enable the Government to respond to an emergency situation and manage the effects of the COVID-19 pandemic. A severe pandemic would lead to a reduced workforce, increased pressure on health services and death management processes. The Act contained temporary measures designed to either amend existing legislative provisions or introduce new statutory powers which were designed to mitigate these impacts. The CVA supplemented the regulations made under the 1984 Act.

266. The CVA enabled a proportionate response to COVID-19 by enabling action in five key areas:

a. increasing the available health and social care workforce by, for example, removing barriers to allow suitably experienced people, such as recently retired NHS staff and social workers, to return to work;
b. easing and reacting to the burden on frontline staff by reducing the number of administrative tasks they had to perform, enabling local authorities to prioritise care for people with the most pressing needs, allowing key workers to perform more tasks remotely and with less paperwork and introducing a power to suspend individual port operations if necessary for the security of the border;
c. enabling vital services such as the Courts to operate in a COVID-secure way, and enabling other non-critical functions, such as elections, to be suspended;
d. managing the deceased with respect and dignity by enabling the death management system to deal with increased demand for its services; and
e. supporting people, (for example by allowing individuals to receive Statutory Sick Pay from day one) and supporting businesses, (for example by providing powers to ensure that the governments of the UK were able to support the food industry in maintaining supplies).

267. As set out in the explanatory notes to the CVA:

> *"7* [The CVA contains] *extraordinary measures that do not apply in normal circumstances. For this reason, the legislation is time-limited to two years, and it is neither necessary nor appropriate for all of its measures to come into force immediately. Instead, many of the measures in this Act can be commenced from area to area and time to time, so as to ensure that the need to protect the public's health can be aligned with the need to safeguard individuals' rights. These measures can subsequently be suspended and then later reactivated, if circumstances permit, over the lifetime of the Act.*
>
> *8 The lifetime of the Act can itself be ended early, if the best available scientific evidence supports a policy decision that these powers are no longer needed. It is also possible to extend the lifetime of the Act for a further temporary period, again if it is prudent to do so.*
>
> *9 This facility can be adjusted so that early termination ("sunsetting") can apply to some provisions; and extensions can be applied to others.*

The aim is to make sure that these powers can be used both effectively and proportionately."

The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020

268. The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (the First Restrictions Regulations) were made at 13:00 on 26 March 2020 and came into force at the same time. In accordance with section 45R of the 1984 Act, they were made without a draft having been laid before and approved by a resolution of each House of Parliament (CW3/495 - INQ000106301 to CW3/500 - INQ000106306 and CW3/224 - INQ000106307).

269. The First Restrictions Regulations required the closure of businesses selling food or drink for consumption on the premises as listed in Part 1 of Schedule 2 and those businesses (save for limited permitted uses) as listed in Part 2 of Schedule 2. Restrictions were also imposed on businesses listed in Part 3 of Schedule 2, which were permitted to remain open. The First Restrictions Regulations also prohibited anyone from leaving the place where they were living without reasonable excuse, and banned public gatherings of more than two people. The Secretary of State was required to review the need for the restrictions and requirements imposed by the First Restrictions Regulations at least once every 21 days, with the first review required by 16 April 2020.

270. The First Restrictions Regulations provided powers to 'a relevant person' to enforce the restrictions and requirements in the regulations, which was defined as: a constable, a police community support officer, or a person designated by a local authority or the Secretary of State.

The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020

271. The Secretary of State agreed, following advice on 29 June 2020, to revoke the First Restrictions Regulations and replace them with the Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020 (the Second Restrictions Regulations).

272. The Second Restrictions Regulations were made at 10:00 on 3 July 2020. They came into force at various times on 4 July 2020 in accordance with reg. 1(2).

273. The Second Restrictions Regulations revoked the First Restrictions Regulations (and the subsequent four sets of amending regulations). They replicated some provisions from the First Restrictions Regulations and made several new provisions. The effect of the regulations included reopening indoor and outdoor public houses, restaurants, cafes and bars. The regulations also prohibited gatherings, both inside and outside, of more than 30 people (save for a small number of exceptions).

274. The Second Restrictions Regulations provided powers to 'a relevant person' to enforce the restrictions in the regulations, which was defined as: a constable, a police community support officer, or a person designated by a local authority or the Secretary of State.

275. The Secretary of State was required to review the need for the restrictions and requirements in the Second Restrictions Regulations at least once every 28 days, with the first review required by 31 July 2020 (CW3/501 - INQ000106514, CW3/502 - INQ000106515 and CW3/503 - INQ000106516).

The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations 2020

276. The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations 2020 (the Third Restrictions Regulations) were made on 16 July 2020 and came into force at 00:01 on 18 July 2020.

277. The Third Restrictions Regulations introduced powers for local authorities to issue directions relating to premises, events and public outdoor places in its area. A direction could only be given if the local authority considered that the public health, necessity and proportionality conditions (as set out in Reg. 2(1)) were met. The Third Restrictions Regulations also gave the Secretary of State the power to direct a local authority to give a direction under the regulations or to revoke (with or without replacement) a direction given by the local authority.

278. The Third Restrictions Regulations provided powers to local authority designated officers and police constables to enforce the restrictions and requirements contained in those regulations (**CW3/504 - INQ000106528 to CW3 507 - INQ000106531, and CW3/509 - INQ000106533 to CW3/512 - INQ000106539)**

SECTION 7: OTHER MATTERS

Population Immunity (sometimes known as herd immunity)

279. The Inquiry has specifically asked about the role of 'herd immunity' in Government policy. In terms of policy, at no point did the Government adopt a so called 'herd immunity' strategy to the pandemic. An understanding of the development of post infection immunity is of course essential in the management of any infectious disease. For example issues such as whether a disease can only be caught once (like chicken pox) or on multiple occasions (like influenza) are highly relevant to disease management. Such an understanding is also essential to the development of vaccines. Immunity was therefore widely and correctly discussed amongst scientists, clinicians and others throughout the pandemic. At the beginning of the pandemic by definition very little could be known about whether immunity occurred or how long it might last. Whether herd immunity should play any role in Government strategy, and whether it might be a by-product of policy, was also discussed along with other alternative strategies such as zero covid. But to the best of my knowledge such a strategy was never proposed to Ministers and it was certainly never adopted as Government policy. Policy remained as described in paragraphs 37 and 38. The development of vaccines later in the pandemic of course transformed the situation and population immunity by vaccination became central to the Government's strategy.

Supply

280. The supply of PPE is captured earlier in this statement at paragraphs 199 to 220. Key issues regarding supply also focused on ventilators, oxygen and critical medicines

281. In the early stages of the pandemic the NHS believed it could need far more mechanical ventilators than were available. By the beginning of March 2020, modelling based on RWCS planning assumptions and assured by SAGE indicated that up to 90,000 adult beds with ventilators may be needed to care for COVID-19 patients. The government's strategy was to rapidly increase UK ventilation capacity by acquiring as many ventilators as possible from both UK and global suppliers. In the early stages of the pandemic the focus was on ICU capabilities and rapidly purchasing equipment and upgrading infrastructure to ensure there was enough capacity in the system to meet the immediate need.

282. The O2VMD&CC Programme contained a number of programmes which included amongst others: Oxygen Production and Distribution; Trust Medical Gas Pipeline Systems; Ventilator Challenge; and Supply Chain Management. Ventilators are covered in more detail under Ventilators and the Ventilator Challenge in Section 4.

283. With regard to medicines, work was carried out to understand the impact of COVID-19 to global supply chains, and then a programme of activity took place to fund, globally source and procure medicines for clinical trials and to stockpile them as potential treatment medicines for a population rollout if approved. A global risk assessment of all medicines supplied to the UK then followed (CW3/513 - INQ000106299). Suppliers of medicines identified as high-risk UK licensed medicines were targeted for information and asked to provide assurance on their ongoing availability. Activity during this period included:

a. monitoring supply and demand of all medicines;
b. action to prevent organisations stockpiling;
c. wholesalers sourcing and purchasing additional stocks where necessary;
d. managing allocations to the NHS where imbalances in supply and demand meant a risk to continuity of supply;
e. working with royal colleges and national experts to agree second and third line alternative treatments and issuing guidance to the NHS; and
f. restricting the export of critical medicines placed on the UK market, for UK patients.

284. In the first months of the pandemic, work was also undertaken to ensure suppliers and wholesalers were aware of the medicines most under pressure to enable them to respond as required. The Department also worked closely with industry bodies to monitor issues in key countries for UK medicines manufacturing and to spot problems which might affect UK supply of both COVID-19 medicines and medicines in general, and then worked with the relevant government and/or suppliers to resolve them .

285. Ministers also agreed to procure key medicines to be held as a central, Government-owned COVID-19 stockpile in the event that further outbreaks resulted in spikes in demand that could not be met by the business as usual supply chain, risking critical shortages (CW3/534 INQ000106436 to CW3/537 - INQ000106439).

Vaccines and treatments

286. From the outbreak of a pandemic, the value of research was recognised and it was felt that vaccines and treatments would be the best long-term route out. Since 2014, the CRN has had Urgent Public Health (UPH) processes in place for the rapid setup and delivery of research on unexpected and severe infections with the potential to cause widespread disease in the UK. These processes are enacted on the instruction of the Department in the event of a declared outbreak. In response to spread of COVID-19, a key first step was the national endorsement of a unified portfolio by the CMOs for England, Scotland, Wales, and Northern Ireland, focusing attention on a single common goal of identifying safe and effective treatments for COVID- 19.

287. In January 2020, on the instruction of the Department, the CRN implemented UK-wide UPH processes to expedite the rapid opening of the International Severe Acute Respiratory and Emerging Infection Consortium (ISARIC) Clinical Characterization Protocol United Kingdom (CCP-UK) study (CW3/514 - INQ000106059). The study, led by Calum Semple, collects data and samples to characterize infectious diseases with the potential to engender public health problems. This study remains on the CRN Portfolio, so that it can be activated as and when needed.

288. Prior to the first COVID-19 case arriving in the UK, work on how to develop, trial, procure, and roll out vaccines had begun building on work of the UK Vaccines Network . The NIHR and UK Research and Innovation (UKRI) worked together to set up a rapid research call on COVID-19 in February 2020 (CW3/130 - INQ000057497 and CW3/131 - INQ000106090). The unprecedented speed of the call allowed the commissioning of 26 projects in March 2020, including two on the Oxford/AstraZeneca COVID-19 vaccine. The funded projects were expected to lead to a benefit in UK and international public health within 18 months. Further details on key therapeutics studies are below:

a. The RECOVERY trial, a study for patients hospitalised for COVID-19 treatment was designated as an Urgent Public Health research study on March 11, 2020, and within a week had been set up at hospitals across the UK, recruiting its first participant just eight days after on 23 March 2020. This trial became the fastest recruiting randomised controlled trial: more than 10,000 patients in 176 hospitals in two months. (CW3/530A - INQ000106905).

b. The PRINCIPLE trial, a study for patients with mild COVID-19. Recruitment started in May 2020, initially looking at preventing hospitalisation for people over 50 with pre-existing health conditions and then later expanding to include adults aged 18 and over. (CW3/531 - INQ000107101)

c. The REMAP-CAP trial for critically ill hospitalised patients had been established before the pandemic to research treatments for community acquired pneumonia but pivoted to focus on COVID-19. (CW3/532 - INQ000106373)

d. The AGILE platform trial opened in July 2020, as a collaboration between the University of Liverpool, the University of Southampton Research Unit, and other external partners, designed for rapid clinical evaluation of potential COVID-19 treatments early in the drug development stage or where additional safety data was necessary. Patients in early stages of COVID-19 infection were recruited to AGILE from the community, in addition to patients who had been hospitalised with COVID-19. (CW3/533 - INQ000106870)

289. The VTF (a joint taskforce between the Department and BEIS) was set up in April 2020 in response to the unique and significant challenges brought on by the COVID-19 pandemic. The aims of the VTF were to:

a. Secure access to promising COVID-19 vaccines for the UK population as quickly as possible;
b. Make provision for international distribution of vaccines; and
c. Strengthen the UK's onshore capacity and capability in vaccine development, manufacturing, and supply chain, to provide resilience for future pandemics.

290. Funding had been successfully secured for a number of projects that were vital to the later success of the vaccine programme. This included providing the funds necessary for the continuation of clinical trials for the Oxford/AstraZeneca COVID-19 vaccine and supporting the deal between the University of Oxford and AstraZeneca.

291. In June 2020 Ministers were asked to agree the proposed assumptions underpinning planning for delivery of a potential COVID-19 vaccine programme (CW3/515 - INQ000106484). These planning assumptions had been drawn up by the

Department, PHE and NHSEI and included secondary legislation to expand the workforce able to administer COVID-19 vaccines.

292. In July 2020 Ministers were asked to agree to using the existing emergency provision under regulation 174 of the Human Medicines Regulations 2012 (CW3/516 - INQ000106509). This would ensure rapid vaccine authorisation / licensing of a safe and effective COVID-19 vaccine should one become available.

293. Also in July 2020 Ministers were asked for their steer on financing delivery of a COVID-19 vaccination programme. Whilst BEIS would cover the costs of developing and procuring the vaccines themselves, the deployment and administration of any COVID-19 vaccine would be financed by the Department.

294. In June-July 2020, the VTF submitted a Programme Business Case to BEIS' Projects and Investment Committee (PIC) and HMT's Treasury Approval Point (TAP) Panel, which secured overall initial funding of £5.23bn for the VTF Programme (CW3/517 - INQ000106523, CW3/518 - INQ000106524 and CW3/519 - INQ000106525). This was essential to enabling the VTF to take a portfolio approach to investment in vaccine options, and to enable speedy UK delivery through increasing domestic capacity for clinical trials and manufacturing.

Vulnerable Groups

295. Consideration of vulnerable groups was at the forefront of the Department's work in responding to the virus from the very beginning and continued throughout, for example, the shielding programme. The Department's understanding of who constituted vulnerable groups developed over time as understanding of the pandemic advanced. Vulnerabilities could be described ranging from variables of clinical conditions (see section on shielding at paragraphs 196-198) and demographic detail (eg age, ethnicity) to social, financial and geographical variation. It was important to recognise the intersectionality of these vulnerabilities and policies and interventions became increasingly more discerning as higher granularity of data became more available. Further detail on this can be found in Chapter 2 of the Technical Report (CW2/1).

296. Our initial understanding of clinical vulnerability i.e. a potentially higher risk of becoming infected or of having a more serious outcome from infection, changed through the pandemic as evidenced epidemiological estimates of infection, hospitalisation and case fatality rates for different conditions became more robust using both UK and international data. The UK was the first to develop a digital risk tool to support individual clinical decision making (QCovid) based on work commissioned on CMO's request by NERVTAG and delivered by Oxford University working with oversight and four nations support from the DCMO (CW3/520 - INQ000106868). Other vulnerabilities were addressed by a number of different individual and joint research programmes, papers and analyses including for example (CW3/521 - INQ000107085 and CW3/522 - INQ000106159) reports on ethnicity, age [articularly children], healthcare workers [SIREN], care home residents and staff [Vivaldi], specific vulnerable cohorts, disabilities and special educational needs, socioeconomic and occupational parameters – the evidence from which was considered during policy development. As with understanding of clinical conditions evidence accumulated through the pandemic with more detail accruing on wider topics over time e.g. multi-generational housing, or occupation, in the community infection survey. A second version of the QCovid risk tool was designed specifically to try to address the intersectionality of socioeconomic deprivation with existing demographic variables and underlying clinical conditions.

297. The Department's consideration of vulnerable groups is reflected in the first version of the Battle Plan (CW3/41 - INQ000106286), in which one of its six workstreams included: 'Protecting the most Vulnerable'; the Government initially sought to achieve this through providing specific advice to those who may benefit from 'shielding' [initially referred to as cocooning]. These two broad cohorts of vulnerable people identified above were then considered separately by the Department through two linked workstreams in version 2 of the Battle Plan: 7A: 'Shielding the clinically extremely vulnerable' (CW3/48 - INQ000107087 to CW3/51 - INQ000106506 and CW3/523 - INQ000106902) and 7B: 'Supporting other disproportionately affected groups and volunteering' (CW3/48).

298. In respect of the implementation of measures designed to protect the vulnerable, on 5 March 2020 SAGE reviewed the evidence in support of the implementation of home isolation measures within 1-2 weeks and social isolation measures for the over 65s or those with underlying medical conditions two weeks thereafter (CW3/424 - INQ000106152). These measures were proposed at that stage

in order to delay the spread of COVID-19, attempt to modify the epidemic peak and reduce mortality rates. Whilst the SAGE minutes recognise that for older and vulnerable patients the isolation would have to continue for a longer period, it was realised that such long periods of social isolation could also carry significant risks. All advice specific to the clinically extremely vulnerable (those shielding) was therefore at all times a recommendation and personal choice and never a requirement imposed by government.

299. In April 2020, the CMO commissioned PHE to review disparities in outcomes and risks from COVID-19 (CW3/524 - INQ000106482 and CW3/525 - INQ000107095). The resulting publication in June 2020, 'Disparities in the risk and outcomes of COVID-19' (CW3/526 - INQ000106459), was a rapid review of transmission, hospitalisation and mortality from COVID-19 data, which showed disparities in the impact of COVID-19 at that time based on age, sex, ethnicity and deprivation. Following the PHE work, the Government commissioned further work through the then Minister for Equalities to improve understanding of drivers for disparities. The Race Disparity Unit which is part of the CO, led this work, with the Department inputting and undertaking periodic commissions and assurance reviews to ensure that its COVID-19 response was building in adequate responses for vulnerable groups (for example, ethnic minority communities and deprived populations).

300. The impacts on vulnerable groups were considered in accordance with the public sector equality duty in, for example, the March 2020 'Hospital Discharge Policy' and the May 2020 'Support Policy' and the June 2020 'Admissions Guidance' (CW3/527 - INQ000106249, CW3/529B - INQ000106403, CW3/530B - INQ000106442). The public sector equality duty was implicitly considered by the Department on an ongoing basis during its response to COVID-19 insofar as one of the key Battle Plan workstreams was the protection of the most vulnerable and this necessarily entailed the development of policies for their protection.

301. In respect of testing of those hospitalised, the Department together with PHE and NHSEI, ensured that testing capacity was prioritised for elderly and vulnerable residents until capacity was sufficiently expanded to deliver more widely.

302. The Oversight Board requested information from Battle Plan workstream SROs on 7 July 2020 (CW3/528 - INQ000106522), requiring that they review their

workstream objectives and planned activities to ensure they reflected considerations for people from ethnic minority communities and deprived populations.

Military Aid to the Civil Authorities (MACA)

303. If there is an emergency in the UK, local emergency services provide the first response; however, Government Departments or civil authorities may then request military assistance from the MoD through MACA procedures. MACA provides deployment of clinically trained staff or other military capabilities such as logistics, security and construction. Requests can be made when there are issues with human resource in the health and social care sectors due to very high levels of staff absences or a sudden and unexpected increase in demand. Once requests are granted by the MoD, military staff will be made available as required. Examples of how MACA was used over the period of this statement include: the construction and resourcing Nightingale hospitals, supporting UK testing capacity and logistics management and the distribution of PPE (CW3/302 - INQ000107096).

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: 29/03/2023