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

UK COVID-19 INQUIRY

FIFTH WITNESS STATEMENT OF CHRIS WORMALD
DEPARTMENT OF HEALTH AND SOCIAL CARE
CORPORATE STATEMENT: 1 AUGUST 2020 – 31 JULY 2021

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. This corporate statement covers the period from 1 August 2020 to 31 July 2021. 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. The period 1 January 2020 to 31 July 2020 is covered in my First Witness Statement for this Module dated 29 March 2023. The period 1 August 2021 to 24 February 2022 will be covered in a future Witness Statement for this Module.

4. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. 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

5. This section of my statement covers changes that occurred during the period 1 August 2020 to 31 July 2021 in terms of the Department's role, responsibilities and its relationships with departmental agencies and other government departments (OGDs).

6. As set out in my First Witness Statement for this Module, dated 29 March 2023, at paragraph 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.

7. In my First Witness Statement for this Module dated 29 March 2023, I set out at paragraph 8 the Department's strategic priorities in its Annual Report and Accounts for 2019/20, for the year ending 31 March 2020. The Department's Annual Report and Accounts 2020/21 (for the year ending 31 March 2021) (CW5/1 - INQ000235008), set out our strategic priorities in 2020/21 as follows:

    a. A response to COVID-19 and health protection that continues to support health care systems, anticipates future demands and utilises lessons learned to enact wider change and reform to health and social care;
    b. A healthier nation that tackles the causes of poor physical and mental health, racial disparities in healthcare, and ongoing efforts to ensure we play a leading role in confronting global health challenges;
    c. A transformation in social care that applies lessons learned from COVID-19 and supports the most vulnerable in our community and integrates effectively with healthcare;
    d. A stronger and more integrated health and care system driven by system reform, spending review and the ambitions set out in the Long-Term Plan that delivers better outcomes, confidence, and patient experience;

e. A workforce fit for the future created by recruiting, retaining, and developing the people we need, and by making the health and care system a rewarding place to work;
f. A digital revolution which will harness the full potential of data and technology to inform better decisions that improve the delivery of healthcare for the twenty-first century;
g. A well-managed end to European Union transition helping the health and care system to manage the complexity and risk associated with our departure; and
h. Building infrastructure for the future to lead on systems reform, build a new relationship between the Department and those delivering care, whilst supporting wider government manifesto commitments.

8. In my First Witness Statement for this Module dated 29 March 2023, I set out at paragraphs 10, 11 and 12 the role of the Chief Medical Officer (CMO), the Chief Scientific Adviser (CSA) and the Director General (DG) for Global and Public Health. In the time period covered by this witness statement, there were changes in senior officials within the Department as follows:

a. Following the departure of David Williams, Shona Dunn became Second Permanent Secretary at the Department in April 2021. She was and remains responsible for all group operations and deputises on all duties in the Department;
b. Following the departure of Professor Sir Jonathan Van-Tam, Professor Thomas Waite became interim Deputy Chief Medical Officer (DCMO) for COVID-19 in July 2021 and was substantively appointed DCMO leading on health protection in April 2022. His responsibilities are similar to those previously held by Professor Sir Jonathan Van-Tam and cover emergency response and preparedness, infectious diseases, vaccines and therapeutics;
c. Matt Hancock resigned as Secretary of State on 26 June 2021 and was replaced by Secretary of State Sajid Javid on the same day;
d. Michelle Dyson was appointed as Director General for Adult Social Care in May 2021 - Interim Director General, Adult Social Care September 2020 to May 2021.
e. Special Advisor Jamie Njoku-Goodwin left the Department on 20 September 2020;
f. Special Advisor Damon Poole joined the Department on 1 September 2020; and

g. Special Advisor Beatrice Timpson joined the Department on 9 November 2020.

9.As explained in paragraph 77 of my First Witness Statement for this Module:

> "*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 (PM) 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).*"

10.These meetings took place regularly, at least weekly and sometimes more often, depending on business. All Gold papers for the time period covered by this statement are exhibited at CW5/1AA - **INQ000257387;** CW5/1AB - **INQ000257388;** CW5/1AC - **INQ000257390;** CW5/1AD - **INQ000257391;** CW5/**284** - INQ000234542; CW5/1AF - **INQ000257404;** CW5/1AG - **INQ000257405;** CW5/1AH - **INQ000257406;** CW5/1AI - **INQ000257407;** CW5/1AJ - **INQ000257423;** CW5/1AK - **INQ000257408;** CW5/1AL - **INQ000257420;** CW5/1AM - **INQ000257421;** CW5/1AN - **INQ000257422;** CW5/1AO - **INQ000257424;** CW5/1AP - **INQ000257425;** CW5/1AQ - **INQ000257426;** CW5/1AR - **INQ000257429;** CW5/1AS - **INQ000257430;** CW5/1AT - **INQ000257431;** [redacted]; CW5/1AV - INQ000234285; CW5/1AW - **INQ000257432;** CW5/1AX - **INQ000257437;** CW5/1AY - **INQ000257434;** CW5/1AZ - INQ000234756; CW5/1BA - **INQ000257438;** CW5/1BB - **INQ000257449;** CW5/1BC - **INQ000257450;** CW5/1BD - **INQ000257439;** CW5/1BE - **INQ000257440;** CW5/1BF - **INQ000257441;** CW5/1BG - **INQ000257454;** CW5/1BH - **INQ000257453;** CW5/1BI - **INQ000257455;** CW5/1BJ - **INQ000257448;** CW5/1BK - **INQ000257451;** CW5/1BL - **INQ000257452;** CW5/1BM - **INQ000257457;** CW5/1BN - **INQ000257458;** CW5/1BO - **INQ000257460;** CW5/1BP - **INQ000257461;** CW5/1BQ - **INQ000257462;** CW5/1BR - **INQ000257463;** CW5/1BS - **INQ000257464;** CW5/1BT - **INQ000257465;** CW5/1BU - **INQ000257466;** CW5/1BV - **INQ000257467;** CW5/1BW - **INQ000257468;** CW5/1BX - **INQ000257469;** CW5/1BY - **INQ000257470;** CW5/1BZ - **INQ000257471;** CW5/1CA - **INQ000257472;** CW5/1CB - **INQ000257473;** CW5/1CC - **INQ000257474;** CW5/1CD - **INQ000257475;** CW5/1CE - **INQ000257476;** CW5/1CF - **INQ000257477;** CW5/1CG - **INQ000257478;** CW5/1CH -

INQ000257479; CW5/1CI - INQ000257480; CW5/1CJ - INQ000257481; CW5/1CK - INQ000257482; CW5/1CL - INQ000257484; CW5/1CM - INQ000234631; CW5/1CN - INQ000257485; CW5/1CO - INQ000257483; CW5/1CP - INQ000257486; CW5/1CQ - INQ000257487; CW5/1CR - INQ000257488; CW5/1CS - INQ000257489;

Devolved Governments

11. Throughout the relevant period, there continued to be regular conversations and engagement with the Devolved Governments. A description of this engagement was set out at paragraph's 14 to 18 in my First Witness Statement for this Module. The UK Health Ministers continued to meet regularly, and often on a weekly basis depending on business to discuss respective approaches and UK wide issues, there continued to be regular meetings of the four UK CMOs.

Other Government Departments (OGDs)

12. The Central Government structures and bodies concerned with the UK's response to the COVID-19 pandemic and the relationship between the UK Government and the Welsh, Scottish and Northern Ireland Governments (the Devolved Governments) are set out in my First Witness Statement for this Module at paragraph 19.

13. COVID-Strategy (COVID-S) and COVID-Operations (COVID-O) continued to be the Cabinet Committees supported by the Cabinet Office (CO) to take the main decisions on COVID-19 response.

14. As set out in my First Witness Statement for this Module at paragraph 19, the Department worked closely with OGDs during the response to COVID-19. This is because a public health emergency is not solely a health matter; many relevant actions are within the purview of OGDs and/or local authorities.

Arms-Length Bodies

15. In addition to the work the Department conducts, it also works through a number of arm's-length bodies (ALBs) to deliver its strategic objectives. For more information on this, and the ALBs through which the Department works, see my First Witness Statement for this Module at paragraphs 20 to 21.

16. During the period 1 August 2020 to 31 July 2021, NHS England (NHSE) continued to lead on measures to manage hospital capacity and primary and community care

services. Public Health England (PHE) provided technical leadership and input in assessing public health risk to the UK during the pandemic. The closure of PHE is covered in more detail at paragraphs 18 to 31 below.

17. From 6 October 2020 onwards, the Department's COVID-19 programme director convened and chaired a monthly COVID-19 ALB Battle Plan meeting to which representatives of the ALBs were invited. The main purpose of these meetings was to ensure ALBs were kept up to date on key aspects of the Government's response to COVID-19 and to give them the opportunity to ask questions and raise issues.

18. Whilst some of the content in the next two paragraphs falls outside the timeframe for this Statement, they provide the context for what follows in this subsection on the closure of PHE.

19. By way of background, the closure of PHE and the creation of the UK Health Security Agency (UKHSA) created a body that returned to a position where the primary focus for the organisation was health protection. Such a body had previously existed from 2003-2013, the Health Protection Agency (HPA). In my First Witness Statement for Module 1, at paragraph 418, I provided more detail on the HPA:

> "*From 2009 to 2013, responsibility for public health services in England rested primarily with the HPA. The HPA was created on 1 April 2003 as a special health authority in England and Wales and was established as a UK-wide non-departmental public body on 1 April 2005 by the Health Protection Agency Act 2004. The HPA's functions in relation to health included the protection of the UK public against infectious disease and other dangers to health, and the prevention of the spread of infectious disease. The HPA exercised these functions alongside NHS Primary Care Trusts (PCTs) who commissioned a range of services to improve or protect the public's health. Policy responsibility for public health services sat with the Secretary of State, supported by DH. The Secretary of State retained the power to direct the HPA to take on other functions in relation to health*."

20. In 2013, the HPA's functions were abolished and transferred to the Secretary of State. PHE was established as an executive agency of the Department in 2013 and was the principal route for discharge of the Secretary of State's public health protection duty (s.2A of the Act) and it also acted under the Secretary of State's public health improvement power (s.2B of the Act). For the first time, health protection and health

improvement responsibilities were combined in the new agency. PHE drew together functions from a number of pre-existing bodies which had performed health improvement and health protection functions, including the HPA.

21. The move from PHE to UKHSA, back to a body with a single focus and competency on health protection, that is the prevention and control of the spread of communicable diseases and other health threats, was a logical decision based on the difficulties presented by the pandemic. The background to the proposal to establish a new body, then proposed as a 'Centre for Health Protection', was set out in a draft paper prepared following a COVID-S meeting on 2 July 2020 (detailed further below) (CW5/2 - INQ000233878; CW5/3 - INQ000233879; CW5/4 - INQ000234403; CW5/5 - INQ000234405; CW5/6 - INQ000234402; CW5/7 - INQ000234404; CW5/8 - INQ000234407).

22. In May 2020, Ministers began to consider the implications of the Department's experience of the pandemic for the public health system in England, focusing specifically on national public health infrastructure. On 5 May 2020 Duncan Selbie, the then Chief Executive of PHE, sent the Secretary of State information covering PHE's COVID-19 and non-COVID-19 activities in advance of a No.10 deep-dive meeting (CW5/9 - INQ000234363; CW5/10 - INQ000234364; CW5/11 - INQ000234365). On 22 May 2020, the Secretary of State wrote to the PM about the impact of the pandemic on the healthcare system and the case for sustained changes to the future of healthcare in England. This letter included early thinking on the need for, and direction of, reforms to the public health system (CW5/12 - INQ000234371). On 11 June 2020 advice was sent to Ministers on whether provisions in the Health and Care Bill could be adapted to give Government the maximum possible level of flexibility to reorganise public health functions, if needed in the future.

23. At the COVID-S meeting on 2 July 2020, it was agreed that ensuring England had the strongest possible disease control function was an absolute priority and that a new health protection organisation would be created. This would bring together the at-scale operational response capability of NHS Test and Trace, the Joint Biosecurity Centre's (JBC) intelligence and analytical capability, and the public health science and health protection expertise of PHE. On 6, 9 and 23 July 2020, advice was sent to Ministers in relation to scope, organisational form and timetable to establish a new health protection body, then referred to as the Centre for Health Protection (CW5/13 - **INQ000233879**, CW5/14 - INQ000234416; CW5/15 - INQ000234417).

24. On 6 August 2020 advice was sent to the Secretary of State on an overall narrative for, and engagement on, plans for public health system reform. This included presentation of options for the future arrangements for preventing non-communicable diseases, including PHE's wider functions, and arrangements for engaging more widely on these decisions (CW5/16 - **INQ000257383;** CW5/17 - **INQ000257386;** CW5/18 - **INQ000257385;** CW5/19 - **INQ000257384;**). Further advice sent on 16 August 2020 addressed the potential to establish a new National Prevention Service (CW5/20 - INQ000234440).

25. On 18 August 2020, the Government announced its intention to create a new body which was initially to be named the National Institute for Health Protection and later formally named UKHSA, which would be dedicated to identifying, preventing and responding to infectious diseases and other health threats (CW5/21 - INQ000234444). At the same time, the Government announced its intention to reform other elements of the public health system in England to ensure a parallel focus on preventing ill health to improve the general health of the population.

26. Following this announcement and receipt of further advice to Ministers on 19 August 2020, the Department established a Population Health Improvement Stakeholder Advisory Group, to advise it on the best future arrangements for prevention and health improvement. This group met for the first time on 2 September 2020 and met a further seven times up to 10 May 2021 (CW5/22 - INQ000234476).

27. On 15 September 2020, the Government published a policy paper "The future of public health: the National Institute for Health Protection and other public health functions", which provided further information on the proposed changes and their supporting rationale (CW5/23 - INQ000234488). During the remainder of 2020 and into 2021, the Government worked with PHE and NHSE and engaged with stakeholders (including through the Population Health Improvement Stakeholder Advisory Group) on both implementation of a new health protection organisation and development of plans for the future location of other national public health functions.

28. From January to May 2021, Ministers took a series of decisions on the transfer of specific functions from PHE to future destinations (CW5/24 - INQ000234911; CW5/25 - INQ000234694; CW5/26 - INQ000234802; CW5/27 - INQ000234803; CW5/28 - INQ000234804; CW5/29 - INQ000234805; CW5/30 - INQ000234773; CW5/31 -

INQ000234774; CW5/32 - INQ000234775; CW5/33 - INQ000234776; CW5/34 - INQ000234777). This enabled formal consultations with PHE and NHS Test and Trace staff to take place, which started on 30 June 2021, and legislation to be implemented to ensure the transfer of PHE functions and staff could take place by the end of September 2021.

29. On 29 March 2021, the Government published a policy document outlining the reforms to the public health system in England, including plans to strengthen the country's national health protection capabilities, put health promotion at the heart of government and more deeply embed prevention and health improvement expertise across local and national government and the NHS (CW5/35 - INQ000234835 and CW5/36 - INQ000234837).

30. On 1 April 2021, UKHSA was formally established as an executive agency of the Department with the appointment of Professor Dame Jenny Harries as its Chief Executive and Ian Peters as its Chair (CW5/37 - INQ000234853 and CW5/38 - INQ000234841). To protect operational continuity and provide for necessary staff consultations and stakeholder engagement, the transition of responsibilities and capabilities from PHE, the JBC and NHS Test and Trace into UKHSA took place over the following six months. Priorities for PHE and UKHSA during this period were set out in their respective remit letters issued by the Department's Ministers (CW5/24 - INQ000234911 and CW5/39 - INQ000234910).

31. From 1 October 2021, UKHSA became operational. All PHE's health protection functions and NHS Test and Trace functions transferred into UKHSA. PHE's other functions transferred to the Department, NHSE and NHS Digital, and PHE ceased to be operational (CW5/40 - INQ000235000).

Expert scientific and analysis advisory groups

32. I understand that expert groups including the New and Emergency Respiratory Virus Threats Advisory Group (NERVTAG), the Scientific Pandemic Infections Group on Modelling (SPI-M) and the role of the Scientific Pandemic Infections Group on Modelling, Operational sub-group (SPI-M-O) will be addressed in the corporate witness statement of the Office of the Chief Medical Officer (OCMO). I will therefore not cover these in any detail in this statement.

33. In addition to those expert scientific advisory groups mentioned in my First Witness Statement of this Module dated 29 March 2023, a new group was established by the Department in July 2020: the COVID-19 Prophylaxis Oversight Group (POG), to guide development of pre- and post-exposure prophylaxis for the COVID-19 infection. The POG was formed of independent experts with expertise on the key issues related to prophylaxis.

International

34. As described in my First Witness Statement for this Module at paragraphs 28 and 29, during this period, the Department continued its engagement with other countries to exchange information on their COVID-19 response. In addition to bilateral engagement, there was engagement with the World Health Organization (WHO), WHO EURO, the G7, the G20, the Global Health Security Initiative and the European Commission.

35. The health track of the 2021 UK G7 Presidency considered actions which G7 countries could take together to manage the COVID-19 pandemic and help ensure better pandemic preparedness and response in the future. In addition to regular exchanges on live issues in the COVID-19 pandemic, the UK's G7 agenda focused on four concrete areas: global health security, antimicrobial resistance, clinical trials, and digital health. Commitments were secured across these issues at the G7 Health Ministerial Meeting in Oxford from 3-4 June 2021, including agreement of a Clinical Trials Charter to build on experience during COVID-19 and enable more effective trials for therapeutics and vaccines globally in a pandemic. The declaration was agreed by all G7 members (CW5/41 - INQ000234916), and the G7 Therapeutics and Vaccines Clinical Trials Charter was published (CW5/42 - INQ000234915).

36. The G7 Leaders' Summit on 11-13 June 2021 built on the work of Health Ministers to agree a specific Leaders' Health Declaration in addition to the Carbis Bay Communique (CW5/43 - INQ000235009), which shared their agenda for global action to build back better following the COVID-19 pandemic. Leaders committed to take action to prevent, detect, respond, and recover from COVID-19 and future pandemics. They made a commitment to work together to invest in innovation with the aim of making safe and effective vaccines, therapeutics, and diagnostics available within 100 days of a Public Health Emergency of International Concern being declared; and a commitment to make a further one billion COVID-19 vaccines available globally to help end the pandemic.

Emergency Response – the development of the role and responsibilities of the Operational Response Centre

37. The role and responsibilities of the Operational Resource Centre (ORC) are set out in my First Witness Statement for this Module dated 29 March 2023 at paragraphs 38 to 52. The ORC was central to the Department's response to the pandemic, as the emergency response function for the Department.

38. From October 2020 the ORC stood up a dedicated Incident Management Team (IMT) to manage the concurrent pressures associated with the second wave of COVID-19, the end of the transition period following the UK's departure from the European Union and other winter risks in the health and social care system. The IMT remained active until end of March 2021.

39. The IMT managed several other COVID-19 issues which had repercussions for the health and social care system during the period with which this statement is concerned:

a. Until the end of October 2020, the ORC continued to coordinate Military Aid to the Civil Authorities requests on behalf of the health and care system, including the process for Ministerial approval. Requests were predominantly COVID-19 related in nature. From the end of October 2020, responsibility transferred to the Department's COVID-19 Programme from thereafter;
b. From 6 November 2020, the ORC also supported the response to a cluster 5 variant of COVID-19 that appeared in mink in Denmark. This work included the development of a first case protocol and briefing for Ministers on mitigations with recommendations on how to reduce the risk to the UK;
c. From 4 December 2020, the ORC responded to the French border closure (associated with the spread of the Delta variant in the UK), including reporting to Ministers on supply chain impacts to the health and care system;
d. From 5 February 2021, the ORC led the response to weather disruption (wind, snow and ice) and the impact this had on testing and vaccination sites;
e. Until February 2022, the ORC continued to represent the Department at the CO chaired COVID-19 Death Management Steering Group, reporting on the NHS' death management system capacity and its ability to absorb the pressures associated with COVID-19 related excess deaths; and
f. From 29 April 2021 the ORC worked with NHSE to mobilise offers of medical support to the Indian authorities in respect of COVID-19.

ORC's engagement with other organisations and the Devolved Governments

40. Between 1 August 2020 to 31 July 2021, the ORC's communication and engagement with other organisations and the Devolved Governments were facilitated by a number of different mechanisms (in addition to those discussed above and in my First Witness Statement for this Module).

41. For context, in June 2020, the ORC established Concurrent Risks and their Mitigations Board (CRAM) to identify and manage concurrent risks and their mitigations in a way that could protect the resilience of the health system, particularly during the COVID-19 response. CRAM considered the wide-ranging factors that could disrupt the continuing operation of the health and social care system, and thereby the response to any further COVID-19 wave. The issues considered included disruption to medicine supply, workforce challenges and extreme weather.

42. The CRAM provided a joined up, centralised, whole system approach to managing concurrent risks and their mitigations. It supported the health and care system in testing and enhancing their preparedness for concurrent risks by carrying out deep dives to test planned mitigations. The CRAM helped to create and encourage support, connections and links across organisations.

43. The ORC presented a paper on Winter and Concurrent Risks to the Department's COVID-19 Oversight Board on 16 September 2020 (CW5/44 - INQ000234489), which compiled the key findings from CRAM.

44. To understand preparedness and response capability across the health and care system the ORC engaged with the system to collate intelligence on disruptive risks. This included:

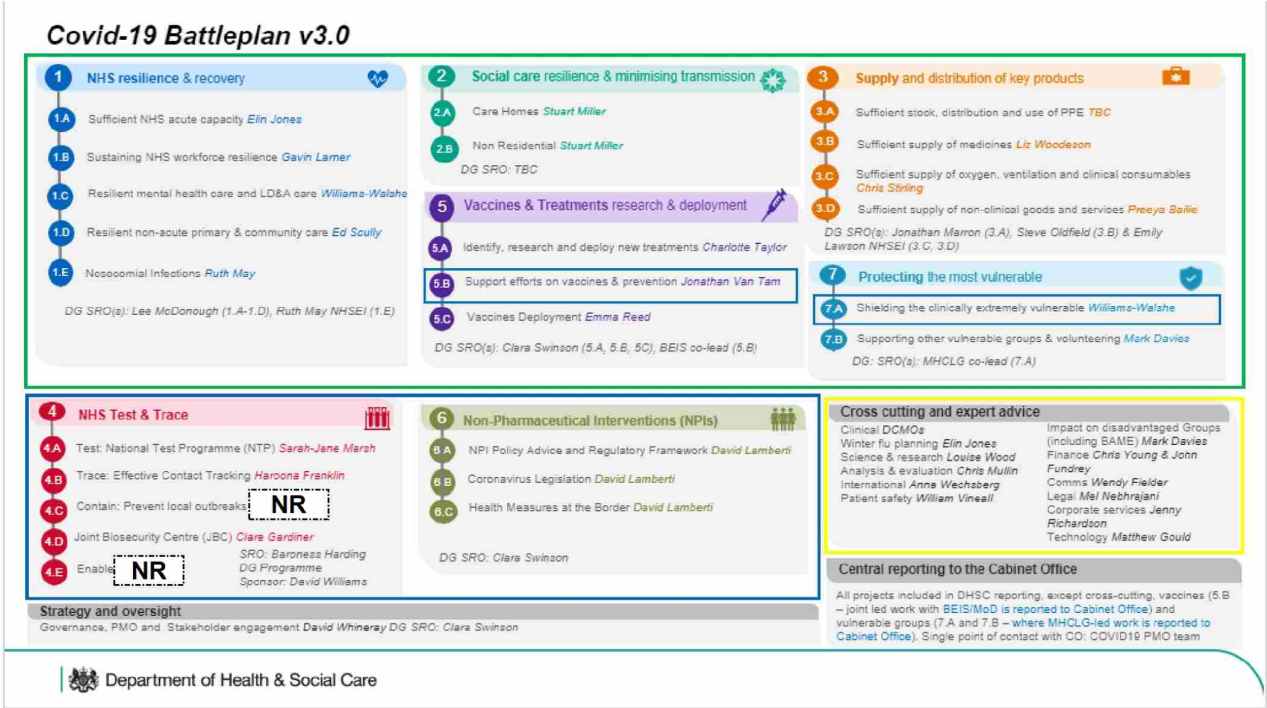
    a. Engagement during an incident. National calls were set up with Emergency Preparedness, Resilience and Response (EPRR) representatives across the health and social care system and the Devolved Governments to provide leadership and coordination during an incident response. These calls took place specifically when incidents occurred that required central intervention from the Department;
    b. Engagement to support the Government's situational awareness. The ORC targeted its engagement with the health and social care system to address

central commissions for intelligence received from CO and the Civil Contingencies Secretariat (CCS). This included weekly engagement with NHSE to gather data for CO in relation to their Death Management Steering Group information requests; and

c. Engagement with the Devolved Governments. The ORC held monthly EPRR meetings with the Devolved Governments from 26 August 2020. These meetings covered a range of COVID-19 and non-COVID-19 related issues with a standing agenda that included a deep dive into risks of interest and horizon scanning for potential issues of interest (CW5/45 - INQ000234475 and CW5/46 - INQ000234454).

COVID-19 Battle Plan

45. By August 2020, the Department's COVID-19 Battle Plan (to oversee and coordinate the response) had been developed into version 3.0 (approved by the Secretary of State on 21 July 2020). Version 3.0 is set out below:



46. In the time period covered by this witness statement, the Department's Executive Committee (ExCo) held two 'Star Chamber' Assurance exercises, which I chaired, to test readiness across all the Battle Plan workstreams, with Senior Responsible Officers (SROs) allocated to individual workstreams and identified in the Battle Plan. These

took place on 9 September 2020 and on 28 May 2021 and included input from representatives of OGDs (CW5/47- INQ000234474; CW5/48 - INQ000234908; CW5/49 - **INQ000234962;** CW5/50 - INQ000234961; CW5/51 - INQ000234497).

47. The purpose of the first Battle Plan Star Chamber meeting on 9 September 2020 was for ExCo to review and challenge the latest Battle Plan and ensure readiness for a potential second wave, by reviewing existing workstream plans using a consistent set of scenarios.

48. On 28 May 2021, ExCo held its second Battle Plan 'Star Chamber'. The purpose of this meeting was to challenge and review Battle Plan plans out to March 2022 and ensure readiness for and discuss risks of a potential third wave.

49. Regular reporting on the delivery of the Battle Plan was provided to both the Reasonable Worst-Case Scenario (RWCS) Oversight Board and to the CO (via the centrally monitored and tracked COVID-19 portfolio of key projects and programmes). On 14 October 2020, the RWCS Oversight Board agreed updated Terms of Reference and was renamed the COVID-19 Oversight Board (CW3/40 - INQ000106564).

50. The COVID-19 Oversight Board meeting frequency was agreed to reflect the assurance needed during particular phases of the pandemic. From August 2020 to June 2021, the COVID-19 Oversight Board meetings were held weekly. This then reduced to fortnightly from June 2021 to reflect the changing phase of the pandemic response. There were 42 meetings of the COVID-19 Oversight Board in the period of this statement.

51. The COVID-19 Oversight Board's standing membership included Senior Responsible Officers (SROs) for each Battle Plan workstream, Directors representing cross-cutting functions including Finance, Legal, Analysis and the ORC, and Non-Executive Directors. The Board was chaired by the DG for Global and Public Health, as the overall Battle Plan SRO, or a delegated deputy. Throughout this period, the COVID-19 Oversight Board discussed a range of themes including various iterations of the Battle Plan (as defined below), Planning Assumptions/Scenarios over winter, and implications of the 'Roadmap out of lockdown' (the Roadmap). These discussions also included delivery plans from COVID-19 Battle Plan workstreams that reflected the objectives of the Roadmap (delivered in phases, beginning February 2021). The COVID-19 Oversight Board had a standing agenda item to run through issues and

updates from each Battle Plan workstream. Through this Board, members discussed regular updates on strategic risk and milestones. They also agreed elements of the COVID-19 response requiring further assurance. The COVID-19 Oversight Board actioned additional assurance to be undertaken through focussed sessions separate to the regular COVID-19 Oversight Board.

Red Team Challenge Sessions

52. Red Team challenge sessions were set up in response to steers from the COVID-19 Oversight Board to undertake additional assurance across elements of the Battle Plan response. The purpose of these Red Team sessions was to review and challenge, in greater depth, readiness and risks for a programme and to assure senior stakeholders that risks had been properly assessed. This included a Vaccines Red Team session on the 30 November 2020 which I chaired; this session reviewed and challenged programme plans for COVID-19 vaccine deployment and to assure readiness for day one delivery and subsequent phases of vaccine deployment (CW5/52-INQ000234632; CW5/1C - INQ000234631; CW5/54 - INQ000234798). A follow-up session on 5 March 2021 was chaired by Clara Swinson, the Director General for Global and Public Health (now DG for Global Health and Health Protection) assuring Vaccine Delivery Plans and was attended by a Challenge Panel (CW5/55 - INQ000234795 and CW5/56 - INQ000234800). Challenge Panels were originally set up in March 2020 to provide greater challenge and assurance on health family response to COVID-19 in specific areas. Red team sessions were attended by a number of senior officials across the Department as well as 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 time period covered by this witness statement – with challenge provided by subject experts including the DCMO, senior officials from OGDs, and Departmental Non-Executive Directors.

53. A separate Health Inequalities Red Team session was held on 29 April 2021 in response to advice from the COVID-19 Oversight Board, on 27 January 2021, that greater challenge and assurance was required from across the health family on the health inequalities implications of the response to COVID-19. This session focused on several Battle Plan areas namely Test and Trace, social distancing, vaccine deployment and the NHS response. The Challenge Panel discussed the plans of Test and Trace, social distancing policy and COVID-19 vaccine deployment to address health equalities impacts. This health inequalities assurance Red Team session was chaired by Jonathan Marron, Director General for Personal Protective Equipment

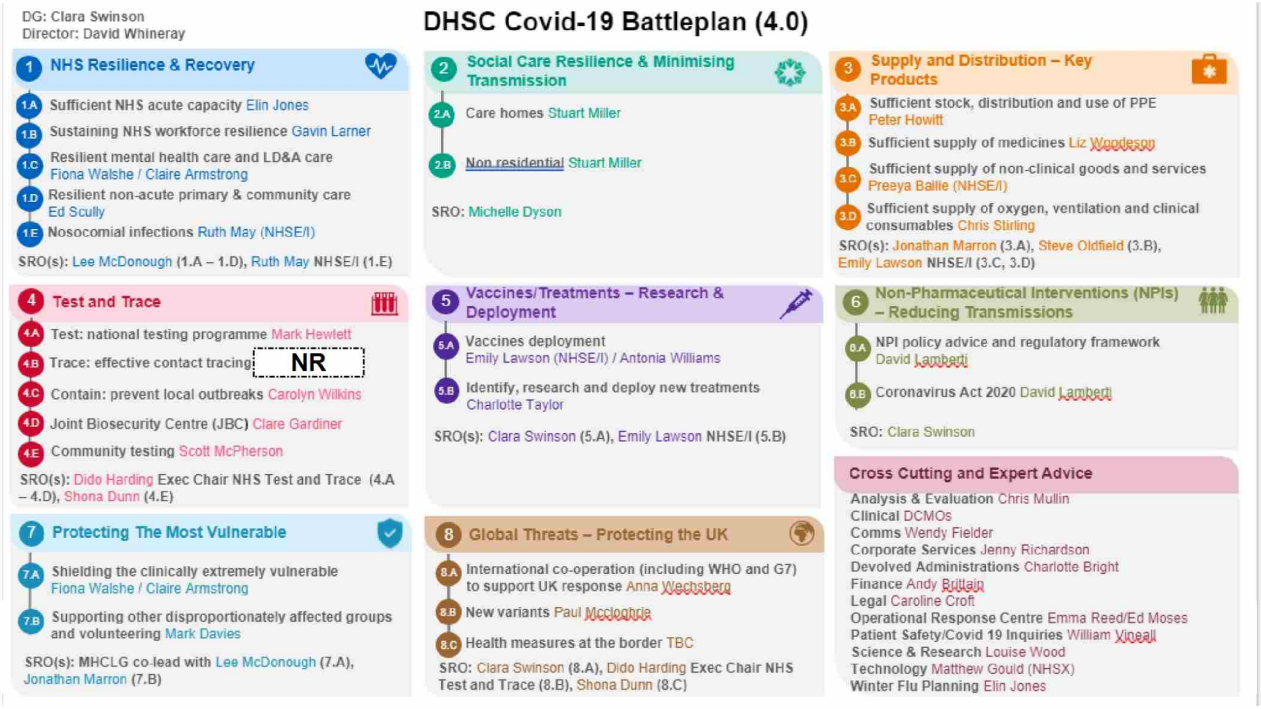
(PPE) and Public Health (28 April 2020 – 30 September 2021). The session resulted in several different actions being agreed most notably that policy teams would consider the impact of a potential third wave on disadvantaged communities (CW5/57 - INQ000234883 and CW5/58 - INQ000234904). This is covered in more detail in paragraph 465 of 'Section 7: Vulnerable Groups' below.

Battle Plan changes in this period

54. Following the September 2020 ExCo Star Chamber discussion, the Battle Plan was updated to version 3.1 to reflect changes to programmes and organisational changes. These changes included acknowledging that Michelle Dyson became the Adult Social Care (ASC) DG and SRO, the removal of the Test and Trace 'Enable' pillar (which included guidance and research segments of Test and Trace) and an update to workstream 5 'Vaccines and Treatments' to reflect the Department's role in vaccines deployment.

55. Several minor changes to the Battle Plan took place between September 2020 and January 2021, including the addition/removal of new sub-workstreams and changing of SROs to reflect organisational changes, and the health and care response priorities as the virus and the Government's response to it evolved.

56. The next significant change to the COVID-19 Battle Plan was made in February 2021 following a discussion at ExCo at which it was agreed to add a new international workstream to the Battle Plan, capturing the growing work the Department was doing in response to international developments and to protect the UK from global threats on COVID-19. After discussions with SROs this workstream was named "Global Threats – Protecting the UK," which covered 'International cooperation,' 'New Variants' and 'Health Measures at the Border.' A new sub-workstream ("Community Testing") was also added under the Test and Trace strand of the Battle Plan reflecting a new project. This version of the Battle Plan (4.0) was shared with the Secretary of State on 15 February 2021 following approval from the Battle Plan SROs. The Battle Plan version 4.0 is set out below:



57. In late May 2021, minor updates were made to the Battle Plan, to produce version 4.1. This version was discussed at the ExCo Star Chamber, which took place on 28 May 2021 (CW5/59 - **INQ000111267)**. The most notable changes from the previous version were the removal of 'Community Testing' as a separate sub-workstream (as it was merged into other areas of the Test and Trace programme) and 'sufficient supply of non-clinical goods and services' (agreed to be removed as a separate workstream with NHSEI) as well as SRO changes to workstreams 4 and 8.

58. The Battle Plan was updated again to version 4.2 in June 2021 to reflect changes following the ExCo Star Chamber discussions. The changes were agreed at the COVID-19 Oversight Board on 23 June 2021 (CW5/60 - INQ000234965). The most significant changes were to remove the shielding programme, which was a separate workstream); add Antivirals Taskforce (ATF) as a separate sub-workstream 5C; include reference to the Vaccine Taskforce (VTF) to reflect joint working on supply between the Department and the Department for Business, Energy and Industrial Strategy (BEIS); and remove 'Variants of Concern' as a separate workstream, as it was subsumed under the JBC sub-workstream under Test and Trace (4D). Version 4.2 was discussed with DGs and this version was included in a briefing to the new Secretary of State on 27 June 2021 (CW5/61 - INQ000234963).

The Vaccine Taskforce and the Medicines and Healthcare products Regulatory Agency

59. In terms of organisational responsibilities and vaccines, procurement was led by the Vaccine Taskforce (VTF), which was established April 2020 (CW5/62 - INQ000234621 and CW5/63 - INQ000234784). The VTF worked closely with science, regulation and deployment teams in the Department, the Medicines and Healthcare products Regulatory Agency (MHRA), UKHSA and NHSEI. MHRA is an executive agency of the Department and is the body that regulates medicines, medical devices and blood components for transfusion in the UK. The MHRA is globally recognised for the high standards that it requires for safety, quality and effectiveness for any vaccine. It has responsibility for continuously monitoring and evaluating relevant products on the UK market. There were regular, and for large parts daily, meetings with our Secretary of State on vaccine readiness and roll out in the time period covered by this witness statement. (CW5/64 - INQ000234785)

SECTION 2: ACCESS TO AND USE IN DECISION MAKING OF MEDICAL AND SCIENTIFIC EXPERTISE, DATA AND MODELLING

60. I understand that the corporate statement being prepared on behalf of GO-Science and the Scientific Advisory Group for Emergencies (SAGE) will address the detail of advice provided to the PM, the CO and its committees on the spread of COVID-19 and the emergence of 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 in its corporate statement.

61. in the time period covered by this witness statement, 1 August 2020 – 31 July 2021, the scientific and clinical understanding of the virus became increasingly well-developed, although there were still unknowns. The two most significant drivers of events and the response of the Government were the emergence of variants and the development of deployable vaccines. New variants, in particular Alpha from late 2020, drove different surges and need for government response. Work on treatments and vaccines continued since the beginning of the pandemic with objectives focused on those set out in the Coronavirus action plan. The COVID-19 vaccine deployment programme began on 8 December 2020 with the main aim to reduce deaths, serious disease, and hospitalisations. Within the first month of deployment over 1 million people in England had received their first dose of the COVID-19 vaccine and, by 18 July 2021, the vaccine programme met its target of offering a first dose of a COVID-19 vaccine to all adults aged 18 and over (CW5/65 - INQ000234994).

62. The developments in medical practice meant that, in the time period covered by this witness statement, there was reduced reliance on ventilators as the primary method of supporting patients with COVID-19 (CW5/66 - **INQ000257490;**). Clinical trials also partially addressed the absence of evidence to support the novel widespread use of different non-invasive ventilation, which had resulted in significant variability both in international guidelines and clinical practice during the first and second waves. The UK RECOVERY-RS (Respiratory Support) trial found that an initial strategy of Continuous Positive Airway Pressure (CPAP), a type of oxygen therapy that delivers constant and steady air pressure to help individuals breathe whilst asleep, significantly reduced the risk of tracheal intubation or mortality compared with conventional oxygen therapy (CW5/67 - INQ000234999 and CW2/1 - INQ000087225).

63. Widespread immunisation, with some additional accumulation of immunity due to prior infection and better treatment of cases before they became severe with drugs proven in clinical trials, were factors in reducing the number of patients requiring intensive care unit (ICU) admission for severe COVID-19, with numbers of patients requiring admission to the ICU falling substantially in spring 2021 (CW5/68 - INQ000234766).

64. Evidence about the virus had emerged over time following evaluation of greater clinical data, increased testing evidence and international data; that is to be expected. In the case of a novel pathogen, scientists relied upon the existing body of scientific knowledge of similar types of viruses whilst rapidly reviewing the emerging data to inform the national response to the virus. All the Department could do to inform its understanding of the nature and spread of COVID-19 in the period from 1 August 2020 to 31 July 2021 was to use the information available to it at that time.

65. The scientific advice relied on by the Government included both independent advisory groups and scientists employed by Government, including the Department, PHE clinicians and public health experts.

66. The scientific community's understanding of the virus changed rapidly over the course of 2020. As new evidence emerged, the scientists advising the Government had to present the strength of evidence at the given time. It was then for the Government to consider this scientific advice alongside wider factors, in order to make the most appropriate policy decision at the given time. Sometimes scientists had a range of

views. This debate and evolution within the scientific view of evidence shaped the advice that the Government received.

Variants

67. On 18 December 2020, representatives of NERVTAG and SPI-M-O met to consider the Alpha variant. In summary, NERVTAG had moderate confidence that the Alpha variant demonstrated a substantial increase in transmissibility compared to other variants (CW5/69 - INQ000234683 and CW5/70 - **INQ000128575)**. Following this meeting, on 19 December 2020 a public statement was given highlighting the concerns as to the transmissibility of the virus (CW5/71 - INQ000234671).

68. On 21 December 2020 NERVTAG announced that the committee had high confidence that the B.1.1.7 Alpha variant could spread faster than other SARS-CoV-2 virus variants that were circulating in the UK at the time (CW5/70 - INQ000234663 and CW5/72 - INQ000234684).

69. On 21 January 2021 NERVTAG prepared a paper for SAGE highlighting available evidence on the Alpha variant (CW5/73 - **INQ000072527)**. A second paper on this topic was prepared by NERVTAG for SAGE on 11 February 2021 (CW5/74 - INQ000234738). It concluded that new analysis was consistent in indicating some increase in disease severity from people infected with the B.1.1.7 Alpha variant and there was a realistic possibility that infection with B.1.1.7 was associated with an increased risk of hospitalisation and death when compared to infection with non-Alpha variant viruses.

70. By April 2021, signals were seen in India of potential new variants, with a surge in cases reported. These variants were later classified as Delta and Kappa. In the UK, cases of Delta and Kappa were initially predominantly in those travelling from India. However, Delta began to exhibit a more rapid growth rate and went on to dominate globally in 2021. This was occurring at the same time as the UK was rapidly vaccinating its population and gradually lifting non-pharmaceutical interventions (NPIs). Laboratory studies showed that Delta was intrinsically more transmissible than previous variants.

SECTION 3: THE DEPARTMENT'S UNDERSTANDING OF, AND RESPONSE TO, THE SPREAD OF COVID-19

71. This section of my statement will cover what the Department understood about the COVID-19 virus during the period 1 August 2020 to 31 July 2021 and the Department's response to that understanding. Detail about legislation which implemented the policy decisions over this time period is contained in Section 6.

72. In my First Witness Statement for this Module, I covered the Department's work from the declaration of the pandemic and the management of and response to the first wave up until July 2020. In the period of this statement (1 August 2020 – 31 July 2021), the virus adapted in the UK and globally and the Government responded accordingly. Health and social care aspects continued to be the main business of the whole Department, working with its ALBs. The Department planned for and responded to future waves, based on scientific and clinical advice, and continued to use the Battle Plan to organise its response. The two most significant drivers of events were the emergence of variants and the development of deployable vaccines.

73. After the first wave of Wuhan or wild-type COVID-19, new variants developed and over time a number of different variants became dominant. There was a strong understanding of the epidemiology of the virus through continued scientific development and very high levels of population testing and genomic sequencing. New variants drove different surges and the need for government response, in particular Alpha from late 2020.

74. As I set out in my First Witness Statement for this Module, the tools available in most pandemics and epidemics especially of respiratory pathogens, are testing, NPIs, vaccines and therapeutics. All pandemics in recent history have been addressed by scientific understanding leading to pharmaceutical countermeasures, such as vaccines and treatments. In the first part of 2020 when there was very little known about the new virus, testing and NPIs were dominant in our response. In the time period of this statement, the scientific and clinical understanding of the virus became increasingly well-developed, although there were still unknowns. The balance of the tools available had therefore changed substantively by summer 2021 to a vaccines-led approach. Continued use of testing, therapeutics and NPIs were also important.

75. Work on vaccines had commenced right at the start of the pandemic with objectives focused on those set out in the 3 March 2020 document: "Coronavirus action plan: a

guide to what you can expect across the UK" (CW3/8 - INQ000057508). The early focus was on research, clinical trials and collaboration across science, industry, and government. In this period, while all these things continued, the development of viable vaccine candidates meant that procurement, supply, regulation, deployment planning and implementation were all primary parts of the Government's response.

76. The development of therapeutics followed a similar path in this period, with continued clinical trials alongside procurement, regulation and deployment. As would be expected the first developments which had impact on mortality were testing of existing, known drugs repurposed for COVID-19. Experience and research also led to improved evidence-based clinical management. Being able to deploy repurposed and newly licensed therapeutics allowed the Government and the NHS to have more effective treatment options for those who did become seriously ill, alongside the preventative effects from vaccines, and therefore reduce the reliance on NPIs.

77. Given the progress of the virus and the vaccine programme, there were therefore periods of loosening and tightening of the NPIs. There were three main phases: loosening from summer 2020 into autumn 2020, the 2020/21 winter period where both regional and national measures tightened, and then the loosening again, as set out in the Roadmap, as the winter waves subsided. As it became evident that there were successful vaccine candidates that were safe and effective, it allowed the Government to respond to the pandemic and a new wave with vaccine rollout. NPIs in this period could also therefore be used with a more certain end point: i.e., when vaccines were available and deployed.

78. Testing also remained a crucial tool in this period, and capacity continued to increase. By 26 April 2021, over 134 million tests had been carried out in England. Increased testing capacity meant more tests could be processed when they were needed, reducing the chance of processing tests causing delays when meeting the clinical needs of patients, staff, and providing free asymptomatic testing to the whole population.

79. This section now sets out a more detailed chronology of the time period summarised above, development of the virus and the relative use of the four tools (testing, NPIs, vaccines and therapeutics) described above.

Vaccines

80. As explained in my First Witness Statement for this Module at paragraph 289, the VTF was set up in April 2020.It was recognised from the beginning of the pandemic that pharmaceutical interventions would be the best long-term route out of the pandemic.

81. This is reflected in the fact that the MHRA was poised to consider any potential vaccine(s) as soon as possible and that the VTF was established to ensure that stocks of vaccines were bought early.

82. The Government set up the VTF with the objective of securing effective vaccines for the UK as quickly as possible. It also played an important coordination role regarding the research efforts of the Government with industry, academics and funding agencies to expedite vaccine development and deployment. In addition to the VTF, the following bodies carried out the roles as set out in the table below in respect of vaccines:

Body	Responsibility
The Department	Central coordination role across organisations, deployment policy and legislation, overall communications and marketing (alongside CO), security (UK Covid Vaccine Security), oversight of key clinical planning scenarios (via CMO/DCMO).
NHSEI	Vaccine deployment, data infrastructure, access & equity, uptake, clinical oversight of deployment programme, operational guidance, vaccine supply chain.
BEIS	Purchasing vaccines, develop manufacturing capacity to secure the UK's supply.
VTF	Commercial, market development, procurement, supply management, research & development, onshoring, future preparedness, international dose sharing.

Joint Committee on Vaccination and Immunisation	Advising on eligibility and prioritisation for vaccination, and on which vaccines can be given to which groups.
MHRA	Providing authorisation for vaccines and monitoring safety after approval.
Commission on Human Medicines	Providing advice to Ministers and the MHRA for the approval of the vaccines.
PHE	Public Health advice on all aspects of vaccination, including updates to 'Immunisation against infectious disease' (the 'Green Book') and the development of patient group directions (PGDs) for the administration of COVID-19 vaccines. Supply, storage and distribution of the vaccine within the UK.

83. From May 2020 the Joint Committee on Vaccination and Immunisation (JCVI) met regularly to consider COVID-19 vaccination. The JCVI considered the emerging clinical and epidemiological data with a view to providing advice on COVID-19 vaccination.

84. In June 2020, JCVI published interim advice (CW5/75 - INQ000106485) on priority groups for vaccination including the priority vaccination of frontline health and social care workers and those at "*increased risk of serious disease and death from COVID-19 infection stratified according to age and risk factor*".

85. On 25 September 2020, JCVI published updated interim advice advising that care home residents and staff receive vaccines first, followed by people aged over 80 and health and social workers, before rolling out to the rest of the population in order of age and risk (CW5/76 - INQ000234514).

86. The UK joined COVID-19 Vaccines Global Access' (COVAX) "Self-Financing Facility" in September 2020 (CW5/77 - INQ000234496). This was an international joint procurement initiative aimed at enabling higher income countries to share the costs and risks of investing in a diverse vaccine portfolio. The VTF made a total upfront payment of £83m to COVAX as a self-financing participant in October 2020 to access procurement options for up to 27 million doses (CW5/78 - INQ000234528).

87. The COVAX Advanced Market Commitment (AMC) was established to support 92 countries and territories eligible for overseas development assistance to access donor-funded COVID-19 vaccine doses. The UK donated £548 million to COVAX AMC specifically to support vaccine access in lower income countries. The UK used its G7 Presidency to mobilise G7 countries to donate vaccines that were surplus to domestic need. In June 2021, ahead of the G7 Summit, the UK committed to donate a total of 100 million doses of COVID-19 vaccines to countries in need.

88. Between 24 September 2020 and 22 December 2020, a JCVI COVID-19 committee met most weeks to provide advice to support the Government in delivery of a vaccination programme to the population.

89. In October 2020, the Government made changes to the Human Medicines Regulations 2012 (the Human Medicines Regulations) to allow the MHRA to grant temporary authorisation of a COVID-19 vaccine without needing to wait for approval by the European Medicines Agency (EMA). Until the end of the transition period of the UK's withdrawal from the EU (31 December 2020), the UK would usually have had to wait for the EMA to approve a vaccine before looking to distribute it. However, in an emergency, EU countries have permission to use their own regulator to issue a temporary authorisation.

90. The Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 provided for the expansion of the workforce legally able to administer a COVID-19 or influenza vaccine under an approved national protocol and allowed vaccinations to happen on sites other than registered pharmacies (CW5/79 - INQ000234567). These regulations were made on 15 October 2020 and the relevant amendments came into force on 17 October 2020 (CW5/80 - INQ000234566). These regulations included measures to support temporary authorisations to supply any unlicensed products in response to public health threats and more flexible deployment of COVID-19 and influenza vaccines, in particular at the end of the supply chain.

91. Regulation 174 of the Human Medicines Regulations already provided for temporary authorisation of the supply of unlicensed medicines in response to public health threats (which became known as 'emergency authorisations'). This provision was subsequently fleshed out to include conditions attached to emergency authorisations. This change was needed to provide certainty about the nature of the MHRA's power in this area and the conditions attached to emergency authorisations. There were also

some modifications to the existing arrangements for partial immunity from civil liability, which are an intrinsic part of the emergency authorisation scheme.

92. These new measures included the creation of new immunisation protocols and revisions of the powers to supply under patient group directions. A new national immunisation protocol was introduced, which allowed those who were registered healthcare professionals who would not normally vaccinate and people who were not registered healthcare professionals to safely administer a licensed or temporarily authorised COVID-19 or influenza vaccine. Additionally, the workforce legally allowed to administer vaccines under health service occupational health schemes was expanded. This allowed additional healthcare professionals in the occupational health workforce to administer these particular vaccines, subject to compliance with the conditions set out in the protocol. Each protocol has to be approved by Ministers and, to date, these protocols have been detailed in what they required.

93. Running in parallel the MHRA used a procedure called 'rolling review' to speed up regulatory approval of promising vaccines. A 'rolling review' can be used to complete the assessment of a promising medicine or vaccine during a public health emergency in the shortest time possible. This is done as the packages of data become available from ongoing studies on a staggered basis.

94. On 10 November 2020, the Secretary of State announced that he had tasked the NHS to prepare and be ready for a vaccination programme to begin from any date after 1 December 2020 (CW5/81 - INQ000234617).

95. On 2 December 2020, the Pfizer COVID-19 vaccine (Pfizer-BioNTech) gained regulatory approval from the MHRA under regulation 174 of the Human Medicines Regulations. On the same day the JCVI confirmed nine priority groups for vaccination, with initial prioritisation given to older people, clinically vulnerable groups, and frontline health and social care staff (CW5/82 - INQ000234638). The Secretary of State updated Parliament the same day.

96. Until December 2020, the only COVID-19 vaccines that have, subject to conditions, been supplied in the UK under emergency authorisations under regulation 174 of the Human Medicines Regulations were the Pfizer-BioNTech and Oxford/AstraZeneca vaccines (the Department's role in the development of the latter is detailed in a separate sub-section below). The amending regulations to the Human Medicines

Regulations detailed above were made during the transition period and so compatibility with EU law was essential. A further set of amendments was made to the Human Medicines Regulations in December 2020 (CW5/83 - INQ000234688) in support of the vaccines deployment, but this did not materially affect the position set out above. No further amendments have been made to the Human Medicines Regulations in support of the vaccine deployment since December 2020, apart from the extension of the provisions that were time limited.

97. The NHS began vaccinating patients against COVID-19 on 8 December 2020. It was the start of the biggest immunisation programme in UK history. The aim of the vaccination programme was to reduce deaths, serious disease, and hospitalisations. The University Hospital Coventry and Warwickshire NHS Trust administered the first vaccine (Pfizer-BioNTech).

98. The table below shows the COVID-19 vaccination first phase priority groups as at 30 December 2020:

Priority	**Risk group**
1	Residents in a care home for older adults and staff working in care homes for older adults
2	All those 80 years of age and over and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)
5	All those 65 years of age and over
6	Adults aged 16 to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over

Priority	Risk group
8	All those 55 years of age and over
9	All those 50 years of age and over
10	Rest of the population (to be determined)

99. Within the first month of deployment over one million people in England had received their first dose of COVID-19 vaccine.

100. On 30 December 2020, the Oxford/AstraZeneca COVID-19 vaccine gained regulatory approval from the MHRA (CW5/84 - INQ000234686). The UK CMOs agreed with the JCVI that, at that stage of the pandemic, first doses should be prioritised to protect the greatest number of at-risk people overall in the shortest possible time meaning the second dose would in general be given 12 weeks after the first. The UK CMOs agreed this approach would have the greatest impact on reducing mortality, severe disease, and hospitalisations, and in protecting the NHS and equivalent health services.

101. The introduction of the vaccine programme over the longer term offered the way in which the Government could relax COVID-19 related restrictions. The progress and impact of the vaccination programme therefore became important considerations when decisions were made on the relaxation of COVID-19 restrictions, as described in the subsequent sections of this statement.

102. Surveillance of vaccine safety and adverse reactions does not stop following approval. The MHRA and UKHSA constantly reviewed a wide range of available data regarding safety of the vaccines, including reports of adverse reactions from the UK and international reports. As part of this surveillance, the MHRA continued to review all suspected Adverse Drug Reaction reports (known as Yellow Card reports) relating to COVID-19 vaccines.

103. Through the MHRA Yellow Card reports scheme, members of the public and healthcare professionals are able to report any suspected side effects. This surveillance strategy aims to alert the regulator and others to any unforeseen adverse reactions to the vaccines. This enables swift action to be taken when required.

104.Moving into 2021 the vaccine roll out had begun, and the UK was in a stronger position to manage COVID-19 using pharmaceutical interventions. By the end of February 2021, 20,275,451 people in the UK had received their first dose of a covid vaccine, with 17,212,804 first doses in England. There were four treatments available to hospitalised patients: dexamethasone, tocilizumab or sarilumab and remdesivir. There were additional treatments in the pipeline being investigated in UK trials and UK-CTAP were identifying scope for further trials to be set up for treatments which did not meet the criteria of existing trials.

105.On 4 January 2021, the NHS rolled out the Oxford/AstraZeneca COVID-19 vaccine, the first health service in the world to deploy the vaccine (CW5/85 - INQ000234692).

106.On 6 January 2021, the JCVI published advice on prioritising first doses, with a maximum interval of 12 weeks between first and subsequent doses (CW5/86 - INQ000234700).

107.On 8 January 2021, the Moderna COVID-19 vaccine gained regulatory approval from MHRA (CW5/87 - INQ000234703).

108.On 11 January 2021, the UK Government published the UK COVID-19 Vaccines Delivery Plan (the Delivery Plan), which set out plans for delivering the target of vaccinating the top four priority cohorts by 15 February 2021, and then expanding the programme so all adults could be vaccinated by autumn 2021. The Delivery Plan also detailed "that the second vaccine dose was likely to be very important for duration and sustaining such protection, and at an appropriate dose interval may further increase vaccine efficacy" (CW5/88 - INQ000234707). The Delivery Plan was developed in close collaboration with the Devolved Governments who published their own delivery plans.

109.The Delivery Plan set out three main routes through which the public could get vaccinated, with the aim of catering to different preferences and making access as easy as possible: (1) hospital hubs, based at NHS trusts, which primarily vaccinated health and care staff; (2) local vaccination services, comprising groups of primary care networks, led by general practitioners (GPs), community pharmacies and including settings such as mobile services, pop-up and walk-in clinics; and (3) vaccination centres set up specifically for COVID-19 vaccinations and based in venues such as

stadiums, theatres and hotels and run by NHS trusts, primary care networks or pharmacies.

110. On 14 February 2021, the NHS met its target, outlined in the Delivery Plan, a day ahead of schedule to offer everyone in the top four priority cohorts a COVID-19 vaccine (CW5/89 - INQ000234748).

111. On 15 February 2021, the NHS extended the rollout to all those aged 65 and over as well as all those aged 16 or above with underlying health conditions (CW5/90 - INQ000234751). These plans formed a key part of the Roadmap.

112. By 31 March 2021, in England, 26,454,219 million people had received their first COVID-19 vaccine with another 3,519,105 million having received their second dose, a combined total of 29,973,324 doses.

113. On 7 April 2021, following reports of extremely rare cases of concurrent thrombosis and thrombocytopenia following vaccination with the first dose of the Oxford/AstraZeneca COVID-19 vaccine, the Government accepted advice from the JCVI that adults under 30 without underlying health issues should be offered an alternative vaccine to the Oxford/AstraZeneca COVID-19 vaccine if available (CW5/91 - INQ000234852). There had been no signal for thrombosis/thrombocytopenia arising from other COVID-19 vaccines approved for use in the UK (Pfizer-BioNTech and Moderna). The JCVI noted there was a high level of uncertainty in estimates of the incidence of this rare adverse event by age group. However, the available data suggested "*there may be a trend for increasing incidence of this adverse event with decreasing age, with a slightly higher incidence reported in the younger adult age groups.*" The JCVI extended this advice in May 2021 to adults under 40 without underlying health issues and the Government accepted it on 7 May 2021 (CW5/92 - INQ000234899).

114. By mid-April 2021, all adults over 50, the clinically vulnerable and frontline health and social care workers had access to COVID-19 vaccination. This met the target to offer a first vaccine dose to priority Groups 1-9 by 15 April 2021 (CW5/93 - **INQ000257443;**).

115. From 13 April 2021, Phase 2 of the vaccine programme initially aimed to have offered a vaccination to all individuals in JCVI groups 10 to 12 by the end of July 2021 (CW5/94 - **INQ000257445** and CW5/95 - **INQ000257444**). Groups 10 to 12 are:

Priority	Risk group
10	All those aged 40-49 years
11	All those aged 30-39 years
12	All those aged 18-29 years

116. However, a new target of offering all adults a first dose, and two thirds of adults their second dose, by 19th July 2021 was set by the PM. By 18 July 2021, the vaccine programme met this target (CW5/96 - INQ000234990).

117. The table below summarises the percentage of priority groups vaccinated with 1 or 2 doses by each date the Roadmap was eased. All data provided reflects uptake as close to the Roadmap dates as possible This means data is published after the Roadmap. As a result, this data does not reflect uptake which was publicly available on the dates requested (CW5/97- **INQ000257491;** CW5/98 - **INQ000257499;** CW5/99 - **INQ000257500;** CW5/100 - **INQ000257501;** CW5/101 - **INQ000257502;** CW5/102 - **INQ000257504;** CW5/103 - **INQ000257503;** CW5/104 - **INQ000257505;** CW5/105 - **INQ000257506;** CW5/106 - **INQ000257507;** CW5/107 - **INQ000257508;** CW5/108 - **INQ000257492;** CW5/109 - **INQ000257493;** CW5/110 - **INQ000257494;** CW5/111 - **INQ000257495;**).

JCVI priority groups	Priority group coverage	Dose	% vaccinated by 09/03/2021	% vaccinated by 30/03/2021	% vaccinated by 13/04/2021	% vaccinated by 18/05/2021	% vaccinated by 20/07/202
1	Older adult care home residents *1	1st dose	91.7	93.4	94.0	94.9	95.9
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	82.5	93.4
	Older adult care home staff*2	1st dose	73.4	77.7	79.5	82.6	87.1
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	60.5	77.2
2	All over 80s **1	1st dose	93.4	94.3	94.7	95.0	95.3
		2nd dose	15.5	40.5	74.5	91.1	93.3
	Trust health care workers in the ESR***	1st dose	80.5	84.9	86.2	87.8	91.0
		2nd dose	10.0	39.1	62.1	78.3	85.7
		1st dose	68.6	73.6	75.3	78.9	84.0

	Independent CQC registered younger adult care homes staff*[2]	2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	55.8	74.5
	Independent CQC registered domiciliary care provider staff*[2]	1st dose	62.9	68.5	70.8	74.9	79.6
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	45.2	63.6
	Social care workers from other settings (including non-registered providers and local authorities)*[2]	1st dose	63.2	68.6	69.5	73.8	76.6
		2nd dose	N/A or not reported	N/A or not reported	N/A or not reported	18.3	31.7
3	All 75-79**[3]	1st dose	93.8	94.5	94.8	95.2	95.4
		2nd dose	0.9	11.8	48.2	92.2	94.2
4	All 70-74**[3]	1st dose	92.5	93.4	93.6	94.1	94.4
		2nd dose	0.5	4.5	21.6	90.4	93.1
	CEV***	1st dose	89.5	91.6	92.3	93.1	94.0
		2nd dose	4.3	13.6	33.6	84.9	91.1
5	All 65-69***[3]	1st dose	86.3	90.4	90.9	91.6	92.2
		2nd dose	0.6	3.2	9.1	79.8	90.4
6	All 16-64 with underlying health conditions and unpaid carers***[1]	1st dose	N/A or not reported	76.9	79.6	81.3	84.8
		2nd dose	N/A or not reported	3.8	8.0	45.3	78.2
7	All 60-64**[3]	1st dose	62.8	86.8	87.9	88.8	90.3
		2nd dose	1.0	4.4	9.0	45.6	87.3
8	All 55-59**[3]	1st dose	38.0	82.3	85.2	86.4	88.4
		2nd dose	1.2	4.8	9.2	33.7	84.7
9	All 50-54**[3]	1st dose	30.6	77.7	81.9	83.7	85.8
		2nd dose	1.1	4.5	8.5	27.8	81.5

Footnote Reference	**Explanation**
*	Adult Social Care residents and staff - https://www.gov.uk/government/statistics/adult-social-care-in-england-monthly-statistics-september-2022 extracted 17 March 2023, time series was not backdated but is published first Thursday of each month. Reported care home data is for week ending 1 day later than the date listed in the table for all dates, e.g., data for 08/03/2021 is week ending 09/03/2021.

**	All age breakdowns - UK COVID-19 Surveillance reports. https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2020-to-2021-season. Publication and extraction dates differ by date in table, they are a day earlier than date requested: 08/03/2021 = Publication date 11 March 2021 (07/03/2021); 29/03/2021 = Publication date 1 April 2021 (28/03/2021); 12/04/2021 = Publication date 15 April 2021 (11/04/2021); 17/05/2021 = Publication date 20 May 2021 (16/05/2021); 19/07/2021 = Publication date 22 July 2021 (18/07/2021).
***	Trust health care workers, CEV and All 16-64 with underlying health conditions. https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/covid-19-vaccinations-archive/ extracted 17 March 2023. All NHSEI data in this table is 1 day before the date listed, e.g., data for 08/03/2021 is data up to 07/03/2021. CEV uptake percentages for second dose have not been explicitly published for 07/03/2021, 28/03/2021, 11/04/2021 and 16/05/2021 but numerators and denominators have, with the numerator being the number of 1st and 2nd doses administered to the clinically extremely vulnerable cohort and the denominator being the number identified as clinically extremely vulnerable. Trust HCW uptake percentages have not been explicitly published, however both numerator and denominator have, the numerator being the number of 1st and 2nd doses administered to NHS trust health care workers and the denominator being the number of NHS trust health care workers in ESR. All 16-64 with underlying health conditions uptake percentages for second dose have not been explicitly published for 28/03/2021, 11/04/2021 and 16/05/2021 but numerators and denominators have, with the numerator being the number of 1st and 2nd doses administered to those aged 16-64 identified as At Risk or a Carer and the denominator being the number identified as At Risk or a carer.
1	Denominators for care home residents, care home staff and social care staff are the totals as reported by care providers in Capacity Tracker. This total may include some residents and staff who cannot currently be vaccinated for valid medical reasons and residents whose vaccination status is currently unknown. The percentage of individuals who have not received the vaccine cannot be directly derived from this data because there are a number of individuals with an unknown vaccination status. Some care providers have reported the total number of staff or residents but not the numbers vaccinated and as a result of this, vaccination rates are affected by response rates.
2	Vaccinations carried out in England are reported in the National Immunisation Management Service (NIMS). This is the system of record for the vaccination programme in England, including both hospital hubs and local vaccination services. England data by vaccination date use UKHSA data. Geographic locations of vaccinations are based on where the people who were vaccinated live, and not where the vaccination was given. Vaccinations to England residents that were given outside of England are included if they have been recorded in NIMS. It is possible that the number of people vaccinated in surveillance figures may reduce over time, due to people dying or moving out of a resident population.

3	Clinically Extremely Vulnerable figures represent those who are currently on the Shielded Patient List as of 1 to 4 days before the end of the reported date, excluding additional patients identified by the QCovid risk assessment tool. These figures exclude a small number of patients who have been flagged as being deceased, who are under 16 years of age or who have not been matched to a GP in England (including those with no GP practice record). With the exception of under 16s, Clinically Extremely Vulnerable individuals are included in these figures regardless of age, therefore some may have been vaccinated as part of a higher priority group.
4	Individuals in this group have been identified from five different data sources: 1) those identified as At Risk or a Carer in GP records, 2) those identified at risk by the QCOVID assessment tool, 3) those in receipt of a carer's Allowance, 4) those on the GP Learning Disability Register and 5) those identified as unpaid carers by Local Authorities. Every individual only appears once in this group so there is no double counting, however individuals are included in these figures who may have been vaccinated as part of another high priority group such as the Critically Extremely Vulnerable (CEV) and Healthcare workers so there is some overlap with this data. Individuals aged 65 and over have been excluded from the figures.

118.A summary of the vaccines ordered is set out below:

Vaccine	**Code-name**	**Details of orders**
Oxford/ AstraZeneca	Triumph / Sceptre	**Initial supply agreement:** 28th August 2020 100m doses were ordered. Of which, 99,755,240 were delivered. 22nd June 2022 The UK Government and Oxford/AstraZeneca mutually agreed that the remaining doses would neither be supplied nor charged for.
Pfizer / BioNTech	Ambush	**Initial supply agreement:** 12th October 2020 40m doses of Comirnaty (BNT162b2, BioNTech/Pfizer) vaccine 29th of March 2021 40m Comirnaty (BNT162b2, BioNTech/Pfizer) vaccine 9th of April 2021 20m Comirnaty (BNT162b2, BioNTech/Pfizer) vaccine 1st of June 2021 5,000 Comirnaty (BNT162b2, BioNTech/Pfizer) vaccine

		COVAX: 7th of June 2021 539,370 Comirnaty (BNT162b2, BioNTech/Pfizer) vaccine 2022/2023 Supply Agreement: 10th of August 2021 35m doses 30th November 2021 35m dose order revised to 89,001,720 (89m split out as 77m adult doses and 12m 5-11yr doses) 16th November 2021 The 89m dose order is revised again so that the split is (77,005,800m adult doses, 10,993,200 5-11yr doses and 1,003,200 6month – 4yr doses) Total ordered is ~189,546,000
Valneva	Victorious	September 2020 60m doses ordered September 2021 This order was reduced to zero doses
GSK/Sanofi	Valiant and Agamemnon	September 2021 Contract signed for 7.5m dose order (2023 delivery)
Novavax	Audacious	March 2021 60m doses
Janssen	Astute	January 2022 10m doses ordered February 2022 10m doses ordered
Moderna	Renown	November 2020 7m doses ordered December 2020

		10m doses ordered November 2021 60m doses ordered

Vaccines – AstraZeneca vaccine development

119. The University of Oxford announced that it had begun research into the development of a vaccine for the novel coronavirus on 7 February 2020. By 18 March 2020 it had identified a vaccine candidate for COVID-19 with clinical trials opening on 27 March 2020. The Government supported this research by investing £10.5m across six successful applicants developing a vaccine, of which the University of Oxford was one (CW5/112 - INQ000234337).

120. On 21 March 2020, Professor Sir John Bell, the Government's Life Sciences Champion, introduced procurement representatives from AstraZeneca to Lord James Bethell and Kathy Hall, then Director of Technology and Data Strategy in NHSX, to discuss setting up a system for accelerated procurement around key products (CW5/113 - INQ000234338). An initial meeting with AstraZeneca was subsequently organised for 22 March 2020 and included Lord Bethell, Sir Patrick Vallance (the Government Chief Scientific Adviser (GCSA)), Sam Roberts (the Director of Innovation and Life Sciences in NHSE), and Kathy Hall (CW5/114 - **INQ000234339;**).

121. Sir Stephen Lovegrove, the Permanent Secretary for the Ministry of Defence, led early conversations, alongside Madelaine McTernan, then Director at UK Government Investments (UKGI) before becoming the Director of the VTF and lead negotiator from December 2020 – October 2022, representing the Government's position with potential manufacturers, including AstraZeneca.

122. The GCSA held a meeting with the University of Oxford on 2 April 2020 to understand the nature of an approach from the American company, Merck, and the proposed relationship between Merck and Oxford University for developing a vaccine. This was reflected in advice submitted to the Secretary of States for the Department and BEIS dated 3 April 2020 (CW5/115 - INQ000234341 and CW5/116 - INQ000234722). The submission highlighted that most of the institutions developing vaccines were often academic groups or small companies and that scaling the manufacture of any vaccine

would be challenging but that the Department was working with the BioIndustry Association to consider those challenges.

123. On 17 April 2020, the GCSA and the Secretary of State agreed to establish the VTF to continue the rapid development and production of a COVID-19 vaccine. The taskforce was led by the GCSA, DCMO Professor Sir Jonathan Van Tam, and additional representatives from Government, academia, and industry (CW5/117 - INQ000234344). The GCSA and DCMO subsequently set up an Expert Advisory Group to advise the VTF on how best to ensure that the UK population had access to clinically effective and safe vaccines as soon as possible. Members included representatives from clinical and manufacturing fields such as AstraZeneca, the Coalition for Epidemic Preparedness Innovations (CEPI), the Engineering and Physical Sciences Research Council (EPSRC), Imperial College London, the Jenner Institute, the MHRA, the University of Oxford and the Wellcome Trust (CW5/118 - INQ000234343).

124. On 20 April 2020, the Secretaries of State for the Department and BEIS were informed that the University of Oxford had initiated discussions with Merck regarding the licensing of Oxford's COVID-19 vaccine. An accompanying submission recommended the approval of initial principles to form the basis of any negotiations of a licensing agreement between the University of Oxford and partner pharmaceutical companies with whom this might be done (CW5/119 - INQ000234345; CW5/120 - INQ000233803; CW5/121 - INQ000234346). The initial principles were (CW5/122 - INQ000234350):

    a. *"HMG's overriding objectives are to provide adequate immunisation courses to the UK domestic market and to ensure the vaccine is available to the world at a scale of billions of doses as soon as possible.*
    b. *HMG are keen to promote manufacturing of the* [vaccine] *in the UK. As such, it is seeking:*

        i. *Support from [company] to train staff in practising viral vectors, initially at the Cell and Gene Catapult in Stevenage and subsequently at the [Vaccine Manufacturing and Innovation Centre (VMIC)].*
        ii. *Oxford to retain the right to contract manufacture the vaccine in the UK for the domestic UK market only.*
        iii. *Engagement with [company] regarding the establishment of a [company] manufacturing facility in the UK.*

c. *Further, recognising the above measures will not result in adequate immunisation courses for the UK in the near term, in order to ensure the secure supply of immunisation courses for the UK, HMG would expect access rights to the vaccine from the point of initial production (with expected timing and location of initial production to be discussed).*

d. *Total UK supply of immunisation courses to be set at an agreed volume to be discussed with pricing at cost during the pandemic period and costs to be agreed post the pandemic period."*

125. Regarding these commissions, the Secretary of State expressed concern that the Government was not doing enough to support the University of Oxford by talking to other pharmaceutical manufacturers such as GlaxoSmithKline (GSK) and AstraZeneca (CW5/123 - INQ000234347).

126. On 25 April 2020, the PM wrote a letter to the Chancellor of the University of Oxford, the Right Honourable Lord Patten of Barnes, and Vice Chancellor, Professor Louise Richardson. The letter acknowledged that the University's objectives aligned with the Government's and that they had commenced discussions with third parties in order to identify the best partner to deliver these objectives. The PM asked to be kept informed about negotiations and that the Chancellor of the Exchequer spoke with the Chancellor and Vice Chancellor of the University of Oxford on HMG's objectives to ensure that a deal did not risk giving *"walk-in rights"* (more commonly known as "step-in –rights") to other countries which could put UK and global supply at risk (CW5/124 - INQ000234348 and CW5/125 - INQ000234349).

127. Professor Sir John Bell led on the issue of corporate vehicles, potential licensing agreements and the coordination across academics from the University of Oxford (CW5/123 - INQ000234347). On 27 April 2020, Ms McTernan informed the Department's Secretary of State that previous discussions between Sir John Bell and GSK found that the company were focused on the candidate vaccine with Sanofi, which was announced a week prior, and did not see an opportunity to further collaborate. A phone call between Sir John Bell and GSK on 26 April 2020 confirmed that their position remained unchanged. The Secretary of State was then informed by Ms McTernan that the University of Oxford had opened discussions with AstraZeneca, who were interested in building a manufacturing facility in the UK (CW5/126).

128.Shortly thereafter, it became clear that Merck would not be able to deliver sufficient quantity of vaccine for the UK (CW5/126 - INQ000234351). At this time, the VTF received a draft non-binding term sheet from AstraZeneca. This was reviewed by the GCSA, the DCMO, Ms McTernan and officials from the Department, BEIS and HMT to ensure that Government principles were captured (CW5/127 - INQ000234352) and an amended term sheet was drafted, drawing on the expertise of Clifford Chance LLP and Sir Stephen Lovegrove (CW5/128 - INQ000234360). On 28 April 2020, the Secretaries of State for the Department and BEIS received the term sheet from AstraZeneca. An accompanying submission recommended that they agree that the University of Oxford and AstraZeneca should announce their collaboration (CW5/129 - INQ000234353).

129. Lord Bethell, Minister Zahawi, the Chancellor, the Secretary of State for BEIS and No.10 confirmed they were content and the feedback from the Secretary of State was that a strong, unwavering commitment was needed from AstraZeneca to supply the whole of the UK population and about ensuring domestic manufacture. On 30 April 2020, the University of Oxford announced a partnership with AstraZeneca for the development and potential large-scale distribution of a COVID-19 vaccine candidate (CW5/130- INQ000234354; CW5/131 - INQ000234355; CW5/132 - INQ000234356; CW5/133 - INQ000234358; CW5/134 - INQ000234359; CW5/135 - INQ000234357).

130.On 1 May 2020, the VTF informed the Secretaries of State for the Department and BEIS of their continued work with officials from HMT, UKGI and the Department for International Development on the final Heads of Terms between the University of Oxford and AstraZeneca. This was to ensure the Heads of Terms had a view to the UK national interest in the University of Oxford's COVID-19 vaccine (CW5/136 - INQ000234361). A business case for the full £65.5 million manufacturing costs, including the £12.2 million upfront costs already approved, and contracts for £19.9 million for clinical trials were also worked on with the University of Oxford and the National Institute for Health and Care Research (NIHR).

131.The business case for further manufacturing funding of £53.5 million to the University of Oxford was submitted to the Secretaries of State for the Department and BEIS on 5 May 2020, with the recommendation to approve (CW5/137 - INQ000234362). The business case was approved by the Secretary of State for BEIS on 5 May 2020 (CW5/138 - INQ000234367), the Secretary of State on 6 May 2020 (CW5/139 - INQ000234366) and the Chancellor on 8 May 2020 (CW5/140 - INQ000234368).

132. On 17 May 2020, Dr Louise Wood, the Director of Science, Research and Evidence in the Department, provided consent on behalf of the Department for the licensing agreement between the University of Oxford and AstraZeneca. The agreement between these two parties was formally announced by the Secretary of State for BEIS later that day (CW5/141 - INQ000234370). The license agreement was to deliver a total of 100m doses to the UK, that the UK would be the first country to get access to University of Oxford's COVID-19 vaccine, and that vaccines would be available to developing countries at the lowest possible cost (CW5/142 - INQ000234369).

133. The Ministerial Vaccines Panel met on 27 August 2020 to discuss the final business case relating to the University of Oxford's COVID-19 vaccine (referred to as AZD1222) including its progression to manufacture at scale by AstraZeneca under their license agreement and the Government's subsequent supply agreement with AstraZeneca (CW5/143 - INQ000234453). The Secretary of State for BEIS, the Chief Secretary to the Treasury, Lord Agnew (Minister of State for the CO and HMT) and Lord Bethell, on behalf of the Department, were content to approve (CW5/144 - INQ000234458). The business case included AstraZeneca's agreement to operate during the pandemic on a "no profit/no loss" basis and the delivery of 100m doses from November 2020 to March 2021. The supply agreement between AstraZeneca and the Secretary of State for BEIS, on behalf of the Government, was published on 28 August 2020 (CW5/145 - INQ000234456).

Vaccine Damage Payments Scheme

134. The Vaccine Damage Payments Scheme (VDPS) was established under the Vaccine Damage Payments Act 1979 (VDPA). It provides a one-off tax-free payment, currently £120,000 to individuals assessed, on the balance of probability, to have been severely (60% or more) disabled by a vaccine for a disease specified in the VDPA. The 60% threshold is aligned to the definition of 'severe disablement' as per the Department for Work and Pension's (DWP) Industrial Injuries Disablement Benefit. Disablement is assessed by UK registered doctors.

135. The VDPS is not a compensation scheme and it does not prejudice the right of the disabled person to pursue a claim for damages through the courts. The VDPS is not designed to cover all expenses associated with severe disablement. Other Government support remains available for those with a disability or long-term health condition, including Statutory Sick Pay, Universal Credit, Employment and Support Allowance, Attendance Allowance, and Personal Independence Payments.

136. Advice was put to Ministers on 5 August 2020 recommending the addition of COVID-19 to the list of specified diseases to which the VPDA applies (CW5/146 - INQ000257398; CW5/147 - INQ000257399; CW5/148 - INQ000257402; CW5/149 - INQ000257403;), which was done via a negative procedure statutory instrument. The Vaccine Damage Payments (Specified Disease) Order 2020 was made on 2 December 2020, laid in Parliament on 3 December 2020 and came into force on 31 December 2020 (CW5/150 - INQ000257410; CW5/151 - INQ000257411; CW5/152 - INQ000257415; CW5/153 - INQ000257412; CW5/154 - INQ000257414; CW5/155 - INQ000257413; CW5/156 - INQ000257419; CW5/157 - INQ000257418; CW5/158 - INQ000257417; CW5/159 - INQ000257416;).

137. The scheme's administration was transferred from DWP to the NHS Business Services Authority (NHSBSA) in November 2021. Following this, the Department has worked with the NHSBSA to scale up the operations of the VDPS by modernising operations, improving claimants' experiences, and providing more timely outcomes.

Vaccine Indemnity

138. Advice was provided to the Secretary of State on 15 July 2020 recommending that Departmental Ministers accepted the inclusion of an indemnity clause in a binding 'Heads of Terms' agreement with one of the vaccine manufacturers (Pfizer – Project Ambush) (CW5/160 - INQ000257379; and CW5/161 - INQ000257380;). The Secretary of State approval and agreement to the indemnity clause was secured on 16 July 2020, paving the way for the Heads of Terms agreement to be finalised on 17 July 2020 (CW5/162 - INQ000257381;).

139. At the Committee meeting on 22 July 2020, Ministers on the COVID-S Committee were asked to recognise that wide-ranging indemnities were being demanded by most COVID-19 vaccine manufacturers as an absolute pre-condition of sale (CW5/163 - INQ000257382;).

140. Ministers were subsequently asked to re-confirm their acceptance of potentially broad Government indemnities for vaccine developers, in the light of updated analysis on the scale of the potential liabilities involved, at the first Vaccines taskforce Ministerial Panel meeting on 27 August 2020 (CW5/164) - INQ000257389;. Updated analysis presented at this meeting showed a strongly positive value-for-money case for entering into vaccine agreements, even with broad indemnity provisions.

141. These agreements paved the way to agree to indemnity clauses in subsequent contractual negotiations with COVID-19 vaccine manufacturers/suppliers.

142. As a result of agreement to the vaccine indemnity clause in the contracts, and following MHRA regulatory approval of each vaccine, the Department's Accounting Officer was required to inform Parliament of the contingent liability taken on as a result of each contract. Notification to Parliament was achieved via a Written Ministerial Statement (WMS) and Departmental Minute being laid in the House, alongside confidential letters from the Department's Accounting Office to the chairs of the Public Accounts Committee, Health and Social Care Select Committee, and Business, Energy and Industrial Strategy Select Committee (CW5/165 - **INQ000257427** and CW5/166 - **INQ000257428**).

Antivirals and Therapeutics

143. In April 2020, the Department established the Therapeutics Taskforce (TTF). The TTF worked closely with the Devolved Governments and was responsible for identifying, trialling and, other than readily available generics, procuring treatments, on behalf of the whole of the UK and the Crown Dependencies.

144. The TTF supported the Department in terms of input into Government strategies for managing COVID-19. It looked at potential pharmaceutical interventions and worked with the NIHR to oversee a number of clinical trials.

145. In early 2020, NERVTAG provided expert advice to PHE to inform what symptoms should be used to define COVID-19 cases. A case definition to diagnose those with COVID-19 naturally differs from a list of all the possible symptoms of COVID-19, of which there was a recognised longer list. These symptoms did not remain the same throughout the year and were updated as new data emerged. The presence of anosmia and ageusia (loss of taste and/or smell) were added to the list of diagnostic features (CW5/167 - INQ000234340 and CW5/168 - INQ000234342). Further discussion was had about whether abdominal symptoms could be indicative of a COVID-19 infection.

146. By August 2020, the TTF had started to collaborate with the VTF in BEIS on a COVID-19 antibodies workstream. The VTF had been investigating the use of antibodies as prophylactic treatments as potential alternative preventative interventions should

vaccines prove ineffective. The VTF had identified six neutralising antibody candidates that showed potential to be used for treatment, as well as prophylaxis, which they shared with the TTF (CW5/169 - INQ000234438).

147. One of these treatments identified, casirivimab/imdevimab (also known as REGN-COV or Ronapreve), was entered into the RECOVERY trial. This was a UK-based randomised controlled clinical trial platform run by the University of Oxford, which aimed to identify treatment that may be beneficial for people hospitalised with suspected or confirmed COVID-19. The trial arm began recruiting in September 2020 and was expanded internationally in February 2021.

148. The TTF Executive Board, which was established in June 2020, provided oversight of the development, manufacture and supply of treatments for COVID-19 under the supervision of DCMO. It enabled key stakeholders from within DHSC and across the wider healthcare system, to come together in one forum. The Executive Board decided in August 2020 that an independent panel should be established to make recommendations on the most promising therapeutics that should be prioritised and testing through the UK clinical trial platforms. As a result, the TTF, in collaboration with NIHR, set up the UK COVID Therapeutics Advisory Panel (UK-CTAP) (CW5/170 - INQ000234433). UK-CTAP was a body of independent scientific and clinical experts who made formal recommendations to the trial leads and the CMO on which treatment candidates to prioritise to enter UK trial platforms, following formal submissions of potential compounds. Professor Patrick Chinnery was the chair of UK-CTAP and the TTF worked closely with UK-CTAP to ensure that all potential candidates were considered. UK-CTAP closed initially in September 2021 but by December UK-CTAP was stood up again on a temporary basis as preparations were being made for the impact of Omicron.

149. The Department also funded other trials to help accelerate early-stage research into novel therapies and to expand the portfolio of national scale trial platforms delivering important research in the UK:

a. In September 2020 it was agreed that government-funded Phase II trials in hospitalised patients would be delivered under the auspices of the RECOVERY trial, to be known as RECOVERY+. This decision was made following the success of the Phase III RECOVERY platform (CW5/171 - INQ000234464); and

b. In September 2020, the Medical Research Council, with strategic input from the NIHR and TTF, agreed to fund an additional early phase I/II trial platform for patients both in the community and in hospitals, called AGILE.

150. The TTF was also conscious from the outset that research needed to be accompanied by mechanisms to get any approved treatments, including those being trialled, to patients quickly and efficiently.

151. In October 2020, NERVTAG noted that case reports of reinfection with COVID-19 were increasing. The conclusion from various accumulated data was that reinfection should be expected with COVID-19 (CW5/172 - INQ000220154).

152. In October 2020, the TTF Executive Board agreed that the TTF's planning, analysis and proposals should be underpinned by the CO's revised RWCS modelling. However, at that time, the CO RWCS had not been updated for winter 2020/21, so the decision was made to use SPI-M-O six-week projections in the interim. The six-week projections were used to estimate volumes of treatments that would be required for patients hospitalised for COVID-19 treatment and for COVID-19 patients in intensive care in autumn/winter 2020/21. Where stockpiling was not possible, supply terms were negotiated to ensure continuity of supply (CW5/173 - INQ000234545 and CW5/174 - INQ000234585).

153. Towards late 2020, rising case rates of COVID-19 in the south-east of the UK were investigated and found to correlate with a negative result for the S-gene target, one of the commonly used probe sets for quantitative polymerase chain reaction (qPCR) tests. This rise in cases, in which PCR tests had failed to detect the increase in the spike protein gene of those infected. was identified as being caused by a new variant, named Alpha (B1.1.7).

154. The TTF supported the development of a prophylaxis trial targeted at vulnerable groups. The PROTECT-CH trial (Prophylactic Therapy in Care Homes trial) received funding approval on 1 December 2020 and commenced on 1 January 2021 (CW5/175 - **INQ000257442**).

155. On 7 January 2021, the REMAP-CAP clinical trial published data which showed that tocilizumab and sarilumab both reduced the relative risk of death by 24% when administered to patients within 24 hours of entering intensive care. The TTF had

started engaging with the suppliers of both drugs in November 2020, based on positive interim results, to ensure the supply was readily available for UK patients and the Department announced on the same day that patients would be able to access treatment with these drugs immediately (CW5/176 - INQ000234737).

156. The proactive planning of the TTF and NIHR meant that the rate of recruitment into the national trial platforms expanded significantly during winter 2020/21. For example, RECOVERY was regularly seeing over 300 patients recruited into the trial daily during this period. On 15 January 2021, the Chief Investigators for the RECOVERY trial confirmed that the total recruitment into RECOVERY since March 2020 had surpassed 28,000 patients (CW5/177 - INQ000234710).

157. On 15 January 2021, the RECOVERY trial asked hospitals to stop randomisations of patients into their convalescent plasma trial arm on the advice of their independent Data Monitoring Committee (DMC). The DMC *"saw no convincing evidence that further recruitment would provide conclusive proof of worthwhile mortality benefit either overall or in any pre-specified subgroup"* (CW5/177 - INQ000234710).

158. On 16 January 2021, REMAP-CAP announced that results from their convalescent plasma trial arm indicated it was also unlikely to be of benefit to hospitalised patients with COVID-19 (CW5/178 - INQ000234711).

159. On 25 January 2021, the PRINCIPLE trial then announced that azithromycin was ineffective as a treatment for patients with milder COVID-19 within the community (CW5/179 - INQ000234720).

160. HEAL-COVID (Helping Alleviate the Longer-term consequences of COVID-19), which was part of a wider Government programme to help better understand Long COVID-19, improve diagnosis and find new treatments for patients who had been hospitalised with COVID-19 and continued to suffer ill-health following discharge, commenced on 1 February 2021 and retrospectively received funding approval on 3 February 2021.

161. The Antivirals Taskforce (ATF) was officially established in April 2021 (CW5/180 - **INQ000256958**). The Secretary of State proposed the programme to the PM and Chancellor of the Duchy of Lancaster (CDL), and it was agreed that an ATF would be established to bring focus and momentum to this programme (CW5/181 - **INQ000256956**). Antivirals are a type of therapeutic medication used specifically to

treat viral infections. They aim to minimise the symptoms of an infection and shorten its duration. They also can help reduce transmission of a virus. Rather than killing the virus directly, antivirals usually suppress the virus's ability to infect and multiply in cells and so are most effective when used early on in infections. The ATF was tasked with the objective of having at least two oral antiviral treatments available for UK patients by the end of 2021 that could be used as a community treatment – that is, one that does not require administration in a secondary care setting (CW5/182 - **INQ000257447**).

162. Prior to this date, and on an ongoing basis, the ATF undertook thorough horizon-scanning activity to identify and monitor antiviral compounds that were being developed globally and that demonstrated efficacy against coronaviruses and had the potential to be made available within a year. This was complemented by recommendations from the Government Office for Science (GO-Science) and the UK COVID Therapeutics Advisory Panel (UK-CTAP). The ATF began to build the offer of a single-entry point into the UK system for companies with potentially viable/deliverable drugs. A shortlist of three priority candidates was agreed by the Antivirals Expert Group (an ad hoc advisory group of industry and clinical experts), the CSA, Sir Patrick Vallance, and the DCMO, Jonathan Van-Tam, based on the criteria of being orally administered, being a direct acting antiviral and having potential to be available to deploy in winter 2021/22.

163. The TTF continued to identify and make available new treatments, with particular focus on neutralizing monoclonal antibody treatments (also called mAbs or MABs). These are proteins made in laboratories that act like proteins called antibodies in our bodies that help stimulate the immune system and have been used to treat a number of conditions including cancer and inflammatory and autoimmune disorders, including allergies. The TTF was proactively engaging with suppliers of potential monoclonal antibody treatments on an ongoing basis throughout the period of this statement.

164. In May 2021, against the backdrop of data on vaccine efficacy, duration of immunity and hugely successful vaccines rollout and uptake, and momentum in establishing the ATF, the TTF's objectives were re-focused to prioritise treatments for individuals whose immune systems put them at greater risk of COVID-19. This included those for whom the vaccine was not effective or who could not have a vaccine.

165.On 28 May 2021, the Government appointed Eddie Gray as the chair of the ATF (CW5/183 - INQ000257456).

166.On 16 June 2021, the RECOVERY trial announced that the novel monoclonal antibody casirivimab/imdevimab (REGN-COV, or Ronapreve) marketed by Roche was effective in treating hospitalised patients who have not mounted their own immune response (seronegative patients) (CW5/184 - INQ000257459). The Vaccines Taskforce agreed to procure 50,000 doses of casirivimab/imdevimab pending a Conditional Marketing Authorisation (CMA): this is when authorisation is given by the MHRA on less comprehensive clinical data than normally required, where the benefit of immediate availability of the medicine outweighs the risk inherent in the fact that additional data are still required.

167.The ATF determined that more data was needed to inform how best to use oral antivirals in a largely vaccinated population because the trial data available to date had been generated prior to wide-spread vaccination. In July 2021, the NIHR launched a research call to identify an investigative team to create and deliver an ambitious, large scale clinical trial platform for oral antiviral treatments in the community. A team from the University of Oxford were selected with their proposal of the PANORAMIC study ('Platform Adaptive trial of NOvel antiviRals for eArly treatMent' of COVID-19 In the Community') and began trial set-up at pace.

Non-Pharmaceutical Interventions

168.I highlighted in paragraphs 142 to 146 in my First Witness Statement for this Module, that by July 2020, relaxation of the first lockdown had started. This continued over August 2020 and schools reopened in September 2020. To promote further compliance with restrictions and reduce transmission of COVID-19, the Government simplified restrictions during this period (for example by introducing the 'Rule of 6' on 14 September 2020 and introduced measures to strengthen enforcement (for example introducing a new offence, from 28 August 2020, for organising an unlawful gathering of more than 30 people). Further information about the legislation which implemented these restrictions is contained in Section 6 of this statement. The Government also responded to evidence about the reported complexity caused by different restrictions being applied in different areas, which made both compliance and enforcement more challenging. From 14 October 2020, therefore, a three-tiered system of restrictions was introduced, which applied the same restrictions across the country, depending on the tier the region was in: regions with higher rates of transmission (and other indicators)

were subject to stronger restrictions. Despite this, the spread of the disease nonetheless led to the introduction of a second national lockdown on 5 November 2020, which was in place until 2 December 2020, when the Government reintroduced a revised three-tiered system. Following the emergence of the Alpha variant in Autumn 2020, and its subsequent significant impact on levels of transmission, a stronger fourth tier was introduced on 20 December 2020. As levels of transmission continued to increase across the country, a third national lockdown was introduced on 6 January 2021, which included the requirement for schools to close (except for vulnerable children and the children of key workers).

169. Successful rollout of the COVID-19 vaccine from 8 December 2020, and the development of more effective treatment options for the seriously ill, led to a shift in the range of options available to combat transmission. It meant the Government could develop a strategy to reduce the degree of reliance on NPIs to control the virus. For example, departmental officials submitted advice to the Secretary of State in February 2021, which highlighted initial evidence of the success of vaccinations (CW5/185-INQ000234747; CW5/186 - INQ000234762; CW5/187 - INQ000234763; CW5/188 - INQ000234764). This success was seen as potentially facilitating a pathway to de-escalation of NPIs at a pace in keeping with the increasing role vaccination could play in responding effectively and sustainably to the pandemic. This advice highlighted the risks of de-escalating too quickly and proposed instead that the direction of travel should be led by the data, as the impact of vaccination would not be immediately clear. On 22 February 2021, the Government published a Roadmap for relaxing restrictions, with a four-step plan (with two parts to Step 1). On 8 March 2021, the country moved to Step 1A, where schools were reopened. Step 1B, which began on 29 March 2021, removed the requirement for people to leave their home only if they had a reasonable excuse. Step 2 was introduced on 12 April 2021 and included re-opening non-essential retail. In Step 3, which was reached on 17 May 2021, there was a further relaxation of rules for businesses and socialising. By June 2021 it was expected that a significant proportion of the population would be vaccinated and Step 4 of the roadmap, which involved the relaxation of most remaining restrictions, would proceed after 21 June 2021. However, the conditions for moving to each step was dependent on the four tests being satisfied. When these tests were not met for Step 4, a four week pause was announced on 14 June 2021 (CW5/189 - INQ000234938). The Government decided to move to Step 4 of the roadmap on 19 July 2021 (CW5/190 - INQ000234967).

170. Local restrictions had been implemented on 4 July 2020 in Leicester, with two further sets of local restrictions introduced in Blackburn and Bradford on 25 July 2020 (CW5/191 - **INQ000257378**). Alongside the relaxation of national measures as stated in the previous statement and outlined here, there was an increasing number of local lockdowns.

171. On 27 July 2020, CO officials contacted Departmental officials regarding the PM's concerns about rising COVID-19 prevalence and the rising trends in Europe and the need to do everything possible to keep transmission down. CO commissioned the Department, the Home Office (HO), the Department for Transport (DfT), the Ministry of Housing, Communities and Local Government (MHCLG) and BEIS to provide further information on the options for making the enforcement of key policies more visible. This was in support of the objectives outlined in the Government's COVID-19 recovery strategy of suppressing the virus and re-opening society and the economy (CW5/192 - INQ000234418 and CW5/193 - INQ000234419).

172. On 30 July 2020, CO officials informed Departmental officials that the PM wanted to enhance existing legislation and guidance to increase compliance and enforcement (CW5/194 - INQ000234434). Following a Gold meeting that morning, the Minister of State for Care (MSC) requested a provisional plan from officials on what was being done to assess and improve compliance with social distancing guidelines across the country and on quarantining and household gatherings (CW5/195 - INQ000234429). Departmental officials briefed MSC that most gathering restrictions in place at that time were in guidance, not legislation, but consideration would be given at COVID-O that evening on whether more could be done to enforce social distancing, including on tightening restrictions on gatherings in local areas (CW5/196 - INQ000234430 and CW5/197 - INQ000234431).

173. Much policy development over this period was therefore aimed at moving back towards normal life and away from the full suite of restrictions which disproportionately impacted certain groups, but also recognising the ongoing risks of transmission, and the impact of people's reactions to those risks and restrictions. For these reasons, it was important to implement effective measures to improve the COVID-19 security of these everyday activities in a way that commanded public confidence.

174. Throughout the development of a national framework for localised restrictions different names were used for the different levels of restrictions, including Local Alert Levels ('Medium', 'High' and 'Very High') and Tiers 1-4.

175. Departmental officials briefed the Secretary of State on a Department for Education (DfE) COVID-S paper for a COVID-S meeting on 6 August 2020 (CW5/198 - INQ000234432). The DfE paper covered the implementation of plans for a return to full-time, on-site education in September 2020, including agreed contingency plans in the event of high rates of COVID-19 transmission building over August 2020. The Department's officials advised the Secretary of State that further work was required to establish the appropriate prioritisation of COVID-19 tests for schools, and that the argument should be made to maintain 1-metre social distancing (where feasible) on school transport. Students returned to school in September 2020.

176. On 12 August 2020, the HO circulated a write-round from the Home Secretary to the Domestic and Economy Implementation Committee about strengthening enforcement measures against those breaking social distancing (CW5/199 - INQ000234435). The write-round process is where a Minister requesting a decision will write to all the members of the relevant committee and ask colleagues to agree with their proposal. The Minister of State for Health responded on 13 August 2020 agreeing to the measures in principle (CW5/200 - INQ000234437).

177. On 13 August 2020, the Secretary of State received advice from officials regarding easing restrictions for businesses and venues from 15 August 2020 (CW5/201 - INQ000233937). The proposed changes to legislation included permitting casinos, skating rinks, bowling alleys, exhibition halls and conference centres (for trial events), and indoor play areas to open. Changes to guidance included restarting indoor performances, pilots for sporting and business events, reopening saunas and steam rooms, and allowing wedding receptions for up to 30 people. These changes had originally been planned for 1 August 2020 (excluding indoor play areas) as the first step in the 'next chapter' of the Roadmap, subject to the five tests for easing measures outlined on 16 April 2020 (see my First Witness Statement for this Module) being met. The planned relaxation of restrictions was, however, delayed because of concerns about data showing the number of people in England testing positive for COVID-19 (CW5/202 - INQ000234436).

178.In parallel, CO officials provided advice about the proposed changes to the PM on 13 August 2020, who took the decision that they should be introduced (excluding areas already under local intervention) on 15 August 2020. A signing submission was sent to the Minister of State for Health on 13 August 2020 (CW5/203 - INQ000109661) and the implementing regulations were made on 14 August 2020 (CW5/204 - INQ000234439).

179.On 21 August 2020, the Secretary of State responded to the submission of 18 August 2020, providing steers to be reflected in the CO paper (CW5/205- INQ000234441; CW/206 - INQ000234442; CW5/207 - INQ000234443; CW5/208 - INQ000234451). These included increased enforcement, including for face coverings; an option for a legal requirement to isolate for those testing positive (or a contact of someone who had); stronger business enforcement and customer logs; area-specific information on GOV.UK website and the application; and the inclusion of simple, clear rules that would work for the whole of the autumn.

180.On 25 August 2020, the CO circulated a paper outlining a draft enforcement package, ahead of a possible speech from the PM about increased compliance with, and enforcement of, regulations. The regulations had been designed to ensure that: businesses were taking reasonable steps to make their premises COVID-19 secure; that customers were complying with regulations whilst on site; and that Test and Trace data was being collected. It sought legal and policy views on options for putting elements of the guidance on a statutory footing, including views on which sectors/premises these should extend to.

181.On 27 August 2020, the Secretary of State met Departmental officials and provided steers on the CO paper (CW5/209 - INQ000234457 and CW5/210 - INQ000234455). The Secretary of State agreed that COVID-19 secure guidance for businesses should be implemented through legislation to make the requirements legally enforceable; to change the approach to enforcement, to make it an obligation for businesses to keep customer records; and to develop simplified social distancing rules to help drive compliance. He also agreed with a proposal to develop a system of tiered restrictions that were clear and consistent, based on the level of risk in the area.

182.On 29 August 2020, the Secretary of State commissioned advice on what could be learnt from the situation in France (where the course of the disease was ahead of the UK position) (CW5/211 - INQ000234459). On 31 August 2020, Departmental officials

provided the Secretary of State with a note on the COVID-19 Taskforce's draft compliance and enforcement paper and the possible design of a tiered system of localised restrictions. They met with the Secretary of State on that date to discuss this proposal. A separate meeting was held between the Secretary of State and Departmental officials on the advice provided on the situation in France and what could be learnt. On the same date, the Secretary of State wrote a note to the PM about risk-based rules on social contact in response to rising case numbers, including simpler, tighter rules, stronger enforcement and a tiered system of rules commensurate with the level of risk in each area. This letter informed the discussion between the Secretary of State and the PM on 1 September, where the Secretary of State's note on risk-based rules was endorsed by the PM (CW5/212 - **INQ000233972** and CW5/213 - INQ000234460).

183. On 1 September 2020, the COVID-19 Taskforce was commissioned by the COVID Secretariat to work with HO, the Department for Digital, Culture, Media and Sport (DCMS), the Department, BEIS, MHCLG, the Foreign and Commonwealth and Development Office (FCDO) and DfT to prepare a short discussion paper on an approach to increase compliance with, and enforcement of, COVID-19 rules and guidelines to be discussed at the COVID-O meeting on 3 September 2020 (CW5/214 - INQ000234463 and CW5/215 - INQ000234462). The Secretary of State received further advice from the Department's officials on 2 and 3 September 2020 about the Local Alert Levels proposal. This proposed new localised restrictions based on green, amber and red zones (to reflect differing levels of risk).

184. Departmental officials provided further advice on 5 September 2020 proposing a tiered system of local restrictions for the Secretary of State's consideration and advice on a framework for simplifying and rationalising the guidance on social contact (CW5/216 - INQ000234465; CW5/217 - INQ000234466; CW5/218 - **INQ000112197**; CW5/219 - INQ000234468). On 6 September 2020, a revised version of this paper was provided to the Secretary of State as a draft paper for the COVID-S meeting on 8 September 2020. On 7 September 2020 it was decided, following a meeting between CO officials and the PM, that the Local Alert Levels would not be included for decision at the meeting or announced that week. Instead, a CO paper provided a range of options for decision on tackling increasing transmission rates (CW5/220 - INQ000234470; CW5/221 - INQ000234469; CW5/22 - INQ000234471; CW5/223 - INQ000233984). This included options for strengthening communications and enforcement and simplifying social contact rules.

185. Departmental officials provided the Secretary of State with a further briefing on the CO's paper for the COVID-S meeting on 8 September 2020 (CW5/224 - INQ000233983, CW5/225 - INQ000234473, CW5/222 - INQ000234471). This recommended supporting the proposal for a legal limit on the number of people gathering socially to simplify the rules. It recommended that the number did not exceed six people so as not to be seen as a relaxation of the existing household restrictions. The COVID-S meeting decided to limit gatherings in all settings to six people (with exemptions agreed on 9 September 2020); to introduce new requirements for businesses to collect Test and Trace data; and to implement key COVID-19 secure principles, with fixed penalty notices (FPNs) for breaches of these rules (CW5/222 - INQ000234471 and CW5/226 - INQ000234477).

186. The Secretary of State received advice on 10 September 2020, which re-iterated the decisions made at COVID-S on 8 September 2020 and sought steers on several outstanding policy issues. Following the Secretary of State's decision, regulations that implemented the policy, including restricting social gatherings of groups of more than six (subject to exceptions), were made on 13 September 2020 by the Home Secretary due to ministerial availability (CW5/227 - INQ000109723; CW5/228 - INQ000234479; CW5/229 - INQ000234478; CW5/230 - INQ000234481; CW5/231 - INQ000109725; CW5/232 - INQ000109727; CW5/233 - INQ000109726; CW5/234 - INQ000109732; CW5/235 - INQ000109730; CW5/236 - INQ000109729; CW5/237 - INQ000109742).

187. The Secretary of State received a draft Departmental COVID-S paper on 15 September 2020 for a planned COVID-S meeting on 16 September 2020 which included a narrative explaining Local Alert Levels, a proposed plan for delivery, and an updated timeline for amending the Test and Trace app to provide members of the public details with the restrictions in place in their area. The Secretary of State cleared the paper, subject to bringing the introduction of the measures forward to 1 October 2020, tightening the policy in Local Alert Level 'Very High', and reducing the minimum period for moving an area from a higher alert level to a lower alert level (CW5/238 - INQ000234490; CW5/239 - INQ000234491; CW5/240 - INQ000234492; CW5/241 - INQ000234493). After the Department submitted the paper, CO outlined that this would need to be taken to COVID-O on 18 September 2020 (CW5/242 - INQ000234494).

188.At a COVID-O meeting on 17 September 2020, Gold recommendations from 17 September 2020 were considered: a package of national measures to curb transmission, which included returning to work from home guidance; increasing the FPN for breaching the COVID-19 secure rules to £10,000; mandating closure from 10pm for businesses selling food or drink; and reducing the number of exceptions to the gathering limits. At this COVID-O meeting it was also agreed to introduce a legal requirement to ensure compliance with the 'rule of six' (and ensure appropriate social distancing, through signage, layout, ventilation, and entry numbers management) in the leisure, entertainment, and tourism sectors, in local authority provided services, and in settings for close contact service provision. These were implemented by Regulations that BEIS led on (CW5/243 - **INQ000257392;** CW5/244 - **INQ000257393;** CW5/245 - **INQ000257394;** CW5/246 - **INQ000257395;** CW5/247 - **INQ000257396;** CW5/248 - **INQ000257397**).

189.At COVID-O on 18 September 2020, the Department presented a paper on its proposed Local Alert Level strategy. The Committee agreed with the approach set out in the paper, including the changes recommended at Gold for Local Alert Level 'High' (e.g., curfews on hospitality business' operating hours) and acknowledged that there was further work to do on shielding. The Department was tasked with working up guidance on shielding and non-essential travel to align with the tier proposal, and to engage with the COVID-19 taskforce and No.10 on next steps for timing and announcement.

190.On 21 September 2020, the Secretary of State asked for the Department's paper going to COVID-S to be an amended version of the COVID-O paper by revising the proposed policy on Local Alert Levels: Local Alert Level 'Medium' was to remain as the baseline; and with Local Alert Level 'High' introducing limits on social mixing as before, but with Local Alert Level 'Very High' adding closure of hospitality and leisure. The Secretary of State received a briefing from Departmental officials and an updated paper on the same day. The CO shared a section of their paper for a COVID-O meeting on 21 September 2020 which covered the Local Alert Levels proposal. Departmental officials provided proposed amendments to this section to the Secretary of State and shared his steer with the CO to strengthen the language. However, a decision was taken to not discuss Local Alert Levels in detail at the meeting.

191.Following a discussion with local authorities about the need for exemptions for childcare, the Department worked with DfE to develop draft regulations and

accompanying guidance to enable 'childcare bubbles'. Having been announced by the Secretary of State in an oral statement in Parliament on 21 September 2020, the next day the Health Protection (Coronavirus, Restrictions) (Protected Areas and Linked Childcare Households) (Amendment) Regulations 2020 were made, which provided that informal childcare became an explicit exception to local restrictions on interhousehold mixing (CW5/249 - INQ000234028; CW5/250 - **INQ000109996** CW5/251 - **INQ000110000**; CW5/252 - **INQ000109999**; CW5/253 - **INQ000109998**; CW5/254 - INQ000234498; CW5/255 - INQ000234503; CW5/257 - INQ000234504). Exemptions for registered childcare were already in place.

192. The Secretary of State sent a note to the PM on the Local Alert Level proposal on 22 September 2020 (CW5/258 - INQ000234506 and CW5/259 - INQ000234507). On 23 September 2020, the PM then provided a steer that the Department should continue to work with the Treasury (HMT) to address their concerns about the economic impact of Local Alert Level 'Very High' (CW5/260 - INQ000234510). The PM also indicated that final decisions for each area in the Local Alert Level 'Very High' should be taken based on the evidence around transmission, the economy and the demographic profile of the area. The process would be for a Gold meeting to recommend that an area be considered for Local Alert Level 'Very High' interventions, but the specific measures would have to be agreed between the PM, Secretary of State and the Chancellor of the Exchequer.

193. The Secretary of State provided a revised note to the PM on 24 September 2020 (CW5/261 - INQ000234511 and CW5/262 - **INQ000234055**). Following this, No.10 commissioned the COVID-19 Taskforce for advice on the Local Alert Level policy. The CO provided advice to the PM on 25 September 2020, with a Departmental contribution, about the economic restrictions involved in the Local Alert Levels and the process for implementing them.

194. The Secretary of State met the Chief Whip, the Cabinet Secretary, No.10 and COVID-19 Taskforce officials on 28 September 2020 to discuss handling of the announcement of the Local Alert Levels policy as well as Parliamentary engagement on changes to national policy on social distancing more widely (CW5/263 - INQ000234056). There was at that point no agreement on the detailed policy content to be applied in Local Alert Level 'Very High' areas. It was agreed that a policy statement outlining the changes would be delayed for at least one week, with local lockdown regulations adjusted accordingly. The feedback from No.10 officials was that the PM had

commissioned two notes from the Department; one about a timetable for a potential announcement and one about Parliamentary engagement. The Department provided these notes on 29 September 2020 (CW5/264 - INQ000234523; CW5/265 - INQ000234524; CW5/266 - INQ000234526; CW5/267 - INQ000234525; CW5/268 - INQ000234527). These were then shared with Chief Whip's office who agreed changes with the Secretary of State before they were submitted to No.10.

195. On 30 September 2020, during the House of Commons debate on the first six-monthly review of the Coronavirus Act 2020, the Secretary of State made the commitment "that for significant national measures with effect in the whole of England or UK-wide, we will consult Parliament; wherever possible, we will hold votes before such regulations come into force".

196. Towards the end of September 2020, incidence was rising across the country in all age groups (CW5/269 - **INQ000070908**).

197. Measures were introduced to reduce transmission through increased compliance with, and enforcement of, COVID-19 measures. This included penalties for regulatory breaches. In addition, the Secretary of State wanted to introduce Local Alert Levels from 1 October 2020, but this was delayed to accommodate further considerations, from the whole Government, of the detail of the measures. Advice provided on 11 October 2020 highlighted that the measures introduced in Local Alert Levels or Tiers would not be sufficient to control transmission on their own (CW5/270 - **INQ000234082** and CW5/271 - INQ000234549).

198. On 1 October 2020, Departmental officials provided the Secretary of State with a draft COVID-O paper, which set out proposals for the Local Alert Level Strategy to standardise local interventions across England (CW5/272 - INQ000234530; CW5/273 - INQ000234532; CW5/274 - INQ000234531). This included the substance of Local Alert Levels 'Medium' and 'High', the proposed regulatory framework, the process for transitioning to the framework, the public messaging strategy, and Parliamentary handling. The Secretary of State received a revised version of the paper to reflect comments from COVID-O-Officials on 2 October 2020 (CW5/275 - INQ000234533; CW5/276 - INQ000234535; CW5/277 - INQ000234534). This was then cleared by the Secretary of State and submitted to Cabinet Office (CW5/278 - INQ000234536).

199. On 4 October 2020, CO provided a paper to the Secretary of State setting out that No.10's views on the Local Alert Levels policy differed from the Secretary of State's in some areas. The Secretary of State asked for advice on the risk of allowing gatherings of six people in gardens. Having considered the advantages (e.g., makes it easier to have a sustainable position over a long period if people have a variety of outside spaces they can meet in) and disadvantages (e.g., the weather might cause such gatherings to move indoors) the Secretary of State agreed to the No.10 position to allow gatherings of up to 6 people in gardens. The paper was then edited and circulated. At the COVID-O on 5 October 2020, the substance of the policy for Local Alert Levels 'Medium' and 'High' was agreed, as well as the legislative timetable for introduction, and the handling and communication materials (CW5/279 - **INQ000090068**). The COVID-O Committee further agreed to amend the Local Alert Level 'Medium' regulations, to keep the effectiveness of existing COVID-19 secure guidance under review. The Covid-O actioned the Department to work with MHCLG, in coordination with No.10 and HMT, on engaging local authorities and local mayors on this proposal including on related support packages and that any move to the Local Alert Level 'Very High' would need to be agreed by the PM, Chancellor of the Exchequer and the Secretary of State.

200. On 6 October 2020 the PM's Office contacted the Secretary of State's office to convey the PM's wish to review the approach being taking on areas of high incidence, including the interplay with NHS capacity, and the measures being considered for these areas (CW5/280 - INQ000234071). The PM asked for the announcement on Tiers to be paused whilst this was worked through. Following this steer, the Department developed the regulations for Local Alert Level 'Medium,' 'High' and 'Very High.'

201. At the Gold meeting on 7 October 2020 the recommendations from Silver on 6 October 2020 were considered alongside JBC data, which was routinely provided and reviewed at Gold meetings. Recommendations were provided about which areas should be in which Local Alert Level, and which areas the Local Action Committee felt should be moved into Local Alert Level 'Very High' subject to further engagement with local leaders (CW5/281 - INQ000234539; CW5/282 - INQ000234540; CW5/283 - INQ000234538; CW5/284 - INQ000234542; CW5/285 - INQ000234541).

202. On 9 October 2020, following officials being provided an update on Local Alert Level 'Very High' position from COVID-19 Taskforce, the Secretary of State received advice from Departmental and JBC officials (CW5/286 - INQ000234543; CW5/287 -

INQ000234077; CW5/288 - INQ000234546; CW5/289 - INQ000234547). This highlighted that the package was a step forward in that it had additional restrictions as a default package, with the opportunity to agree further measures with local leaders. The advice also highlighted that the package of measures was weaker than that discussed at the Gold meeting on 7 October 2020 and which local areas may have been expecting. It outlined that the Department would support more extensive measures as the default, highlighting that the public health view was that these measures were necessary but not sufficient if the intent was to suppress the virus in the most affected areas.

203. On 10 October 2020, the Secretary of State received advice from Departmental officials on the substance of Local Alert Level 'Medium' and Local Alert Level 'High' (CW5/290 - INQ000109820). CO produced a paper on the approach for rolling out the Local Alert Levels, the areas that would be covered by each Level, the policy for Local Alert Level Very high, and minor changes to the previously proposed Local Alert Levels 'Medium' and 'High', the specific Local Alert Level 'Very High' package that had been agreed with local leaders in Merseyside, and the next steps for implementing them. This was shared with the Secretary of State on 11 October 2020 with Departmental officials providing a briefing that set out that this package would not be sufficient to bring down transmission and to reduce pressure on the NHS; that Government needed to agree packages with other high-level areas (not just Liverpool City Region (LCR)); and that the communications needed to be agreed with No 10 to set out the policy and its objectives (CW5/291 - INQ000257400 and CW5/292 - INQ000257401).

204. On 11 October 2020, COVID-O discussed and agreed the package of restrictions for Local Alert Level 'Very High' (CW5/270 - INQ000234082; CW5/295 - INQ000234083; CW5/296 - INQ000234552). This incorporated those elements in place for Local Alert Levels 'Medium' and 'High', but with additional measures: no household mixing either indoors (as in Local Alert Level 'Medium') or in gardens or other private outdoor settings (with exceptions for support or childcare 'bubbles'); no wedding receptions; closure of 'wet led' pubs and bars, which rely entirely on the sale of drinks for their business. In addition, it was agreed that there would be scope to agree with local leaders a broader package from a menu of other closures and restrictions, dependent on the epidemiology, demography, and economy of the area.

205.COVID-O on 11 October 2020 also confirmed that the LCR would move to Local Alert Level 'Very High' and would also implement additional restrictions. These were the closure of indoor sport facilities (gyms, dance studies, fitness centres), subject to exemptions for elite sport and dance, supervised activities for children and disability sport, as well as the closure of betting shops, adult gaming centres and casinos.

206.On 12 October 2020, signing submissions were sent to the Secretary of State for the introduction of Local Alert Levels 'Medium', 'High' and 'Very High'. The regulations were made on the same day and came into force on 14 October 2020. Please see paragraphs 420 to 422 below for further detail about these regulations.

Implementing the Local Alert Levels approach

207.The relevant regulations required that the necessity of the restrictions in all three Local Alert Level be reviewed at least every 28 days. There was also a requirement to review, at least every 14 days, whether each local authority area allocated to Local Alert Level 'High' should remain allocated to that level. Tier 3 areas were to expire automatically after 28 days.

208.Following the introduction of the Local Alert Levels, the Government negotiated with those relevant local authorities which were identified as potentially needing to move into Local Alert Level 'Very High' on what additional restrictions were needed to address high or rising rates of COVID-19 transmission in their area. These negotiations were led by the CO and restrictions were put in place through regulations once negotiations had concluded.

209.On 14 October 2020, the PM asked for further advice on areas and measures for Local Alert Level 'Very High' and for further potential measures to be implemented following discussions at Gold that day.

210.On 14 October 2020, COVID-O agreed with the recommendations of Gold held the same day to engage with local leaders on moving Greater Manchester, Lancashire, West and South Yorkshire, the North-East and Nottingham City to Local Alert Level 'Very High'; and what specific measures would apply. The COVID-O meeting agreed to continue engagement with local leadership on moving Coventry to Local Alert Level 'High' and to move London, Elmbridge, Essex, Barrow in Furness, Chesterfield, York, North-East Derbyshire and Erewash to Local Alert Level 'High'. It was agreed the Secretary of State would announce the areas moving into Local Alert Level 'High' that

week, and that regulations would be made that would come into effect on 17 October 2020 (CW5/297 - INQ000090102).

211. On 16 October 2020 following conclusion of discussions with Lancashire Local Authority, the relevant regulations were amended to move Lancashire into Local Alert Level 'Very High' along with the closure of some additional businesses (e.g., casinos). In addition, it was decided that negotiations on Greater Manchester would continue (CW5/298 - INQ000109868; CW5/299 - INQ000234569; CW5/300 - INQ000109869; CW5/301 - INQ000109870; CW5/302 - INQ000109872; CW5/303 - INQ000234568; CW5/304 - INQ000109874; CW5/305 - INQ000109877; CW5/306 - INQ000109876).

212. A COVID-O on 19 October 2020 considered a COVID-19 Taskforce paper on how to proceed if an agreement was not reached with local leaders from Greater Manchester by midday on 20 October 2020 and on what measures to introduce (CW5/307 - INQ000234572). Following the meeting, further negotiations were not able to reach an agreement, so the Government decided to introduce measures in Manchester. These restrictions were based on those in place in Lancaster with some minor amendments.

213. The COVID-19 Taskforce provided a paper to a COVID-O meeting on 21 October 2020 on improving local authority powers to enforce COVID-19 secure rules (CW5/308 - INQ000059096; CW5/309 - INQ000234573; CW5/310 - INQ000234108; CW5/311 - INQ000234575). Departmental officials briefed ministers on the same day before the meeting on measures to enable local authorities to make a more effective contribution to enforcement with proposed guidance changes and the development of more proposed regulatory amendments, including providing local authorities with new powers to issue notices based on existing health and safety powers.

214. On 22 October 2020, the Secretary of State received a briefing for the COVID-O meeting later that day about DfE proposals for students safely returning home for Christmas (potentially moving from one Local Alert Level to another) as committed to by the Government. Departmental officials recommended agreeing the general approach and the specific proposals to enable movement to happen safely, but that any necessary legislative changes should be considered as part of the wider Christmas strategy (not student specific), and more time allocated to the consideration of public health and equalities implications. It advised that wider public messaging around inter-household mixing and social distancing should not be undermined by the approach to Higher Education (HE). The Secretary of State responded to the briefing on 22 October

2020 and outlined his disagreement with the DfE approach that was to be proposed at COVID-O, but that he was content for further discussion to be held at the COVID-O meeting (CW5/312- INQ000234577; CW5/313 - INQ000234578; CW5/314 - INQ000234579).

215. Following the introduction of the Local Alert Levels, various decisions were taken as to which Levels different local authority areas should be placed into with appropriate regulations being made as required. This was managed by recommendations from the 'Gold' process going to COVID O for collective agreement, with DHSC leading the agreed implementation.

216. Also on 28 October 2020, the Secretary of State undertook a statutory review of the Local Alert Level regulations and decided that the restrictions remained necessary and proportionate and that no change was required, but that some areas should be escalated to Local Alert Level 'Very High' where the evidence supported this. There was a further recommendation that discussions should be held with local leaders to agree a local package, in line with the evidence considered at Gold earlier that day (CW5/315 - INQ000058651; CW5/316 - **INQ000109910**; CW5/317 - **INQ000234130**; CW5/318 - **INQ000090298**; CW5/319 - INQ000109906; CW5/320 - INQ000109907; CW5/321 - INQ000109909; [redacted]; CW5/323 - INQ000109911).

217. To simplify and standardise local rules, a three-tiered system of Local COVID-19 Alert Levels in England was announced on 12 October 2020 and legally came into force from 14 October 2020 (CW5/324 - INQ000235001).

Adapting the Local Alert Levels approach for the second national lockdown

218. On 29 October 2020, the Secretary of State commissioned Departmental officials to consider what a new Local Alert Level above 'Very High' would look like, based on new national measures that had been announced in France (CW5/325 - INQ000234583 ; CW5/326 - INQ000234587; CW5/327 - INQ000234584). The measures in France were similar to the UK measures from March 2020. In particular, the commission asked for the inclusion of the closure of all hospitality; a requirement to stay at home except for work and education; closure of non-essential retail; travel bans between areas and the reintroduction of a form of shielding advice.

219. On 30 October 2020, the Secretary of State met the PM about the growing incidence rates, and pressures on the NHS (CW5/328 - INQ000234132 and CW5/329 -

INQ000234133). A No.10 paper was shared with the Secretary of State, which set out a proposal to introduce a national intervention to apply for four weeks, with a regional de-escalation approach. A Cabinet meeting was held on 31 October 2020, where a COVID-19 Taskforce paper on national lockdown was discussed (CW5/330-INQ000234588; CW5/331 - INQ000234589; CW5/332 - **INQ000058812**). The November 2020 lockdown was announced by the PM later that day, which confirmed the new measures would take effect from 5 November 2020 for four weeks (CW5/333 - INQ000234586).

220. On 31 October 2020, the Secretary of State received advice with a proposed timeline for regulations to be made on 3 November 2020 (and debated on 4 November 2020, to come into force on 5 November 2020) that would introduce a second national lockdown, as agreed at the meeting the previous day (CW5/334 - INQ000234590 and CW5/**332** - **INQ000058812**. Further advice was submitted to the Secretary of State on 1 and 2 November 2020 on the substance of the policy for the proposed national lockdown (CW5/336 - INQ000058813; CW5/337 - INQ000058814; CW5/338 - INQ000234592; CW5/339 - INQ000234593; CW5/340 - INQ000234594). Decisions on outdoor sport and takeaway alcohol were made by No.10.

221. Further advice was submitted on 5 November 2020 to the Secretary of State which sought approval to expand the number of outdoor ceremonies on Armistice Day on 11 November 2020 (CW5/341 - INQ000058886). On 9 November 2020, Ministers made regulations that gave legal effect to these amendments (CW5/342 - INQ000234609; CW5/343 - INQ000234610; CW5/344 - INQ000234611; CW5/345 - INQ000234604; CW5/346 - **INQ000110042**; CW5/347 - **INQ000112970**; CW5/348 - **INQ000110044**; CW5/349 - INQ000234608).

222. In response to a worsening epidemiological situation, on 10 November 2020, Departmental officials drafted a paper for the Secretary of State ahead of the Gold meeting the following day about introducing a revised Tiers system from 2 December 2020, when the Fourth Restrictions Regulations were due to expire. The paper set out the principles, produced by the COVID-19 Taskforce, for designing the approach, which included some amendments to the system in order to enhance effectiveness. This set out that a further Tier should be added, which would mirror the November 2020 national restrictions with the Tiers below that containing a strengthened package of measures and that the lowest Tier should contain some slight restrictions to encourage greater compliance (CW5/350 - **INQ000234144**).

223.On 12 November 2020, following steers from the Secretary of State and No.10, further advice was submitted to the Secretary of State to update on the policy content for reinstating Tiers and to seek steers on outstanding issues. In line with the steers, this proposal consisted of three Tiers, rather than four (consistent with what had been implemented in October); and proposed some changes to each of the Local Alert Levels, including putting the "working from home" guidance into legislation in all Tiers.

224.On 15 November 2020, the Secretary of State provided steers for the policy content for Tiers 2 and 3, based on the proposed changes in the submission on 12 November 2020 (CW5/351 - INQ000234615 and CW5/352 - **INQ000058986**). For Tier 2 his preference included following the 'rule of six', with no household mixing indoors; a complete ban on large gatherings; and to introduce a requirement that hospitality venues only serve alcohol with a substantial meal. For Tier 3 his preferences included barring any form of household mixing; allowing all outdoor sport to continue; for takeaway alcohol rules to mirror the November lockdown rules (a prohibition on take-away alcohol); for religious venues to remain open in all circumstances; and for there to be no changes to support bubbles.

225.On 16 November 2020, the UK CMOs met to discuss the approach to contacts of index cases and further the proposals to change the 14-day isolation period for contacts of index cases, considering modelling papers from PHE, SPI-M and advice from SAGE. Advice to reduce the self-isolation period for contacts of positive cases from 14 days to 10 days was provided in December (detailed further below).

226.The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 (the Tiers Regulations) came into force on 2 December 2020, which replaced the Fourth Restrictions Regulations with a revised Tiers system (CW5/353 - INQ000059129; CW5/354 - INQ000110146; CW5/355 - INQ000110139; CW5/356 - **INQ000110141;** CW5/357 - **INQ000110142;** CW5/358 - **INQ000110144;** CW5/359 - INQ000110145; CW5/360 - INQ000234628; CW5/361 - INQ000234629; CW5/362 - INQ000234630), see paragraph 423 to 425 below for further detail.

227.On 19 November 2020, the Secretary of State received advice from Departmental officials, setting out changes to Tiers, agreed at COVID-O on 17 November 2020 (CW5/363 - **INQ000091216**; CW5/364 - INQ000234161; CW5/365 - **INQ000071757**; CW5/366 - **INQ000071758**; CW5/367 - INQ000234618; CW5/368 - INQ000234619;

CW5/369 - INQ000234620). The advice also sought steers from the Secretary of State on specific policy issues, including in respect of changes to support bubbles and each Tier, ahead of the following COVID-O, scheduled for 21 November 2020. This COVID-O meeting sought final decisions on Tiers and Christmas, based on a paper produced by the CO.

228. On 23 November 2020, the PM set out the COVID-19 Winter Plan in Parliament, which put forward the UK Government's programme for suppressing the virus, protecting the NHS and the vulnerable, keeping education and the economy going, and providing a route back to normality (CW3/55 - INQ000106867).

229. On 24 November 2020, the Secretary of State requested a briefing on proposals for Christmas, ahead of a COBR meeting the same day (CW5/370- INQ000234622; CW5/371 - INQ000234623; CW5/372 - INQ000234177). Departmental officials provided a note setting out that a limited easing to social contact rules, set out in law, was being proposed for over the festive period. This would permit each household across the UK to form one exclusive "Christmas bubble" with up to two other households, enable people to see, and travel to, their Christmas bubble between 23-27 December 2020, enable people to travel between Tiers and between nations; and permit people to be with their Christmas bubble in the home, a place of worship or an outdoor public place. The briefing outlined that, in line with SAGE guidance, the Government should aim for the lowest possible prevalence in the build up to Christmas, to reduce the risk associated with reducing social distancing over the Christmas period. Although the briefing highlighted that the proposal would increase transmission risk, it was also thought that not introducing a change could have led to more people breaking the existing rules, and to their doing so in an unplanned and perhaps more significant way, which could provide an even greater risk. As a result, a package was proposed that set out defined new rules that ministers could be confident would be more likely achieve greater public acceptance, as a possible option to avoid these problems.

230. The same day, on 24 November 2020, Departmental officials provided a submission to the Secretary of State to update on outstanding policy issues and Parliamentary handling of the reinstating of Tiers (CW5/373 - INQ000234624 and CW5/374 - **INQ000234183**). The submission highlighted a number of outstanding policy issues, including ongoing policy discussions around dealing with Christmas and that DfE and DCMS were seeking exemptions to the gatherings/'rule of six' for supervised activities in education for over 18s and for youth services for vulnerable 18- to 25-year-olds. On

26 November 2020, the Secretary of State provided steers that he agreed with DfE and DCMS that all extra-curricular activities provided by an education provider should be part of the 'education' exemption.

231. Later the same day, Departmental officials provided further advice to the Secretary of State on the details of the policy steers that he had provided and on 27 November 2020 the Secretary of State agreed each of the proposals (CW5/375 - INQ000234627).

232. On 25 November 2020, the PM committed in Parliament to publish evidence of the impact of Tiers. On 27 November 2020 Secretary of State received advice from Departmental officials on publication along with a draft (CW5/376 - INQ000059108; CW5/377 - INQ000059109; CW5/378 - INQ000059110). Following feedback from the Secretary of State and other ministers a version cleared by Secretary of State was sent to No.10 on 30 November 2020 (CW5/379 - INQ000234633 and CW5/380 - **INQ000136696**). The analysis was then published by the Department on the same day.

233. On 26 November 2020, the Secretary of State issued a WMS confirming the decision to exit the national lockdown and revert to a localised approach for managing the virus from 2 December 2020 (CW5/381 - INQ000235016).

234. On 30 November 2020, a submission was sent to the Secretary of State to make the Tiers Regulations.

235. On 1 December 2020, the CMO's office submitted advice to the Secretary of State on reducing the self-isolation period for contacts of positive cases from 14 days to 10 days, as agreed by the four UK CMOs (CW5/382 - INQ000234637 and CW5/383 - **INQ000071961**). The Secretary of State agreed with the recommendation for the reduction to be introduced as soon as possible, with an aligned approach across the four nations, and agreed to put this forward for agreement at COVID-O. On 9 December 2020, No.10 confirmed the timeline for the change, to align with the Scottish Government and Northern Ireland Executive, with the changes to come into effect from 14 December 2020 (CW5/384 - INQ000234639 and CW5/385 - INQ000234640). Also on 9 December 2020, a submission was sent to the Secretary of State detailing the plan for the implementation of this policy and to seek steers on amending the process for a household needed to wait between ending a support bubble and forming a new one from the previous agreed 14 days to 10 days, to be consistent with the change to

the self-isolation period (CW5/386 - INQ000234209). On 11 December 2020, the Health Protection (Coronavirus, Restrictions) (Self-Isolation and Linked Households) (England) Regulations 2020 were made by the Secretary of State to bring these changes into force as of 14 December 2020 (CW5/387 - INQ000234646; CW5/388 - INQ000234644; CW5/389 - **INQ000234645;** CW5/390 - INQ000234641; CW5/391 - INQ000234642; CW5/392 - INQ000234643).

236. On 14 December 2020 data showed an exponential rise in confirmed cases, as well as rising hospital admissions in London, parts of Essex and Hertfordshire (CW5/393 - INQ000234649 and CW5/394 - INQ000234648). Regulations were made to move several areas from Tier 2 to Tier 3, in line with what had been agreed at COVID-O, earlier the same day, which came into force on 16 December 2020.

237. On 14 December 2020, Departmental officials provided advice to the Secretary of State that proposed a two-pronged approach for addressing concerns that Tier 3 measures were not effectively curbing transmission in some parts of England, particularly in Kent where case numbers had continued to increase. The proposal was that Tier 4 should include a simple "stay at home" message, along the lines of the March 2020 lockdown, and the closure of non-essential retail, providing that the data supported that decision (CW5/395 - INQ000234650; CW5/396 - INQ000234667; CW5/397 - INQ000234668). The Secretary of State confirmed on 18 December 2020 he supported this proposal; and, later the same day, the Minister for Care confirmed this was her preference.

238. On 16 December 2020, the statutory review of the Tiers Regulations took place in which the latest data was considered and, balancing a cautious approach going into the festive period with the appetite to sustainably de-escalate areas as rapidly as possible, COVID-O provided agreement to move areas between Tiers. On 17 December 2020, a submission was sent to the Secretary of State and the Minister for Care on amending regulations to move several local authority areas to different Tiers based on the five indicators (CW5/398 - INQ000234660; CW5/399 - **INQ000110194**; CW5/400 - **INQ000110196**; CW5/401 - **INQ000110198**; CW5/402- **INQ000110199**; CW5/403 - INQ000234658; CW5/404 - **INQ000110202**; CW5/405 - **INQ000110200**; CW5/406 - INQ000059306; CW5/407 - INQ000059307; CW5/408 - INQ000234662):

a. Case detection rates in all age groups;
b. Case detection rates in the over 60s;

c. The rate at which cases are rising or falling;
d. Positivity rate (the number of positive cases detected as a percentage of tests taken); and
e. Pressure on the NHS, including current and projected occupancy.

239. These amending regulations were made by the Minister for Care on 17 December 2020 and came into force on 19 December 2020.

240. A CO paper, which had already been shared with the Secretary of State, was presented at COVID-O on 19 December 2020 (CW5/409 - INQ000234670), where collective agreement was given for the introduction a 'Tier 4' of additional restrictions in London, areas of the South and East of England, as a result of a rapid rise in cases due to the new variant of COVID-19. Tier 4 would establish a 'stay at home' requirement in law; set out further restrictions on gatherings; and close additional businesses including non-essential retail. These measures were similar to the November 2020 restrictions but included a wider range of exceptions for outdoor recreation. COVID-O also agreed to amend the 'Christmas bubble' gathering exemption so that it applied on 25 December 2020 only for Tiers 1-3, with no exception for people from a Tier 4 area, again with the aim of reducing transmission. In addition, schools in Tier 4 were to limit on-site attendance to vulnerable children and the children of critical workers only. However, the position on whether schools could reopen after the Christmas holidays was to be kept under review. Amendments were also agreed for Tier 4 to correct the omission of schools from the exemptions to gatherings restrictions; and allowed safari parks, and other outdoor attractions (such as zoos and other places where animals were exhibited) to open, along with other minor amendments. Later the same day a submission was sent to the Secretary of State to seek agreement for these changes. The PM announced the introduction of Tier 4 in London, the South East and the East of England later that day.

241. On 20 December 2020, a submission was sent to the Secretary of State to make the Health Protection (Coronavirus, Restrictions) (All Tiers and Obligations of Undertakings) (England) (Amendment) Regulations 2020 (CW5/410 - INQ000234676; CW5/411 - **INQ000110215;** CW5/412 - **INQ000110213;** CW5/413 - **INQ000110214;** CW5/414 - **INQ000234675;** CW5/415 - **INQ000110218;** CW5/**401** - **INQ000110198;** CW5/417 - **INQ000110220;** CW5/418 - **INQ000110221;** CW5/419 - **INQ000110217;** CW5/420 - **INQ000234682**). These introduced the 'Tier 4' of additional restrictions in

the areas outlined above. The regulations were made and came into force the same day, on 20 December 2020. Further detail is provided at paragraph 428 below.

242.Following a COVID-O meeting on 23 December 2020, a signing submission was sent to the Secretary of State to make regulations to move certain local authority areas into Tiers 2, 3 and 4, and to make amendments to the Tier 4 restrictions, including an exemption to the gatherings restrictions for schools (CW5/421 - INQ000110262; CW5/422 - INQ000110264; CW5/423 - INQ000110263; CW5/424 - INQ000110250; CW5/425 - INQ000110251; CW5/426 - INQ000110252; CW5/427 - INQ000110253; CW5/428 - INQ000110254; CW5/429 - **INQ000091098;** CW5/430 - INQ000110256; CW5/431 - INQ000110257; CW5/432 - INQ000110258). The regulations were made by the Secretary of State on 24 December 2020 and came into force on 26 December 2020. A further set of regulations were made on 30 December 2020 following a COVID-O meeting to clarify the application of Tier 4 restrictions.

243.At this point, Departmental advice on the process of moving areas in England to different Tiers was driven by the epidemiological evidence, pressure on the NHS, and human travel patterns as set out in the COVID-19 Winter Plan, published November 2020 (CW5/433 - INQ000234653). At the same time, the Government had also committed to prioritising keeping schools open as much as possible, to mitigate the impacts on children's education and wellbeing, a commitment that was reaffirmed in the COVID-19 Winter Plan (CW3/55 - INQ000106867) and in the decision to exempt education from the 'stay at home' order given for the November 2020 lockdown (CW5/333 - **INQ000234586**).

244.As concerns about the impact of the Alpha variant grew, keeping schools open in areas with high prevalence was challenging, particularly in London and the South East, with the Government position being that schools would remain open until the Christmas break and would re-open after Christmas (CW5/434 - INQ000234647). This was reflected in the Secretary of State's announcement on 10 December 2020, which included a commitment to surge mobile testing in schools in an effort to keep schools open (CW5/435 - INQ000234548). On 17 December 2020, the Secretary of State for DfE re-iterated this commitment but said that secondary schools would have a staggered return to facilitate the roll-out of testing.

245.Although the introduction of the fourth tier included the commitment to keep education open (CW5/436 - INQ000234651), by late December discussions between relevant

Government Departments and Directors of Public Health reflected concern over the 'patchwork' approach to proposals to manage school re-opening (CW5/437 - INQ000234689 and CW5/438 - INQ000234690). When the Secretary of State announced on 30 December 2020 (CW5/439 - INQ000234687) that further areas would move into Tier 4, this was accompanied by the decision to delay return of primary schools in areas with highest transmission risk (CW5/440 - INQ000234685).

246. A decision was taken on 4 January 2021 to impose a third national lockdown starting on 6 January 2021 (CW5/441 - INQ000234693). When the PM announced the impending lockdown on 4 January, he advised that learning should move to remote delivery the following day. Some schools re-opened on 5 January 2021 only to close again the following day.

The third national lockdown

247. On 4 January 2021, the four UK CMOs recommended that the National Alert Level should move from Level 4[1] to Level 5[2]. In response to this recommendation, and concerns about rising transmission rates in Tier 4 areas, COVID-O agreed on 4 January 2021 to move all areas in England into Tier 4 and tighten some of the Tier 4 restrictions in order to achieve a national lockdown. The same day the Secretary of State received a paper from the COVID-19 Taskforce which he considered at the PM dashboard (the daily dashboard produced for the PM showing changes in the number of cases, etc.) which set out a proposal for a nationwide lockdown. Following this meeting a Cabinet call agreed to move all areas in England into Tier 4 and tighten some of the Tier 4 restrictions in order to achieve a national lockdown. Later that day the PM announced that England would have to go into a national lockdown and asked that people to stay at home, leaving only for the limited reasons permitted in law. As part of this announcement the PM outlined that primary schools, secondary schools and colleges across England were required to remote provision from the next day, except for vulnerable children and the children of key workers (CW5/442 - INQ000234691; CW5/443 - INQ000234696; CW5/444 - INQ000234697; CW5/445 - INQ000234695).

[1] Level 4: COVID-19 is in general circulation in the UK; transmission is high and direct COVID-19 pressure on healthcare services is widespread and substantial or rising.
[2] Level 5: As level 4 and there is a material risk of healthcare services being directly overwhelmed by COVID-19.

248.The Health Protection (Coronavirus, Restrictions) (No. 3) and (All Tiers) (England) (Amendment) Regulations 2021 were made on 5 January 2021. These regulations amended the Tiers Regulations to place all of England into Tier 4; strengthened the Tier 4 restrictions to impose a national lockdown; and extended the expiry date of the Tiers Regulations to 31 March 2021. Please see paragraph 429 below for further detail about these regulations.

249.On 6 January 2021, the PM made a statement in the House of Commons which set out the national lockdown and wider measures to address the rising transmission of the new variant (CW5/446 - INQ000234699).

250.On 7 January 2021, Departmental officials provided a note to the Secretary of State which sought steers on allowing for an explicit legal exemption for elite sport competitions to come into force the following week (CW5/447 - INQ000234701). The Secretary of State confirmed he was content with this proposal the same day (CW5/448 - INQ000234701).

251.On 10 January 2021, Departmental officials provided a briefing to the Secretary of State on a CO paper produced for a COVID-O meeting the same day (CW5/449 - INQ000234704 and CW5/450 - INQ000234705). The CO paper set out options for increasing the effectiveness of the lockdown, in light of the data and position with the NHS. Departmental officials were broadly supportive of the CO paper and agreed with the recommendation that a continued 'Stay at Home' message around compliance should be the main lever and the communications should be strengthened, and that any additional measures taken should be applied nationally. It was agreed at COVID-O to remove the 'rule of two' provision for exercising with someone from another household, and to put several options to the PM for decision on how to achieve this (CW5/451 - INQ000234706).

252.On 11 January 2021, a submission was sent to the Secretary of State that set out proposed amendments to the Tiers Regulations (CW5/452 - INQ000234708 and CW5/453 - INQ000234709). Primarily, these amendments were intended to clarify changes to the Tier 4 restrictions which were in force across all of England. On 12 January 2021, Departmental officials provided a follow up note on points that the Secretary of State had expressed reservations about, providing a more detailed explanation in respect of each of the proposals (CW5/454 - INQ000110343). The Secretary of State's view was that, as these were minor amendments, any changes

could wait to be done jointly with any enforcement amendments agreed at COVID-O scheduled for 15 January 2021.

253. On 18 January 2021, the Secretary of State confirmed he was content with the full list of proposals in the submission on 11 January 2021 and the follow up note on 12 January 2021 (CW5/455 - INQ000234712).

254. On 19 January 2021, the Secretary of State undertook a statutory review of the geographical allocation of areas and confirmed he was content that the geographical allocation of all areas of England remained appropriate and the restrictions were proportionate and necessary to achieve the objectives of the regulations (CW5/456 - INQ000059632; CW5/457 - INQ000110399; CW5/458 - INQ000110400; CW5/459 - INQ000110402; CW5/460 - INQ000110403; CW5/461 - INQ000110404; CW5/462 - INQ000110405; CW5/463 - INQ000110406; CW5/464 - INQ000110407; CW5/465 - INQ000110408).

255. On 25 January 2021, following COVID-O on 15 January 2021, a submission was sent to the Secretary of State about the introduction of a new FPN for people attending a prohibited gathering of more than 15 people that takes place in a private dwelling or educational accommodation, or constitutes an indoor rave (CW5/466 - INQ000110472; CW5/467 - INQ000110473; CW5/468 - INQ000234719). This new offence was implemented in regulations which were made on 28 January 2021 and came into force the following day.

256. On 27 January 2021, CO presented a paper to a meeting of COVID-O about the re-opening of schools, which set out that this should not be before 8 March 2021 at the earliest and was also conditional on the epidemiological position. Departmental officials advised the Secretary of State to endorse this timeline.

257. On 2 February 2021, a submission was sent to the Secretary of State for the statutory review of the Tiers Regulations (CW5/469 - **INQ000110543;** CW5/470 - INQ000234728; CW5/471 - **INQ000059779;** CW5/472 - **INQ000110522;** CW5/473 - **INQ000110545;** CW5/474 - **INQ000059780;** CW5/475 - **INQ000110551;** CW5/476 - **INQ000059778;** CW5/477 - INQ000110560). The submission recommended that, based on the epidemiological data available from JBC and PHE, all areas of England should remain in Tier 4. The Secretary of State confirmed he was content with this

recommendation. A WMS was issued on 4 February 2021 setting out the outcome of this review (CW5/478 - INQ000234731).

258. After this review, work began on the development of the Roadmap, and the easing of the third national lockdown. As the Roadmap summary set out, the vaccine rollout had not yet reached a point at which it was making a sufficiently significant impact on controlling the virus; but the programme of NPIs had contributed to protecting the NHS (CW5/479 - INQ000234765), which now meant that the possibility of a degree of de-escalation of national restrictions had started to become a viable option[3].

Development and implementation of the Roadmap

259. On 27 January 2021, the PM made a commitment to review the national measures in mid-February 2021 and publish a Roadmap for taking the country out of lockdown in the week commencing 22 February 2021. The Roadmap would detail the Government's approach to exiting lockdown and set out policy on the continued response to COVID-19, including the reopening of schools from 8 March 2021, the lifting of social contact restrictions, and the reopening of businesses, alongside plans for the further use of testing and for the vaccine rollout. CO led on drafting the Roadmap, with input from the Department. The Roadmap was implemented on the following dates: Step 1A on 8 March 2021, Step 1B on 29 March 2021, Step 2 on 12 April 2021, Step 3 on 17 May 2021 and, after a short delay, Step 4 was reached on 19 July 2021, at which point all legal limits on social contact were removed.

260. On 19 January 2021, Departmental officials provided the Secretary of State with a note and a data pack from the JBC ahead of a meeting later that day for initial discussions about de-escalating the national restrictions (CW5/480 - INQ000234713; CW5/481 - **INQ000072491;** CW5/482 - **INQ000072492)** On 21 January 2021, Departmental officials submitted to the Secretary of State a paper with an outline strategy for coming out of lockdown (CW5/483 - INQ000234717 and CW5/484 -

[3] From 8 March, people in England will see restrictions start to lift and the government's four-step roadmap offer a route back to a more normal life.

The success of the vaccination programme is one factor - so far over 17 million people have had their jabs - but by no means the whole story. The public have also risen to the challenge of suppressing COVID-19: by obeying the law; staying at home; getting tested when needed; isolating when required, and following the 'hands, face, space' and 'letting fresh air in' guidance.

Taken together, this means that even though absolute case numbers remain relatively high, we will be able to begin relaxing the current strict lockdown. While we must all remain vigilant - in particular against the threat from new COVID-19 variants - and continue to protect the NHS, a safe exit from lockdown can begin. It will take place in four steps; and at each step, we plan to lift restrictions across the whole of England at the same time.

INQ000234718). The paper set out high-level issues, and the range of considerations in planning such a de-escalation; and the decision points that would shape the process for reviewing the data through Bronze, Silver and Gold meetings. Following steers from the Secretary of State, a paper setting out the Department's proposal for coming out of lockdown was sent to the COVID-19 Taskforce on 27 January 2021.

261. On 3 February 2021, as part of the development of the Roadmap strategy, the COVID-19 Taskforce commissioned a paper, with support from the Department to set out the options and key considerations for relaxing social contact rules. On 5 February 2021, Departmental officials submitted a paper titled 'Increasing Social Contact' to the Secretary of State providing advice on policy proposals on how to ease social contact restrictions from 8 March 2021 (CW5/485 - INQ000234732 and CW5/486 - INQ000234733). The Secretary of State confirmed that he agreed with a slow de-escalation model; and provided a steer that he favoured following the Tiers framework, which would be followed by steps for further reducing restrictions on social contact. The Secretary of State confirmed that he was content for the paper to be shared with officials from the COVID-19 Taskforce and it was shared on 8 February 2021 (CW5/487 - INQ000234734 and CW5/486 - INQ000234733)

262. On 9 February 2021, Departmental officials submitted a draft paper to the Secretary of State setting out the Department's proposed approach to de-escalating national restrictions in the context of scenarios suggested by the COVID-19 Taskforce for modelling purposes (CW5/489 - INQ000257433 and CW5/490 - INQ000234736). Following steers from the Secretary of State, the paper was updated (CW5/491 - INQ000257435 and CW5/492 - INQ000257436).

263. On 14 February 2021, Departmental officials provided a submission to the Secretary of State setting out the Department's view of the Roadmap ahead of a COVID-S meeting the following day (CW5/493 - INQ000234298 and CW5/494 - INQ000234297) The submission discussed key decisions that would need to be taken prior to publication of the Roadmap and sought steers on the policy and the Department's input. The Secretary of State responded requesting a note detailing key issues for discussion. The following morning a paper setting out the key issues and contextualising NHS capacity modelling within the four scenarios set out by COVID-19 Taskforce was provided ahead of the COVID-S meeting (CW5/495 - INQ000234752 and CW5/496 - INQ000234753).

264.The COVID-S meeting on 15 February 2021 discussed the approach to easing national restrictions (CW5/497 - INQ000234754). Following the meeting the Secretary of State wrote to the Chair of the Health and Social Care Committee, with input from No.10, setting out the Department's position on the easing of national restrictions (CW5/498 - INQ000110688 and CW5/499 - INQ000110689).

265.At a Gold Local Action Committee (LAC) held on 17 February 2021, the Secretary of State gave a steer that Gold would need to devote time to exploring further two key issues: i) new variants of COVID-19 that were of concern or under investigation and; ii) local authority areas where disease rates were either not decreasing sufficiently quickly or were instead rising (CW5/**1AZ** - INQ000234756 and CW5/501 - INQ000234755).

266.On 19 February 2021, Departmental officials sent a submission to the Secretary of State explaining that decisions would need to be made about the Roadmap over the coming weekend. The submission also provided advice on a further statutory review of the Tiers Regulations (CW5/502 - INQ000110701; CW5/503 - INQ000110702; CW5/504 - INQ000110703; CW5/505 - INQ000110704; CW5/506 - INQ000110706; CW5/507 - INQ000110707; CW5/508 - INQ000110708; CW5/509 - INQ000110709; CW5/510 - INQ000110710; CW5/511 - CW5/502 - INQ000110711;). On 22 February 2021, the Secretary of State completed a further statutory review of the allocation of the necessity of the measures contained in the regulations and the allocation of areas to Tiers to ensure the timing of the next review to aligned with the timeline of upcoming Roadmap decisions (CW5/512 - INQ000110724).

267.On 20 February 2021, Departmental officials briefed the Secretary of State ahead of the COVID-S meeting the following day. The COVID-S was held on 21 February 2021 in order to finalise the route out of national lockdown ahead of the publication on 22 February 2021. A CO paper was produced for the meeting which indicated a cautious and conditional approach to lifting restrictions, committing to a minimum of 5 weeks between steps and being guided by data rather than dates. The COVID-S meeting attendees agreed that the Secretary of State would amend the current lockdown regulations with a single statutory instrument to make changes as part of Step 1 prior to 8 March 2021. This would be followed by another statutory instrument to put the Roadmap into regulations (replacing and repealing the All Tiers Regulations) prior to Parliament's Easter Recess, and which would have an expiry date of the end of July 2021. It was agreed that the Government would introduce a 'Stay in the UK' provision

into legislation, which would replace 'Stay at Home' restrictions as the legal mechanism to prohibit unnecessary international travel as part of overall efforts to manage the risk of importing and exporting variants. It was also agreed that legislation should be in place to require those who were travelling abroad to complete a form to outline the reason for their travel and that this would apply until at least 17 May 2021. (CW5/513 - INQ000234760; CW5/514 - INQ000234758; CW5/515 - INQ000234761; CW5/516 - INQ000234767; CW5/517 - **INQ000088275)**

268. On 22 February 2021, CO published the '*COVID-19 Response - Spring 2021: Roadmap out of lockdown*' (CW5/518 - INQ000234770). This set out that restrictions would be eased via four incremental 'Steps', with the first step in two parts on 8 March 2021 and 29 March 2021, as was agreed at COVID-S on 21 February 2021. The Roadmap also set out how the Government would progress through Steps 2 to 4 only when it was safe to do so, and that before moving to a subsequent Step, the Government would review the data to assess the impact of the previous Step. This assessment would be based on four tests, which were designed following consultations with the whole of Government and with scientific advisors. The four tests were that:

a. The vaccine deployment programme was continuing successfully;
b. The available evidence showed that vaccines were being found to be sufficiently effective in reducing hospitalisations and deaths in those vaccinated;
c. Infection rates were not risking a possible surge in hospitalisations which would put unsustainable pressure on the NHS; and
d. The assessment of the risks was not fundamentally changed by any new Variants of Concern.

269. The progress and impact of the vaccination programme was an important consideration when decisions were made on the relaxation of COVID-19 restrictions. The PM made this clear in Parliament on 22 February 2021, when announcing the Roadmap for easing lockdown restrictions. He noted that the data suggested both vaccines in deployment were effective against the dominant strains of COVID-19, so that as more people were inoculated, the protection afforded by the vaccines would gradually replace the need for restrictions.

270.On 22 February 2021, Departmental officials submitted advice to Ministers on the handling of the Roadmap. The submission recommended implementing Step 1 of the Roadmap through the two statutory instruments identified at paragraph 266 above. On 23 February 2021, the Secretary of State confirmed that he was content with this approach (CW5/519 - INQ000060079 and CW5/520 - INQ000060085).

271.On 22 February 2021, a submission was sent seeking a steer from the Secretary of State on proposed changes to the agendas and content of the LAC Silver and Gold meetings. (CW5/521 - INQ000234769 and CW5/522 - INQ000234768) It also proposed that the JBC would produce a summary note from Silver which would set out public health officials' consensus view in order to inform decision making at Gold. The same day, on 22 February 2021, the Secretary of State confirmed that he was content with the proposed revised agenda, content, slide packs and sequencing for the Silver and Gold meetings (CW5/523 - INQ000234778). The Secretary of State also noted the proposed framework for reporting on the four key tests set out in the Roadmap, which were likely to follow the format: (1) a submission on Mondays with decisions of escalation/de-escalation; (2) the formalisation of that decision by Silver and Gold; and (3) that decision being sent to the COVID-19 Taskforce to inform their paper for COVID-O.

272.On 24 February 2021, a submission was sent to Ministers seeking steers on outstanding policy issues for Step 1 of the Roadmap. This included the policies on wraparound care, exemptions from the 'Stay at Home' requirements to allow for election activities and extending support bubble eligibility for the recently bereaved. On 25 February 2021, the Secretary of State agreed with these policy proposals (CW5/524 - INQ000234779 and CW5/525 - INQ000234780).

273.Further advice was provided to the Secretary of State on 25 February 2021 about the implementation of 'Stay in the UK' provisions, which had been agreed at the COVID-S meeting on 21 February 2021 and seeking steers on an exemptions policy. On 26 February 2021, the Secretary of State gave his steers (CW5/526 - INQ000060117 and CW5/527 - INQ000234782).

274.On 26 February 2021, officials provided an update to the Secretary of State to note that No.10 had agreed that that the 'Stay in the UK' provision should be given legal effect through upcoming regulations; and that No.10 had agreed with the majority of the exemption recommendations but had also requested worked examples for some

of the exemptions, to help in the development of clear guidance (CW5/528 - INQ000234783).

275. However, on 2 March 2021, Departmental officials provided further advice to the Secretary of State on legislating for 'Stay in the UK' provisions, recommending delaying the introduction of this measure until 29 March 2021 so that a full assessment of public health advice and delivery options could be conducted. On 3 March 2021, the Secretary of State confirmed that he was content with the recommendation to delay legislating for 'Stay in the UK' provisions until 29 March 2021 but also to introduce the mandatory declaration of travel form from 8 March 2021. He also confirmed he was content with the public outdoor spaces recommendations, and with No.10's position on counting linked households as one (CW5/529 - INQ000234794 and CW5/530 - INQ000110802).

276. On 4 March 2021, a submission was sent to the Secretary of State seeking steers on outstanding policy issues for the second set of implementing regulations for the Roadmap, which were due to come into force on 29 March 2021 (CW5/531 - INQ000234796). On 8 March 2021, the Secretary of State confirmed he was content with the proposed definition of self-contained accommodation, and that businesses implicitly closed by the Stay at Home order (e.g., animal groomers, photography studios, and car valet services) could reopen in Step 1B, but that those explicitly closed by the regulations (e.g., nightclubs, hospitality and entertainment venues) could not (CW5/532 - INQ000234799).

277. A submission was provided to Ministers on 5 March 2021 for the statutory review of the Tiers Regulations and to make the regulations implementing Step 1A of the Roadmap (to come into force on 8 March 2021). On 8 March 2021, Lord Bethell completed a review of the allocation of the areas to Tiers under the Tiers Regulations and made the regulations which implemented Step 1A of the Roadmap (CW5/534 - INQ000060158; CW5/535 - INQ000060159; CW5/536 - INQ000060160; CW5/537 - INQ000060162; CW5/538 - INQ000060163; CW5/539 - INQ000060164; CW5/540 - INQ000060165; CW5/541 - INQ000060166; CW5/542 - INQ000060167; CW5/543 - **INQ000060149;** CW5/544 - INQ000060169; CW5/545 - INQ000060170). See paragraphs 430 below for further detail as to the regulations.

278. On 9 March 2021, officials provided a submission to the Secretary of State on a further set of regulations to revoke and replace the Tiers Regulations and implement Steps

1B – 3 of the Roadmap. The submission sought steers on policies for wedding receptions and life events for Steps 2 and 3 of the Roadmap; the use of the Regulations to extend the eviction ban; and provided an update on 'Stay in the UK'. The Secretary of State did not agree to extend wedding receptions in Step 2 to any indoor setting, preferring these to be permitted only in COVID-19 secure outdoor venues in Steps 2 and 3. He agreed the extended ban on evictions (CW5/546 - INQ000060223 and CW5/547 - INQ000234801).

279. Further submissions were sent to the Secretary of State regarding steers on the implementation of Steps 1B to 3 of the Roadmap (including in respect of FPNs) on 10, 11, 12, 15-18, 20-21 and 26 March 2021 (CW5/548 - INQ000060252; CW5/549 - INQ000060338; CW5/550 - INQ000060338; CW5/551 - INQ000060366; CW5/552 - INQ000110870) upon which he provided his comments where appropriate (CW5/553 - INQ000234807; CW5/554 - INQ000234808; CW5/555 - INQ000234818; CW5/556 - INQ000234820; CW5/557 - INQ000234821; CW5/558 - INQ000234822; CW5/559 - INQ000234819).

280. On 21 March 2021, a signing submission was provided for the draft regulations to revoke to the Tiers Regulations and replace them with the framework for the remaining Roadmap Steps. The Secretary of State made the Health Protection (Coronavirus, Restrictions) (Steps) (England) Regulations 2021 (the Steps Regulations) on 22 March 2021, which came into force on 29 March 2021 (CW5/560 - INQ000234823; CW5/560 - INQ000234823; CW5/561 - **INQ000059439;** CW5/562 - INQ000234825; CW5/563 - **INQ000059450;** CW5/564 - **INQ000110891;** CW5/565 - **INQ000110888;** CW5/566 - **INQ000060422;** CW5/567 - **INQ000060420;** CW5/568 - **INQ000110893;** CW5/569 - **INQ000060421;** CW5/570 - **INQ000110897;** CW5/571 - **INQ000060392)**.

281. On 29 March 2021, the 'rule of six' or two households' restrictions regarding outdoor gatherings were introduced (including for weddings and civil partnerships). Outdoor sports facilities were reopened. The 'Stay at Home' requirement ended, but the public were encouraged by way of guidance to stay local. 'Stay in the UK' travel restrictions were introduced.

282. On 31 March 2021, a submission was provided to the Secretary of State about the regulations that would be needed to implement Step 2 of the Roadmap on 12 April 2021 (CW5/572 - INQ000110936). On 3 April 2021, the Secretary of State agreed all the recommendations in the submission (CW5/573 - INQ000234850).

283.On 6 and 9 April 2021 amending regulations were made in respect of various matters under the Steps Regulations. Further detail is provided in Section 6 below.

284.On 12 April 2021, amending regulations enabled non-essential retail, hairdressers, and public buildings such as libraries, self-contained holiday accommodation to reopen. Outdoor venues that also included restaurants, pubs, theme parks, zoos as well as indoor leisure settings such as gyms were allowed to open. Indoor activities resumed for children and for sport. Limits were set for 30 people attending funerals, and 15 attending wakes, weddings and receptions. The number of permitted visitors to care homes increased to two.

285.A submission to the Secretary of State on 19 April 2021 sought confirmation of the Department's position on CO proposals for extending the numbers permitted in support and parent and child groups from 15 to 30 in Step 3 (CW5/574 - INQ000111022). On 20 April 2021, Ministers agreed to the proposal (CW5/575 - INQ000234872).

286.On 21 April 2021, a letter was sent from the Secretary of State to the PM confirming that all remaining higher education students could return to face-to-face learning as part of Step 3 of the Roadmap. It also set out several outstanding policy questions (CW5/576 - **INQ000257446**).

287.The COVID-O meeting on 10 May 2021 considered the 'four tests' evidence pack, jointly produced by the JBC, SPI-M, the Office for National Statistics and PHE and concluded that the four tests had been met and that the data supported moving England to Step 3 on 17 May 2021 (CW5/577 - INQ000234902 and CW5/578 - INQ000234903). The Secretary of State made the corresponding regulations on 14 May 2021. On 12 May 2021, a signing submission was provided to Departmental Ministers for implementing Step 3 and minor amendments to COVID-19 restrictions.

288.Following a request from the Secretary of State, a briefing note was provided on 15 May 2021 to clarify how holiday and travel in England and Wales would interact. Confirmation was received on 16 May 2021 that the Secretary of State was content with this position.

289.On 17 May 2021, the Health Protection (Coronavirus, Restrictions) (Steps and Other Provisions) (England) (Amendment) Regulations 2021 moved every area in England

from the Step 2 restrictions to Step 3. See paragraphs 431 to 432 below for further detail.

290. The planned move to Step 4 in early June 2021 was delayed by four weeks so more adults could be vaccinated (CW5/190 - INQ000234967).

291. On 14 June 2021, officials advised Department Ministers about extending Step 3 until 19 July 2021, following consideration of the evidence at a COVID-O meeting on 14 June 2021 (CW5/579 - INQ000111393; CW5/580 - INQ000111376; CW5/581 - INQ000234945; CW5/582 - INQ000111375; CW5/583 - INQ000111378; CW5/584 - INQ000111380; CW5/585 - INQ000111381; CW5/586 - INQ000111382; CW5/587 - INQ000111385; CW5/588 - INQ000111384; CW5/589 - INQ000111383; CW5/590 - INQ000111386; CW5/591 - INQ000111392; CW5/592 - INQ000111391; CW5/593 - INQ000061077) This extension was implemented through regulations which the Secretary of State made on 15 June 2021 (CW5/594 - INQ000234959).

292. On 21 June 2021, restrictions were lifted on the maximum number of attendees at weddings, civil partnership ceremonies and receptions, and commemorative events. The number of people who could attend these events was restricted by how many people a COVID-19 secure venue could safely accommodate, with social distancing measures in place, including any staff working at the event. These events including funerals could also now take place inside private homes in line with social contact limits (six people, or larger groups where everyone present was from two households), except in the case of deathbed weddings.

293. The same day, a submission was sent to the Secretary of State which provided options for gathering evidence on the safety of domestic cruises and Step 4 decision-making (CW5/595 - INQ000111447). The previous submission of 14 June 2021 had highlighted concerns about social distancing and capacity limits for cruises in Step 4. COVID-O agreed to the recommendations in the submission on 24 June 2021. On 22 June 2021, the Secretary of State indicated that he was content to move to 50% capacity for domestic cruises (CW5/596 - INQ000234960). The remaining period in Step 3 would give time to gather further evidence to allow for an informed decision on how cruises would operate from Step 4.

294. The CO published a review of social distancing on 5 July 2021 (CW5/597 - INQ000182182 and CW5/598 - INQ000235017). This considered the scientific,

economic, social, and behavioural evidence about the impact of the measures taken up to that point; as well as the implications of a shift towards lifting these measures. It also considered the economic and social benefits, assessed against people's protected characteristics, of any move towards the lifting of restrictions, and also of the potential increased transmission risks of such changes. Development of the report was led by the COVID-19 Taskforce, with the Department supporting and contributing, and the outputs helped inform considerations about Step 4 in the COVID-19 Roadmap. The CO published a review on 6 July 2021 of whether COVID-19 status certification could play a role in the reopening the economy, in enabling restrictions on social contact to be lessened, and in reducing the risk of transmission generally. This concluded that the Government had decided against a policy of mandating COVID-19 status certification as a condition of entry to settings.

295. At the COVID-O meeting on 12 July 2021 it was agreed that Step 4 of the Roadmap out of lockdown could be implemented from 19 July 2021. On 14 July 2021, a submission was sent to Department Ministers in respect of the Health Protection (Coronavirus, Restrictions) (Steps etc.) (England) (Revocation and Amendment) Regulations 2021, which were made by the Secretary of State later that day and which came into force on 18 July 2021 (CW5/599 - **INQ000092034;** CW5/600 - INQ000234970; CW5/601 - **INQ000111581;** CW5/602 - **INQ000111580;** CW5/603 - **INQ000111577;** CW5/604 - **INQ000111579;** CW5/605 - **INQ000111584;** CW5/606 - **INQ000111585;** CW5/607 - INQ000234978; CW5/608 - **INQ000111586;** CW5/609 - **INQ000111583;** CW5/**564** **INQ000110891**).

296. On 19 July 2021, the Secretary of State was briefed about a COVID-19 Taskforce paper on Certification for a COVID-O meeting scheduled for later that day (CW5/611 - INQ000234991; CW5/612 - INQ000234992; CW5/613 - INQ000234993; CW5/614 - INQ000234997; CW5/615 - INQ000234998). This highlighted that the COVID-19 Taskforce led on the development of policy on certification and highlighted outstanding policy points and challenges with delivery. COVID-O considered a COVID-19 Taskforce paper that recommended that the Government should announce a plan to introduce a requirement that acquiring full vaccination status should, from the end of September 2021, become a condition of entry to nightclubs and other venues where large crowds gather. The Department was commissioned to work with NHSX, UKHSA, DCMS, BEIS and the COVID-19 Taskforce to develop this policy, including defining the settings in scope, considering the risks and impacts, and developing a

communications plan. The PM then announced this intention at the COVID-19 press conference later that same day.

297.The same day, all legal restrictions on social contact were therefore removed (CW5/616 - INQ000234995). Premises that had remained under restrictions, including nightclubs were reopened. Restrictions on large events and performances, which had applied in Step 3, were eased. Restrictions on weddings and funerals were also removed. The 'hands, face, and space' messaging remained in guidance, as did legal measures to ensure compliance with COVID-19 secure requirements. Businesses were still required to ensure that self-isolating workers did not come to work, including workers and customers who felt unwell did not attend the setting. Employers also still had a legal duty to manage risks which affected their business. This was achieved by carrying out a health and safety risk assessment, including the risk of COVID-19, and to take reasonable steps to mitigate the risks they identified

SECTION 4: POLICY APPROACHES

298.This section of my statement will cover decisions taken by the Department as part of the overall Government response aimed at controlling the spread of the virus, whilst also developing policy aimed at moving towards business as usual. In covering the period from 1 August 2020, I will sometimes of necessity refer to actions taken, or decisions made before then.

NHS: Capacity

299.On 31 July 2020, guidance was issued to local NHS providers and commissioners outlining the third phase of the NHS response (CW5/617 - INQ000234420). The focus was on accelerating the return of non-COVID-19 health services, fully restoring cancer services and making full use of available capacity between July 2020 and winter 2020, whilst preparing for winter demand pressures. The guidance advised that clinically urgent patients would continue to be treated first, with priority then given to the longest waiting patients. Trusts, working with GP practices, were asked to ensure that every patient whose planned care had been disrupted by COVID-19 received clear communication about their treatment. Continued access to independent sector capacity was put in place to support the recovery and restoration of elective services.

300.The introduction of a three-tier system of Local Alert Levels in England ('Medium', 'High', and 'Very High') in the middle of 2020 allowed three packages of measures to

be implemented in response to different levels of incidence and risk. This was followed by the introduction of the third national lockdown in January 2021 due to the significant increase in cases of a newer COVID-19 variant across the country, which contributed significantly to the increased prevalence of COVID-19 illness and mortality over the course of the second wave.

301. The NHS was able to create capacity to manage the challenges presented by COVID-19, ensuring that urgent and emergency care and COVID-19 related care were not overwhelmed. During Winter 2020-21, the Government ran a significantly expanded seasonal flu vaccination programme to support the most clinically vulnerable and to ease pressure on the NHS. This programme reached over 19 million people from the priority patient groups, making it the largest seasonal flu programme ever in the UK.

302. During the second wave of the pandemic there was a significant impact on hospital bed capacity. NHSEI enacted a range of interventions including the use of independent sector capacity; Nightingale Hospitals; enhanced patient discharge arrangements; and the transfer of patients between regions. Work continued to help drive up activity to pre-pandemic levels and reduce long waiting lists, such as through the Elective Recovery Board, which brought programme oversight of the NHS's elective recovery, including the £1 billion Elective Recovery Fund.

303. While the impact of COVID-19 continued to put pressure on healthcare services, the NHS worked to deliver elective care as much as possible, with priority given based on clinical urgency and then length of wait. Despite a further COVID-19 peak in January 2021 (second wave), the NHS continued to deliver urgent and elective services, with increased activity to try and tackle the backlog.

304. At the peak of the second wave in January 2021, there were over 34,000 beds occupied by COVID-19 patients. For elective activity, per working day, admitted activity was around 50% of pre-pandemic levels and per working day non-admitted activity was around 75% of pre-pandemic levels. Significant investment was being made to recover elective activity and address the impact of the pandemic on the waiting list. In February 2022, the NHS published 'Delivery plan for tackling the COVID-19 backlog of elective care' setting out ambitions to eliminate waits longer than a year for elective care by March 2025 as well as further ambitions on cancer and access to diagnostic tests (CW5/618 - **INQ000087534)**

NHS: Ventilators

305. With the subsidence of the initial surge of COVID-19, the Ventilator Programme realigned with the Government's COVID-19 Recovery Strategy, NHS and Care Capacity, and Operating Model to maximise confidence in managing new cases. In particular, renewed focus was placed on preparation for a potential winter 2020/21 surge in COVID-19 cases.

306. The Ventilator and the Ventilator challenge programme, as described in my First Witness Statement for this Module at paragraphs 158 to 161, continued to manage the deployment of ventilators and associated equipment across health and care, including ongoing logistics and handling requirements; appropriate storage, testing and asset management. The summer period in 2020 afforded time and space to address the potential capacity requirements and demands associated with subsequent surges of COVID-19. Consideration was also given to the longer-term management of equipment assets and the robustness of ventilator consumables availability, ensuring everything required was available at the right time and place and in the right quantity.

307. During the second wave, focus was on identifying opportunities to improve long-term resilience within the ICU Consumable supply chain. This was aligned with the broader, whole of Government Battle Plan. Whilst the immediate work of securing NHS supply through stockpiling was taking place, focus was also:

Phase Two Workstream	**Phase Two Objective**
Oxygen Production & Distribution and Pipework	Enable existing contingency measures to be quickly ramped back up as needed.
Ventilation and Equipment	Put in place a strategic equipment management process.
Clinical Consumables	Create a formal stockpile of consumables for use in future surges and broader supply disruption events.
Logistics and Warehouse Operations:	Manage transition into medium and long-term storage and distribution.
Programme Core	Provide Project Management Office (PMO) support to the programme.
Future Data	Future data programme and a new organisation design activity.

Global Supply Risks	The Global Supply Risks workstream did not take place due to lack of funding availability.

308. Ventilation and Equipment objectives were to put in place a strategic equipment management process. Phase 2 which ran from June 2020 to December 2020, started in a significantly improved position from Phase 1 which ran from March 2020 to May 2020, as significantly enhanced quantities of devices were available. Key activities included:

a. Managing strategic deployment of scarce equipment across the NHS estate, including strategic reserve;
b. Equipment operations together with handling ongoing allocations, asset management, and distribution issues;
c. Taking receipt of the ventilator challenge devices, ensuring effective programme close;
d. Managing the deployment of assets to maximise quality, strategic fit.
e. Creating a strategic reserve of devices for use as part of any future response;
f. Ongoing contract management activities to ensure receipt of remaining devices ordered as part of Phase 1; and
g. Planning was also undertaken for strategic allocation of devices for winter and handling surplus (donation / sale) stock.

NHS: Nightingale Hospitals

309. I have set out the purpose of the Nightingale hospitals in my First Witness Statement for this Module at paragraphs 162 to 163.

310. From an NHS capacity perspective, the surge on bed occupancy during the first wave of COVID-19 was unlike the usual pressures on the NHS during winter. During a usual winter, general and acute (G&A) bed occupancy increases, which impacts on 'patient flow' through hospital and leads to patients queuing in emergency departments and ambulances queuing outside to hand over patients. From 2 November 2020 to 31 January 2021, during the second wave of COVID-19, the average G&A bed occupancy in all Acute Trusts in England was 87% and pressure was also felt in the intensive care units within hospitals (CW5/619 - **INQ000257496;** CW5/620 - **INQ000257497;** CW5/621 - **INQ000257498**). Critical care beds expanded from usual levels of 4,000 beds to over 6,000 beds reported as available, and the success of our interventions

meant that none of the Nightingales were required to function to their initial planned capacity. However, retention of the Nightingale sites was one of the measures expected to support capacity planning for the winter period – a period where the NHS usually experiences greater pressure.

311. In July 2020, the PM announced an additional £3 billion of funding to the NHS in England to get ready for winter (CW5/622 - INQ000234406). The funding was intended to allow the NHS to continue to use the extra hospital capacity acquitted from the independent sector and also to maintain the Nightingale hospitals until the end of March 2021.

312. Planning assumptions based on SAGE-endorsed SPI-M-O reasonable worse case scenarios were that over winter, at peak up to 5,000 ICU (critical care) beds would be required with a total of 21,500 beds for COVID-19 patients- compared to 19,000 during the first peak in April. The modelling also suggested that a second wave could require up to a total of 323,000 hospitalised patients – higher than the first wave and would require a significant amount of NHS capacity (CW5/623 - **INQ000234114**).

313. The additional capacity was planned to be met through mitigations announced as part of the £3 billion winter support package including:

a. Maintain increased bed capacity – £516m to maintain 7 Nightingale hospitals for surge capacity, £1.87b to continue independent sector capacity;
b. Increase space in A&Es – up to £450m for NHS trust to make improvements to their A&Es, including expanding space in emergency departments to help with infection prevention and control and social distancing, point of care testing, and increased use of same day emergency care for delivery by 1 January;
c. Improve patient discharges - £588m for those to reduce length of stay and improve discharges by funding out of hospital care packages to free up acute beds;
d. Expanded flu vaccinations – £206m to expand flu programme to include more patient cohorts with over 7m additional doses secured and aiming for 75% uptake and 100% for frontline healthcare workers;
e. NHS 111 'First' – increased call capacity and clinical input to avoid unnecessary A&E attendances and directly book appointments into GPs, urgent treatment centres and A&E slots (CW5/624 - INQ000235003);

f. Reduce ambulance conveyances – maximise use of See and Treat/Hear and Treat pathways to reduce avoidable conveyances to hospital from 999 calls.

314. In October 2020, NHS England wrote to HM Treasury outlining its proposed process for activating the Nightingales (CW5/625 - INQ000235004). As per the table below, it was expected that the Manchester site would be the first to be re-activated.

315. On 21 October 2020, a submission was made to the Minister for Health for information outlining HMG support for the activation of Nightingale sites in response to increased demands on existing NHS capacity driven by COVID-19. A national activation point would be when the COVID-19 prevalence rates suggested nearing full capacity in three weeks and no mutual aid was available. At that point, NHSEI was anticipating that sites in Manchester, Harrogate and Sunderland would need to be reactivated. Discussions were taking place with HMT to confirm the exact process for authorisation as HMT had previously stated that approval would need to be granted on a case-by-case basis (CW5/626 - INQ000234576).

316. The seven Nightingale hospital sites were Manchester, Harrogate, Sunderland, Midlands, Exeter, Bristol and London. As of 30 December 2020, the table below shows the clinical use of sites which varied across the regions.

Region & Nightingale	**Clinical Model**	**Position on 30 December 2020**
Southwest: Exeter	- A facility for the Devon and Cornwall population and wider SW region. Provides capacity for mechanical ventilation, non-invasive ventilation and ward based oxygen treatment for patients with COVID-19. Site has also been operating CT scanning. CQC approved. - 116 (V, O+ and O) beds. - *License expiry date: 06/05/2021.*	- Treating COVID-19 inpatients – clinical model in operation as of 26/11/2020. - 26 beds stood up. 24 inpatients on 29/12/2020. - Scale-up plan involves moving to 48 beds as more staff are released from the rosters.
Southwest: Bristol	- Dedicated critical care model providing surge capacity to the North-Southwest network (NBT, UHBT, RUH, GRH, GWH, TST). CQC approved. - 301 (v beds).	- Ophthalmic diagnostic service went live w/c 23/11/2020. 231 assessments carried as at 18/12/2020.

	- *License expiry date: 31/03/2021.*	- Paediatric medical day cases went live w/c 30/11/2020. 47 cases undertaken at 18/12/2020.
Midlands: Birmingham NEC	- Medical ward-based provision for patients who are not escalation to ITU, including those with palliative care needs; those stepping down from acute care, and those with rehabilitation and convalescence. CQC approved. - 387 (V, O+, O). - *License expiry date: 31/03/2021.*	- Additional use – exploring use of site for mass vaccinations.
Northwest: Manchester Convention Centre	- Non-COVID-19 step down care. Focus on a non-COVID-19 step down discharge and planning cohort. The model places greater emphasis on D2A and integration with intermediate care to promote flow from hospitals for community placements. - 633 (O and O+). - *License expiry date: 04/04/2021.*	- Clinical model in operation since 28/10/2020. - 113 total admissions as at 30/12/20, average length of stay 8.2 days. - 36 beds staffed and available. 12 patients currently on the ward.
Northeast and Yorkshire: Harrogate Convention Centre	- Level two and three critical care for COVID-19 patients including those needing supplemental oxygen and to step to non-invasive ventilation. CQC approval for extended use awaited – no issues anticipated based on initial feedback. - *License expiry date: 31/03/2021.*	- Additional use – during standby has been providing CT scanning facility. - 3614 CT scans have been completed as at w/c 21/12/20.
Northeast and Yorkshire: Sunderland	- Critical care model for COVID-19 positive acute inpatient decompression. Pathway for patients will include home, step down discharge facilities and palliative care. CQC approved. - 460 (V, O and O+). - *License expiry date: 31/03/2021.*	- Additional use – exploring use of site for mass vaccinations.
London: Excel	- Step down for care for non-COVID-19 patients. Greater emphasis on D2A and integration with intermediate care to promote flow from	N/A

	hospitals to community placements. Construction works have commenced. Also being mobilised as a large vaccination centre. - *License expiry date: rolling month extension.*	

317. On 5 January 2021, the PM met with the Secretary of State and Sir Simon Stevens, the Chief Executive of NHSEI, to discuss NHS capacity. One of the potential interventions discussed was accelerated discharge into social care and intermediate step-down facilities including Nightingale hospitals. The Secretary of State emphasised that he had asked NHS colleagues to look at what more could be done to use Nightingale hospital capacity as step-down both in London and elsewhere.

318. Demand peaked in late January 2021, cases of COVID-19 in England steadily declined, with pressures on bed occupancy and critical care reducing accordingly. 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 mainly provide overflow support for the most critical patients requiring ventilated care, rather than being designed to provide routine NHS care. Other Nightingale hospital facilities were designed to deliver step-down care for recovering patients. In early March 2021, it was announced publicly that the Nightingale hospitals would start to close from April 2021. Throughout April 2021 ministers worked closely with NHSEI to confirm decommissioning plans.

319. In April 2021, the NHS transferred the patient care provided in Nightingale hospitals back to local NHS services.

NHS: Independent Sector

320. The NHS used block contracts with the independent sector to secure all available capacity to continue treatment for the most urgent cases. The contract covered facilities, diagnostic equipment and staffing with the sector agreeing to support on a cost recovery basis. In March 2020, NHSEI put in place national commissioning arrangements with 26 independent sector providers to secure 100% of their facilities, resources and staff to aid the NHS response to COVID-19 on an at-cost basis. Over the course of 2020, de-escalation clauses in these contracts were triggered to reduce

the level of capacity the NHS had access to in line with the requirements of the NHS, and the number of participating independent providers fell. A final set of contracts was put in place for Q4 of FY20-21 with the final 14 participating providers to cover the winter wave of COVID-19 infections. These contracts used different terms allowing the NHS to activate surge capacity as needed.

321. Arrangements with independent sector providers returned to business as usual from 1 April 2021. NHSEI worked with independent providers to use business as usual mechanisms to increase the activity these providers can perform for NHS patients to reduce backlogs for elective treatment, which the pandemic exacerbated.

NHS: Staffing

322. The table below shows that, as of July 2021, there were almost 1.2m full-time equivalent staff in NHS hospitals and clinical commissioning groups. This was over 28,800 (2.5%) more than in July 2020 (CW5/627 - INQ000235015). This included:

a. Over 3,900 (3.3%) more doctors; and
b. Over 9,900 (3.4%) more nurses.

323. There was an increase in the NHS workforce in the decade between July 2010 and July 2020 of over 157,000 (15.6%):

	Jul-10	Jul-15	Jul-20	Jul-21		Change between Jul-20 & Jul-21	Change between Jul-10 & Jul-20	Change between Jul-15 & Jul-20
Doctors	95,005	104,505	120,457	124,377		3,920 (3.3%)	25,452 (26.8%)	15,952 (15.3%)
Nurses	272,188	269,919	294,399	304,340		9,941 (3.4%)	22,211 (8.2%)	24,480 (9.1%)
Total Staff	1,008,953	1,005,767	1,166,566	1,195,405		28,839 (2.5%)	157,613 (15.6%)	160,799 (16.0%)

324.A vacancy is defined as a post that is unfilled by permanent or fixed-term staff. Many vacant posts will be filled by agency or temporary staff. As shown by the table below, vacancy rates pre-pandemic were steady/falling slowing.

325.Vacancy numbers and rates were noticeably lower during the pandemic due to both increases in staff in post and NHS trusts being unable to prioritise workforce planning.

		Jun-18	Jun-19	Jun-20	Jun-21	Jun-22
Nursing	Vacancy rate	12.0%	12.3%	10.3%	10.3%	11.9%
	WTE Vacancies	42,589	44,195	37,760	38,814	47,232
Medical	Vacancy rate	9.6%	9.0%	6.0%	7.0%	7.4%
	WTE Vacancies	12,025	11,630	8,075	9,659	10,639
Total	Vacancy rate	9.4%	9.2%	6.6%	7.6%	9.7%
	WTE Vacancies	110,278	111,864	83,203	98,827	133,104

326.In the first wave of COVID-19, nearly 4,000 final year medical students graduated early from their degrees and joined the NHS in Foundation Interim Year One (FiY1) roles.

327.FiY1 roles offered more supervision than a standard Foundation Year 1 role, but also an opportunity for medical graduates to help on the COVID-19 response.

328.Students then started their standard Foundation Year 1 roles as usual in August 2020.

NHS: International Recruitment

329.On the 31 March 2020, as part of the response to the COVID-19 pandemic, the government announced that NHS frontline workers visas would be extended (CW5/628 - **INQ000257376**) and on 29 April 2020, it was announced that other frontline health and care workers would also receive visa extensions. Healthcare professionals whose

visas were due to expire between 31 March 2020 and 1 October 2020 were given a free, year-long extension (CW5/629 - **INQ000257377**).

330. On 20 November 2020, it was announced that this had been extended to cover visas expiring between 1 October 2020 and 31 March 2021 (CW5/630 - **INQ000257409**) and on 9 April 2021, a further extension was announced that would cover visas expiring up until 30 September 2021. Since starting the free extensions on 31 March 2020, the Home Office extended the visas of 10'000 people across the UK and it was expected that this further extension could benefit a further 14'000 applicants (CW5/631 - INQ000234855).

331. The NHS programme of international nurse recruitment continued during the pandemic period, in spite of challenging travel barriers. Additional funding was provided to the NHS in 2020/21 to increase the rate of overseas arrivals of nurses.

332. The Department also introduced an exemption from the requirement to quarantine in Managed Quarantine Service (MQS) facilities (hotel quarantine) for newly recruited nurses from overseas, as long as they could quarantine under the same conditions in hospital-arranged accommodation. This exemption was in place until India and the Philippines were removed from category 3, the travel 'red-list' on 23 April 2021.

333. Advice on the impact and options for international recruitment during the pandemic was provided in May 2020 to the Department's DG for Workforce.

334. As a result of high COVID-19 rates in India in April 2021 and extreme pressure on its health system, officials provided advice to Ministers on continuing recruitment even with MQS exemptions in place. This resulted in a six-week pause on recruited Indian nurses travelling to the UK to take up employment from April to June 2021.

NHS: Emergency Register

335. In response to the COVID-19 pandemic, the Government enabled some healthcare professional regulators to establish temporary registers. The Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) established emergency registers using powers conferred to them under the Coronavirus Act 2020 (the CVA). The General Medical Council (GMC) and the General Pharmaceutical Council (GPhC) established emergency registers using their existing powers.

336.The GMC granted temporary registration to doctors in good standing who had left the register in the last six years.

337.The 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.

338.The GPhC and Pharmaceutical Society of Northern Ireland granted temporary registration to pharmacy professionals in good standing who had left the register in the last three years.

339.The 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.

NHS: Volunteers

340.The NHS Volunteer Responders programme (NHSVR) was launched in March 2020 to support the NHS and people who were shielding or self-isolating. Volunteers provided help with collecting prescriptions, shopping, welfare calls, plus delivery of equipment for the NHS and patient transport. In December 2020, the vaccination steward role was added to ensure support to vaccination clinics across the country.

341.Over 2.5 million tasks have been undertaken through the NHSVR since the first tasks were carried out on 7 April 2020, including over 1 million hours of support to over 1,000 vaccination venues which started 17 December 2020, the vaccination centre support programme remains ongoing.

342.Of the 750,000 volunteers who initially stepped forward to help in March 2020, over half of these have been active.

Adult Social Care: Hospital Discharge

343.From 15 April 2020, when the Department's 'Action Plan for Adult Social Care' was published, and as in the NHS discharge policy published 21 August 2020, guidance confirmed that it was the responsibility of the NHS to test all patients prior to admission to a care home in advance of a timely discharge (CW5/632 - INQ000058130). The guidance stated where a test result was still awaited, the patient should be discharged

and, pending the result, should be isolated in the same way as a COVID-19 positive patient.

344. In September 2020, discussions began for a 'designation scheme' in conjunction with the Care Quality Commission (CQC) to identify and prepare premises, known as designated settings, which were safe for people leaving hospital who have tested positive for COVID-19 or are awaiting a test result. The departments Adult Social Care Winter plan, published in September 2020, contained a commitment to deliver on the designation scheme, this was announced in letters to local adult social care systems in October and November 2020 (CW5/633 - INQ000234612 and CW5/633a - INQ000234564).

345. These included the new requirement that "no one be discharged into or back into a registered care home setting with a COVID-19 test result outstanding". The first designated settings were opened from November 2020 and guidance was published on 16 December 2020 (CW5/634 - INQ000234652). The designated setting scheme remained in place for winter 2021/2022.

Adult Social Care: Winter Plan

346. On 18 September 2020, the Department published the 2020/21 Adult Social Care COVID-19 Winter Plan (CW5/635 - INQ000234495). This covered testing, PPE, management of local outbreaks and ongoing support from local government and the NHS. This drew heavily on the recommendations from the Social Care Sector COVID-19 support taskforce which were published at the same time. The ASC Winter Plan also established the Social Care Sector COVID-19 Stakeholder Group, with Sir David Pearson as chair, to support the delivery of the plan. In November 2020, the Department set up the Regional Assurance team to have oversight and provide assurance and intensive support to local delivery of the Winter Plan. 17 sector experts were recruited to work across the 9 local authority regions in England.

347. On the 22 February 2021, the government announced the National Roadmap out of Lockdown beginning with Step 1 (implemented in two stages on the 8 and 29 March 2021). Whilst the roadmap did not specifically reference ASC, the Department later made changes to guidance to reflect the steps for wider society.

348. The ASC visiting guidance was updated on:

a. 15 October 2020, to reflect the tightened infection prevention and control measures required to enable visits to continue safely (CW5/636 - INQ000058553);
b. 5 November 2020, to support visits during the period of national lockdown, with a focus on safe forms of visiting (CW5/637 - INQ000234603);
c. 1 December 2020, at the end of the national lockdown, to introduce:

i. Testing for visitors prior to entry to the care home and infection prevention and control procedures within the home;
ii. Ability for working age residents to join their families in their homes subject to protective measures.
iii. Allowing bubbles between care home residents and one other household (CW5/638 - INQ000234635 and CW5/639 - INQ000234636).

d. 19 December 2020, to align with the creation of local tiers of response (CW5/**638** - **INQ000234635**);
e. 8 March 2021, to allow one named visitor per resident plus Essential Care Givers (who could visit during outbreaks) (CW5/641 - **INQ000234980**);
f. 12 April 2021, to allow two named visitors (CW5/642 - INQ000234851);
g. 4 May 2021, to allow visits out of the care home to spend time outdoors (CW5/643 - INQ000234884);
h. 17 May 2021, to allow visits out of the care home for medical appointments, work, education or to attend a day centre, and to allow five named visitors for visits within the care home (CW5/644 - INQ000234905);
i. 21 June 2021, to allow overnight visits out of the care home (CW5/643 - INQ000234884); and
j. 19 July 2021, to remove the limit on the number of visitors each resident could have (CW5/**641** - INQ000234980).

Adult Social Care: Testing, PPE and Vaccines

349.Testing across the country was scaled up over 2020. Pilots were undertaken to support the introduction of testing across the wider ASC landscape, specifically:

a. Regular asymptomatic testing of staff in high-risk extra care and supported living settings was piloted from August 2020.
b. Visitor testing in care homes using lateral flow tests were piloted in November 2020.

350. Regular asymptomatic testing of staff using PCR in domiciliary care was introduced from 23 November 2020 and was extended to extra care and supported living settings from 9 December 2020. Testing was again scaled up for staff and introduced for all visitors from 23 December 2020.

351. From December 2020, the Department prioritised residents of care homes and staff in ASC receiving the COVID-19 vaccine, and this priority continued to the second dose and the booster vaccine, which was delivered or offered to all care homes within six weeks in November 2021. The Department also continued to provide free flu vaccines to ASC staff and residents throughout the pandemic.

Adult Social Care: Stakeholder Engagement

352. Departmental officials met regularly with stakeholder groups formed to discuss specific issues which included:

a. From 22 October 2020, weekly meetings with providers, local authorities and representatives of residents and visitors, to discuss the testing of visitors into care homes;
b. From October 2020, monthly catch-ups with Care England, the National Care Association and the Care Provider Alliance, and fortnightly catch-ups with Local Government Association and the Association of Directors of Adult Social Services, to discuss market sustainability and provider viability;
c. From 28 October 2020, the Workforce Advisory group, comprised of stakeholders across ASC, providing their expertise to policy aimed at improving workforce capacity over the winter;
d. Between November 2020 and April 2021, a series of engagement panels for PPE ASC 'customers' to have in-depth discussions regarding PPE experiences and concerns;
e. From November 2020, regular stakeholder meetings on care home visiting;
f. From 5 November 2020, a fortnightly designated settings working group to support the implementation of designated settings and provide feedback on their effectiveness; and
g. From November 2020, a weekly Vaccines Stakeholder group.

353. Departmental officials also met regularly with stakeholder groups formed to discuss specific issues which included:

a. From November 2020, regular stakeholder meetings on care home visiting;
b. From 5 November 2020, a fortnightly designated settings working group to support the implementation of designated settings and provide feedback on their effectiveness;
c. Between November 2020 and April 2021, a series of engagement panels for PPE ASC 'customers' to have in-depth discussions regarding PPE experiences and concerns; and
d. In December 2020, £149 million funding was announced to support the rollout of lateral flow testing in care homes. The Infection Control Fund (ICF) was extended four times and eventually combined with funding to support testing. A further £120 million was announced in January 2021 to support workforce capacity (CW5/646 - INQ000059732).

Adult Social Care: Funding

354. In September 2020, the Department announced the creation of designated settings for people discharged from hospital to a care home with a positive COVID-19 test. These settings began operating in November 2020 with funding of £588 million until the end of March 2021.

355. The other main funding announcements during this period were:

a. The first Infection Control Fund (ICF) was announced on 15 May 2020 and ran until 30 September 2020. On 23 December 2020, a further £149 million to support the rollout of lateral flow testing in care homes. The ICF was extended four times and eventually combined with funding to support testing. By the end of March 2022, the Department had provided over £2.2 billion in funding for infection prevention and control and testing measures;
b. On 16 January 2021, a £120 million fund to support workforce capacity (the Workforce Capacity Fund); and
c. On 19 January 2021, the Designated Settings Indemnity Support (DSIS) scheme, providing temporary, state-backed indemnity cover for designated settings which were unable to obtain sufficient insurance to operate this vital service. The DSIS was later extended and came to an end at the end of March 2022.

Adult Social Care: Data monitoring

356. As mentioned in my First Witness Statement for this Module at paragraphs 182 to 192, the ASC Capacity Tracker was developed to enable the system to better manage hospital discharges by identifying available capacity in care homes.

357. In September 2020 work commenced to establish the ASC COVID-19 dashboard with support from the company Palantir Technologies (Palantir). This dashboard brought together: (a) NHS Test and Trace data to assess COVID-19 prevalence and outbreaks in care settings; with (b) CQC data on notified deaths and other metrics from Capacity Tracker, such as PPE stock levels, workforce including absence (COVID-19 and non-COVID-19 related), staff movement and other Infection Prevention and Control metrics covered by the ICF. It was introduced to provide a single point of information for local, regional, and national government, and was widely used by local authorities as well as for operational use within the Department, PHE and the CO.

358. In October 2020, local authorities were given access to the ASC Dashboard and reporting (over 85% had at least one registered user).

359. In November 2020, the Infection Prevention and Control questions were amended in Capacity Tracker, to reflect measures supported by the second round of the ICF. The first local authority reporting template for ICF spending was distributed, to cover spending for reporting points 1 and 2 (October and November 2020 spending). Monitoring continued throughout all iterations of the fund, with metrics updated as needed. Data items collected included staff movement between settings, up to date IPC training including COVID-19 specific updates, number of staff self-isolating due to COVID-19, paying staff normal wages to self-isolate, the ability to create isolation beds, limiting the use of public transport by staff and staff choosing to stay away from their families if accommodation was being given to them to do so.

360. In early December 2020 ASC completed the transition of circa 10,000 home care providers from CQC Home Care survey reporting into Capacity Tracker in line with the updated grant conditions of the second round of the ICF (CW5/647 - INQ000235006).

361. In late 2020, the Department produced an ASC Situational Report (SitRep) on COVID-19 detail and frequency developed from the end of 2020 with increasing focus on COVID-19 vaccination rounds. This included outbreaks data from PHE, deaths and other notifications data from CQC and data on PPE availability, workforce

pressures/absence. Data from NHS Test and Trace and COVID-19 vaccinations were added once available. The report went to Departmental and DLUHC senior officials and Ministers, as well as senior officials in CQC, PHE and then UKHSA and NHSEI vaccinations teams as they were put in place.

362. In July 2021, the dashboard was migrated from Palantir's platform Foundry to the Department/UKHSA owned and managed environment 'EDGE' (the Environment for Data Gathering and Engineering).

Data

363. Over the course of the pandemic, as new COVID-19 variants emerged and population immunity developed (both natural and vaccine-induced) the ability to link core data to disease outcome, vaccination status, past infection and COVID-19 variants became essential. This continued to be challenging to do properly, for example, linking to past infection required an individual to have been tested and to provide identical details for linkage.

364. A range of organisations, therefore created and/or held relevant data. For example, each of the national public health organisations: PHE, then UKHSA, Public Health Wales, Public Health Scotland and the Public Health Agency in Northern Ireland, as well as the National Health Services for each of the UK nations (both hospital data and GP records).

365. COVID-19 SitReps continued to be utilised to collect key management information across the Four Nations. As the pandemic evolved, the range of management information collected was expanded to include beds occupied by patients with COVID-19, beds occupied by patients without COVID-19, and availability of general, acute and ICU beds.

Shielding

366. At the beginning of the relevant period, 1 August 2020, approximately 2.2 million individuals were on the Shielding Patient List (SPL) who were considered Clinical Extremely Vulnerable (CEV). The criteria agreed by UK Chief Medical Officers can be found below:

a. The below conditions were agreed on the 18 March 2020:

i. Solid organ transplant recipients;
ii. People with specific cancers:

1. People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer;
2. People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment;
3. People having immunotherapy or other continuing antibody treatments for cancer;
4. People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors;
5. People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.

iii. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD;
iv. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell);
v. People on immunosuppression therapies sufficient to significantly increase risk of infection;
vi. People who are pregnant with significant heart disease, congenital (or acquired).

367. The List continued to increase as GPs and clinicians in NHS trusts and NHS foundation trusts (trusts) completed the necessary clinical review of their patient lists. As part of the clinical decision-making process set out by UK CMOs they added or removed people based on their clinical judgement, local patient records, and as individuals' medical conditions changed.

368. The below conditions were added at later dates:

a. Dialysis (recommended entire patient population addition on 22 April 2020);
b. CKD Stage 5 (recommended case by case addition at the panel on 28 April 2020, recommended entire population addition on 25 September 2020);
c. Motor Neuron Disease (recommended case by case addition by the panel on 28 April 2020);

d. Laryngectomy and tracheostomy (recommended case by case addition by the panel on 28 April 2020);
e. Rare diseases (recommended case by case addition by the panel on 28 April 2020);
f. Decompensated liver disease (recommended case by case addition on 8 July 2020 after reviewing paper commissioned from NHSEI);
g. Down's Syndrome (recommended case by case addition on 8 July 2020 after reviewing paper commissioned from NHSEI, recommended entire population addition on 25 September 2020).

369. A breakdown of the increase in the size of the CEV for context can be found below:

20 March 2020	867,789 CEV identified.
12 April 2020	Cumulative 1.3 million people identified as CEV (additional 417,639 added since 20 March 2020).
18 April 2020	Cumulative 1.8 million people identified as CEV (additional 417,639 added since 12 April 2020 – single biggest increase, driven by GP and clinician review of SPL).
1 May 2020	Cumulative 2.16m identified as CEV (addition of 316,033 since 18 April 2020, again primarily driven by GP and clinician additions).
7 May 2020	Shielded Patients List stabilised at 2.2 million CEV people. (net increase of 49,320 since 1 May 2020 – from here on there is little significant change to size of SPL as GP and clinician review completed).

370. These criteria remained in place during both local (tiered) and national lock downs, and on the 3 February 2021, the Secretary of State agreed with COVID-O that GPs could use the QCOVID Clinical Assessment Tool to add vulnerable individuals to the SPL. This added approximately 1.5m individuals to the SPL. The list remained the same during the relevant period. On the 23 August 2021, following an evidence review, children and young people were not, in general, considered to be at high risk of serious illness from COVID-19, and were removed from the SPL (unless clinically advised otherwise).

371. Shielding for the CEV was always Government advice and was never mandatory. A submission recommending pausing the shielding advice was sent to and agreed by the Parliamentary Under Secretary of State and Secretary of State on 9 June 2020 (CW5/648 - **INQ000050887;** CW5/649 - INQ000234388; CW5/650 - INQ000234385; CW5/651 - **INQ000050876)**. On 12 June 2020, a further submission was sent which outlined MHCLG's intention to align clinical and support timelines and extend support

for those shielding until the end of July 2020. The Department's Ministers agreed with this extension (CW5/652 - INQ000234389; CW5/653 - INQ000234391; CW5/654 - INQ000233842; CW5/655 - INQ000234390). Following this agreement, on 1 August 2020, the advice to shield was paused nationally, except for local lockdown areas. These were areas where shielding advice continued due to high COVID-19 infection rates. For instance, shielding advice continued until 5 October 2020 in Leicester and other parts of Leicestershire and Blackburn with Darwen. Letters were sent to individuals from the CEV cohort based in these areas every three to four weeks, updating them and extending their shielding notification period so that they would be eligible for support (e.g., Statutory Sick Pay).

372. On 24 September 2020, a submission was sent to the Department's Parliamentary Under Secretary of State and the Secretary of State on options for linking shielding advice to Tiers (CW5/656 - INQ000234513). The submission recommended that there should be:

a. Tiered advice for the CEV cohort;
b. The advice to shield should not automatically be triggered at Tier 3, but only introduced in the very highest risk areas on the recommendation of DCMO and Gold; and
c. That a recommendation should be put to COVID-O that shielding should not be introduced nationally.

373. On 4 November 2020, a patient letter from the Department and MHCLG was sent to the full CEV cohort which outlined new guidance and informed them of the new national restrictions that would run from 5 November 2020 to 2 December 2020, 'the Government has taken the following action requiring people to stay at home, except for specific purposes, preventing gathering with people you do not live with, except for specific purposes and closing certain businesses and venues, like hospitality and non-essential retail (CW5/657 - INQ000234602 and CW5/658 - **INQ000058856)**.

374. On 27 November 2020, a letter from the Department was sent to the CEV cohort (CW5/659 - INQ000059087). This informed them that their guidance was changing, and that the Government was no longer advising them to stay away from work or school. Instead, they should continue to minimise social interactions and reduce the amount of time spent in settings where they would be unable to maintain social distancing.

375. On 20 December 2020, letters from the Department and MHCLG were sent to individuals from the CEV cohort based in areas placed into new Tier 4 restrictions, advising them to follow extra precautionary shielding measures similar to those advised in November's national lockdown (CW5/670 - INQ000059347). Areas under Tier 4 restrictions were extended on 29 December 2020 and the individuals from the CEV cohort in those areas were sent another letter from the Department and MHCLG on 30 December 2020 advising them to continue shielding (CW5/671 - INQ000059396).

376. Following the PM's announcement on 4 January 2021 that a further national lockdown would be put in place, letters from the Department and MHCLG were sent to the full CEV cohort on 7 January 2021 (CW5/672 - **INQ000059496)**. These letters outlined the new lockdown measures, stating that 'the Government is also advising all clinically extremely vulnerable people to take extra shielding measures to protect themselves. This advice applied until 21 February 2021.

377. On 15 February 2021, letters from the Department and MHCLG and guidance were sent to the full CEV cohort extending shielding advice until 31 March 2021 (CW5/673 - INQ000059953 and CW5/674 - INQ000059955). As a result of increasing data availability related to COVID-19 and the continued maturation of the QCOVID predictive risk model which analysed a combination of risk factors based on medical records, to assess whether somebody may be more clinically vulnerable than was previously understood, and following clinical agreement, around 1.5m people were added to the Shielding Patient List (SPL). On 17 February 2021, letters from the Department and the NHS were sent to these individuals, informing them that they were newly identified as CEV and that they were advised to shield until 31 March 2021 (CW5/675 - **INQ000110718)**.

378. On 17 March 2021, letters from the Department and MHCLG were sent to the full CEV cohort informing them that the advice to shield would end on 1 April 2021. Shielding was paused on 1 April 2021 and guidance updated (CW5/676 - INQ000060345).

379. On 17 May 2021, guidance for the full CEV cohort was updated to provide advice on meeting friends and family inside and outside homes (CW5/677 - INQ000234906)

380.On 19 July 2021, guidance for the full CEV cohort was updated to advise them to follow the same guidance as the rest of the population (CW5/678 - INQ000234996).

Personal Protective Equipment (PPE)

381.During the period 1 August 2020 to 31 July 2021 over 10.5 billion items of PPE were distributed to the health and care sector. The parallel supply chain that was established shortly after the outset of the pandemic ensured that acute shortages of PPE ceased during this period. The ePortal ensured the supply of free PPE to over 50,000 social care and primary care providers.

382.On 25 August 2020, approximately 30,000 items of PPE were delivered to schools and further education institutions (CW5/679 - **INQ000234452**). This included face masks, aprons, gloves, and visors, as well as hand sanitiser. The PPE was provided by the Department at no charge to help build resilience across the education sector to respond to suspected cases of COVID-19 arising in schools and colleges.

383.On 9 September 2020, with agreement from the Secretary of State, the advice on considerations in case of acute PPE shortages was withdrawn. This advice was contingency planning in place during exceptional circumstances at the start of the pandemic (although it was never implemented in practice) and was withdrawn on the basis that the UK now had a healthy PPE stock position.

384. On 28 September 2020, use of the PPE Portal (the Portal) which was designed to be an online ordering system for health and social care settings, had significantly increased. Most sectors that Local Resilience Forums (LRFs) had been supporting had been invited to use the Portal though there were several residual services, such as personal assistants, unpaid carers and education and childcare services that were not eligible. The Department asked LRFs to continue supplying these with PPE directly.

385.On 28 September 2020, the PPE Strategy was published by the Department, reiterating the offer of free PPE until the end of March 2021 and providing confidence in UK supply of PPE (CW5/680 - INQ000234522). The strategy set out how the Government was moving beyond the emergency COVID-19 response to stabilise and build resilience through getting a clearer view of demand, developing a more resilient and diverse supply chain, and building up a stockpile of PPE. Amongst other things, the strategy outlined the steps the Department had taken to establish a strong domestic supply base through 'UK Make' and to create a four-month stockpile available

across all categories of PPE to accommodate any future surge in place by December 2020.

386. On 25 November 2020, National Audit Office (NAO) published a report on the supply of PPE and on 26 November 2020, NAO published findings of its investigation into Government procurement of PPE (CW2/29 - INQ000057714 and CW5/681 - INQ000234626).

387. On 25 January 2021, the Department issued communications to local authorities and LRFs about supplying free PPE to extra resident unpaid carers (all 151 local authorities then supported extra resident unpaid carers) (CW5/682 - INQ000059659).

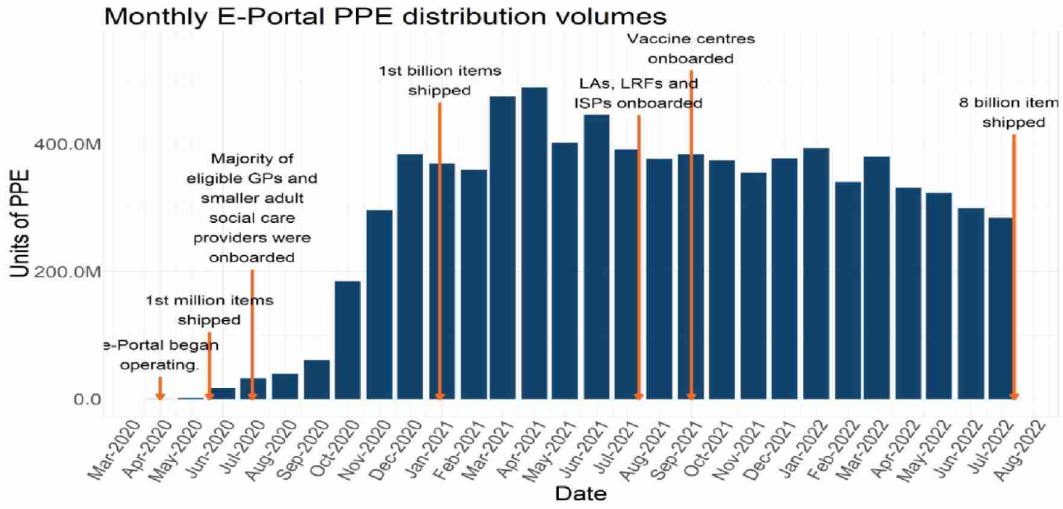
388. The Public Accounts Committee published a series of recommendations to the Department working with OGDs on 10 February 2021. These included:

a. Ensuring the recommendations from the Boardman Review of Government COVID-19 Procurement were implemented across Government;
b. Improving the approach to managing and distributing stocks of PPE;
c. Publishing lessons learnt from the procurement of PPE during the pandemic;
d. Revising emergency response plans to better consider who was supported, how and when; and
e. Improving understanding of the experience of frontline staff, particularly focusing on those from different ethnic backgrounds.

389. In July 2021, local authorities and LRFs were invited to register for the PPE Portal themselves. The vast majority of local authorities and LRFs then submitted regular orders to the Portal, which they received and then distributed to the various sectors they were supporting.

Date	e-Portal Developments
August 2020	Further sectors in both primary care and social care were invited to register.
September 2020	On 17 September 2020, the EU Commission approved the state aid notification for the PPE portal scheme to move from Emergency top up to the main distribution route.

	Hence, a broader range of sectors registered, more types of PPE available using the e-Portal, and the order limits on accounts were adjusted - for example to reflect updated government guidance on PPE use.
June 2021	Public services overseen by other OGDs including the police, Human Fertilisation and Embryology Authority (HFEA), the HO, HM Revenue and Customs (HMRC) and Department for Work and Pensions (DWP) were invited to register.
July 2021	Local authorities, LRFs and independent sector providers were invited to register. Independent sector providers include providers who undertake NHS contracts for diagnostic and therapeutic work and mental health providers.



390. Between 9 April 2020 and 30 September 2022, 8.75 billion PPE items were ordered through the e-Portal (CW5/683 - INQ000235007).

Testing

391. Testing capacity started to increase from March 2020 (CW5/684 - INQ000234854). NHS Test and Trace, supported by the Department, increased both laboratory capacity for PCR tests and introduced new forms of testing, most notably lateral flow testing, during the time period covered in this Statement. In parallel, as capacity increased, both the eligibility and channels for provision of testing (for example increased 'local test sites' and test delivery by mail) also increased culminating in the launch of the 'universal offer' of testing for all residents in England on 9 April 2021 using lateral flow

tests. Testing volumes peaked in March 2021 with over 2.3 million tests reported at the end of March 2021.

392.The initial focus in 2020 was to increase laboratory capacity for PCR tests and in parallel expand eligibility for these tests and access to them through additional test sites. This started with expansion in the existing 'lighthouse laboratories' to increase their throughput and adding new laboratories to the network culminating with the opening of the new Rosalind Franklin 'mega laboratory' in June 2021. In September 2020 laboratory capacity was exceeded by demand for a two week period that coincided with the return of children to school. Capacity significantly exceeded demand from October 2020 onwards.

393.A number of new models for distributing and encouraging uptake and reporting of test results were trialled from September 2020 to December 2020, including increased access to testing and testing infrastructure by Local Directors of Public Health through the Community Testing Programme, mass testing exercises in specific locations e.g., city-wide testing in November 2020 and testing trials in specific workplaces and settings. This work informed the further expansion and rollout of testing from January 2021. This approach to mass testing using Lateral Flow Devices was characterised in the media at the time as the Moonshot Programme.

394.Trials in the mass testing programme included:

a. City-wide testing in Liverpool in November 2020 to detect as many positive individuals as possible;
b. Trials in schools and universities in November 2020 to detect asymptomatic cases; and
c. Workplace testing trials starting in December 2020 to detect asymptomatic cases and prevent secondary spread.

395.The use of pilots and rapid evaluation enabled lateral flow testing to be rolled out rapidly to support the country in 'living with COVID'. Notably visitors were allowed into Care Homes in December 2020 with the use of lateral flow tests. All secondary schools, colleges and universities used lateral flow tests at the start of January 2021 to test students and teachers and prevent the spread of the virus. Testing eligibility and use expanded over the course of 2021 culminating in the 'universal offer' of testing to everyone in the country in April 2021.

Events Research Programme

396. The Events Research Programme (ERP) was set up as a scientific research programme that would build evidence on the risks associated with COVID-19 transmission at mass gatherings of various sizes and identify activities that might increase and/ or mitigate transmission. It had been announced as part of the Roadmap and was originally designed to take place only in a single phase. However, given that Phase I of the ERP had not been able to provide sufficient data, further research was thought to be needed, with larger events therefore being included in a Phase II and a Phase III used to evaluate the use of certification at such events.

397. On 12 March 2021, a submission was provided offering an update on the proposed announcement by DCMS to launch a list of events being included in the ERP, the proposed governance arrangements, and proposals for testing to support the safe re-opening of events/hospitality to maximum capacity.

398. On 26 March 2021, a meeting was held between the Secretary of State and Secretary of State for Digital, Culture, Media and Sport about the ERP (CW5/685 - INQ000234836). There was agreement between the Department and DCMS that they should be more aligned and the public health implications, governance arrangements and approval methods of the programme were discussed.

399. On 30 March 2021, a submission was provided seeking approval to proceed with detailed planning of the pilot events identified by the ERP and the proposed communications approach. The Secretary of State approved these points on 31 March 2021 following discussion at a Small Ministerial Group (SMG) meeting. (CW5/686 - INQ000234838; CW5/687 - INQ000234839; CW5/688 - INQ000234840)

400. A submission was provided on 1 April 2021 that sought approval of the final list of ERP pilot events. The Secretary of State approved this on the same date (CW5/689 - INQ000234849).

401. A submission was provided on 14 April 2021 on issuing directions under the Steps Regulations to disapply parts of the Health Protection (Coronavirus, Restrictions) (Obligations of Undertakings) (England) Regulations 2020 (the Obligations of Undertakings Regulations) for the ERP, to enable the World Snooker Championships and the FA Cup Semi Finals to take place from 17 April – 3 May 2021 and 18 April

2021 respectively (CW5/690 - INQ000234856; CW5/691 - INQ000234857; CW5/692 - **INQ000060601;** CW5/693 - **INQ000059425;** CW5/694 - **INQ000060604;** CW5/695 - **INQ000059430)**. Lord Bethell signed the directions on the same date (CW5/696 - INQ000234862).

402. A joint Department and DCMS submission was provided on 14 April 2021 asking the Secretary of State to agree the addition of the Live Nation outdoor music event on 2 May 2021, and of the Dante Festival at York racecourse on 12-14 May 2021; and to note that options were being explored for a further mass participation event for the ERP, and that post-event PCR testing (without incentives) was being proposed. Ministers agreed that the trials could go ahead, but also required further information on actions to encourage post-event testing returns, precise testing plans and to fully set out the timetable, format, and content of pilot results.

403. A joint Department and DCMS submission was provided to the Secretary of State on 19 April 2021 to disapply parts of the Obligations of Undertakings Regulations to enable two ERP events, the Luna Outdoor Cinema and the Carabao Cup Final, to take place (CW5/697- INQ000234863; CW5/698- **INQ000060736;** CW5/699- INQ000234865; CW5/700- **INQ000060657;** CW5/701- **INQ000059466;** CW5/702 - **INQ000060654)**. The directions were made by the Secretary of State on 20 April 2021 (CW5/703 - INQ000234869,CW5/704 - **INQ000060669;** CW5/705 - **INQ000060650)**

404. On 26 April 2021 a further joint submission from the Department and DCMS provided advice on the disapplication of Obligations of Undertakings Regulations to enable the third batch of pilot events under the ERP to take place (CW5/706 - INQ000234873; CW5/707 - **INQ000111056;** CW5/708 - **INQ000059446;** CW5/709 - **INQ000059424;** CW5/710 - **INQ000060697;** CW5/711 - INQ000234878; CW5/712 - CW5/706 - **INQ000060706)**. These were the Good Business Festival, Circus Nightclub and Sefton Outdoor Music Event. The directions were issued by the Secretary of State and the Secretary of State for DCMS on the same day.

405. On 29 April 2021, a submission was provided to Departmental Ministers to set out the interim report on the ERP that DCMS were to submit to the PM the following day (CW5/713 - INQ000234880; CW5/713 - INQ000234881; CW5/715 - INQ000234882).

406. On 4 May 2021, a further joint submission from the Department and DCMS was provided with advice on the second phase of the ERP and proposals to use home

testing for larger events. It sought agreement on the objectives, approach, mixed model testing approach and provisional pilot list and to note the critical dependencies, including the timescales for an app (CW5/716 - INQ000234885; CW5/717 - INQ000234887; CW5/718 - INQ000234886). The Secretary of State confirmed on 6 May 2021 he was content with the proposals and with at-home testing (CW5/719 - INQ000234888).

407. On 6 May 2021, a further joint submission from the Department and DCMS was provided with directions to disapply the Obligations of Undertakings Regulations to enable batch 4 of the ERP events to take place (the BRIT awards, Kempton Park run, Luna Cinema and FA Cup final) (CW5/720- **INQ000111093;** CW5/721- INQ000234890; CW5/722- **INQ000111095;** CW5/723- **INQ000111096;** CW5/724- **INQ000111099;** CW5/725- **INQ000111100;** CW5/726- **INQ000111097;** CW5/727- **INQ000111101;** CW5/728- **INQ000111102;** CW5/729 - **INQ000111098)** The Secretary of State approved and signed the Directions on 7 May 2021 (CW5/730 - INQ000234900).

408. A submission was provided on 7 May 2021 updating the Secretary of State on seven positive COVID-19 cases that had been identified following the Liverpool ERP Events (Circus Nightclub and Sefton Park music festival), with a further three positive COVID-19 cases being investigated (CW5/731 - INQ000234901).

409. On 3 June 2021, a joint submission from DCMS, CO and the Department to the Secretary of State provided an update on the UEFA European Football Championship (13 June to 11 July 2021) and raised concerns about planning of the event as part of the ERP (CW5/732 - INQ000234912; CW5/733 - INQ000234913; CW5/734 - INQ000234914). It requested a Secretary of State steer on whether he was content with the DCMS approach, which did not include arrangements for pre and post-event PCR testing which presented public health risks; on the rationale for the disapplication of the Obligations of Undertakings Regulations; the research focus; the move to greater than 50% capacity limits; and on whether such an event should still form part of the ERP. The Secretary of State approved this on 4 June 2021, stating that he did not want any changes to the quarantine requirements for overseas visitors attending the event but asking for further advice on how certification for the event could address this (CW5/735 - INQ000234917).

410.A joint signing submission from the Department and DCMS was provided on 7 June 2021 on the disapplication of Obligations of Undertakings Regulations to enable the first events of Phase II of the ERP to take place (Royal Ascot, two Euros matches and test cricket matches) (CW5/736 - **INQ000111315;** CW5/737 - **INQ000111316;** CW5/738 - INQ000234928; CW5/739 - **INQ000111319;** CW5/740 - **INQ000111320;** CW5/741 - **INQ000111321;** CW5/742 - **INQ000111317;** CW5/743 - **INQ000111318)** The direction was issued by the Secretary of State on 8 June 2021 (CW5/744 - INQ000234934; CW5/745 - **INQ000061044;** CW5/746 - **INQ000061046;** CW5/747 - **INQ000061045)**.

411. A further joint signing submission from the Department and DCMS was provided on 14 June 2021 on the disapplication of Obligations of Undertakings Regulations to enable batch two of Phase II of the ERP events to take place (CW5/748 - INQ000234939; CW5/749 - **INQ000111365;** CW5/750 - **INQ000111366;** CW5/751 - INQ000234942; CW5/752 - INQ000234966). The direction was approved and signed by the Secretary of State on 15 June 2021 (CW5/753 - INQ000234958).

412.On 25 June 2021, the findings of Phase 1 of the ERP were published (CW5/754 - INQ000234964).

SECTION 5: PUBLIC HEALTH COMMUNICATIONS

413.As mentioned in my First Witness Statement for this Module, communications during the early months of the pandemic were led by the Department with input from OGDs and with liaison with CO.

414.The Department's communications team and COVID-19 hub led all communications for NHS Test and Trace until a separate NHSE Test and Trace communications team was established in September 2020, working within the COVID-19 hub and the Department. This continued until October 2021 when NHS Test and Trace was subsumed into UKHSA who subsequently led on all communications for Test and Trace.

415.As the vaccination programme moved from planning and procurement to implementation and delivery in October, November and December 2020, the Department led all COVID-19 vaccine communications working closely with the

COVID-19 hub, BEIS, NHSEI, MHRA and PHE (who led all communications for the JCVI).

SECTION 6: LEGISLATION AND REGULATIONS AND THEIR PROPORTIONALITY AND ENFORCEMENT

416.Please refer to paragraphs 253 - 254 of my First Witness Statement for this Module which outlines the decision-making processes and the powers relied on in the Public Health (Control of Disease) Act 1984 (the 1984 Act) to make the relevant legislation, including use of the emergency procedure. The information in those paragraphs also applies to the legislation made in the time period covered in this statement.

417.A large volume of legislation was made by the Department between 1 August 2020 – 31 July 2021, primarily to legally implement policies in the areas of social distancing, face coverings, international travel and self-isolation. This section outlines the key legislation made in those areas during the relevant time period. To help ensure that any legal restrictions in place during this period remained necessary and proportionate, most of the regulations discussed below (other than amendment regulations) imposed a legal duty on the Secretary of State to carry out a review (usually at least once every 28 days) regarding whether the restrictions in those regulations continued to be necessary for the purposes of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection in England with COVID-19.

Social Distancing

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

418.The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020 (the Second Restrictions Regulations) were the national regulations in place at the beginning of the time period covered by this witness statement (see paragraphs 271 – 275) of my First Witness Statement) (CW5/755 - **INQ000109985;** CW5/756 - **INQ000109485;** CW5/757 - **INQ000109987;** CW5/758 - **INQ000051159;** CW5/759 - INQ000234396; CW5/760 - **INQ000051148;** CW5/761 - **INQ000109991;** CW5/762 - **INQ000109993;** CW5/763 - **INQ000109992)**. The Second Restrictions Regulations were amended for the third time on 15 August 2020 by the Health Protection (Coronavirus, Restrictions) (No. 2) (England) (Amendment) (No. 3) Regulations 2020 which permitted further businesses and venues to reopen on 15 August 2020 (such as bowling alleys and conference centres) (CW5/764 - INQ000109659; CW5/765 -

INQ000109658; CW5/766 - INQ000109655; CW5/767 - INQ000109654; CW5/768 - INQ000109656; CW5/769 - INQ000109660). The existing enforcement regime was not changed by these regulations (please see paragraph 277 of my First Witness Statement).

The Health Protection (Coronavirus) (Restrictions on Holding of Gatherings and Amendment) (England) Restrictions 2020.

419. The Health Protection (Coronavirus) (Restrictions on Holding of Gatherings and Amendment) (England) Restrictions 2020 (the Gatherings Regulations) were made on 26 August 2020 and came into force on 28 August 2020 (CW5/770 - INQ000109682; CW5/771 - INQ000109683; CW5/772 - INQ000109684; CW5/773 - INQ000109685; CW5/774 - INQ000109686). The Gatherings Regulations amended the Second Restrictions Regulations to impose restrictions on the holding of gatherings (both inside and outside) of more than 30 people. These regulations provided that a fixed penalty notice may be issued by 'authorised persons' (a constable, a police community support officer or a person designated by a local authority or the Secretary of State) to persons aged 18 or over whom they reasonably believed contravened the new restrictions on holding prohibited gatherings. The amount of the fixed penalty notice was £10,000.

Local Lockdowns

420. In addition to the national restrictions, specific restrictions for local areas were introduced by way of regulations made under the 1984 Act where it was considered the restrictions were necessary for public health reasons. An example of these local lockdown regulations is the Health Protection (Coronavirus, Restrictions) (Leicester) Regulations 2020. However, the difference across local COVID-19 restrictions led to a complex legislative picture, and as set out above the Government therefore decided to introduce 'Local Alert Levels' to provide greater clarification and improve legal certainty and understanding among the public and enforcement bodies.

The COVID-19 Local Alert Level Regulations

421. The Health Protection (Coronavirus, Local COVID-19 Alert Level) (Medium) (England) Regulations 2020 (CW5/775 - INQ000234556; CW5/776 - INQ000109830; CW5/777 - INQ000109827; CW5/778 - INQ000109832; CW5/779 - INQ000109833; CW5/780 - INQ000234557; CW5/781 - INQ000109834), the Health Protection (Coronavirus, Local COVID-19 Alert Level) (High) (England) Regulations 2020 (CW5/781 -

INQ000109834; CW5/782 - INQ000234555; CW5/783 - INQ000109826; CW5/784 - INQ000109828; CW5/785 - INQ000109829; CW5/786 - INQ000234558), and the Health Protection (Coronavirus, Local COVID-19 Alert Level) (Very High) (England) Regulations 2020 (CW5/787 - INQ000234563; CW5/788 - **INQ000109839;** CW5/789 - **INQ000109843;** CW5/790 - **INQ000109842;** CW5/791 - **INQ000109841)** were all made at 17:00 on 12 October 2020 and came into force on 14 October 2020. The intent behind these regulations was to enable a coherent set of interventions across England, making it easier to communicate to the public what restrictions applied in each area.

422. These regulations established three Local Alert Levels of COVID-19 restrictions in England, leading to a tiered response. Local Alert Level 'Medium' consisted of the national measures in place at the time the regulations came into force. Local Alert Level 'High' was for geographical areas where there was a rise in COVID-19 transmission, or nationally where there had been a rise in transmission which could not be contained through localised means. Local Alert Level 'Very High' was for geographical areas where Local Alert Level 'High' measures had not contained the spread of the virus or where there had been a significant rise in COVID-19 transmission. The restrictions imposed on a particular area in Local Alert Level 'Very High' were based on a set of measures that were agreed with the relevant local authorities.

423. The Secretary of State was also required to review the need for the restrictions in the regulations at least once every 28 days, and the areas allocated to Local Alert Levels High and Very High were also subject to regular statutory review. These regulations all provided powers of enforcement to a 'relevant person' which was defined as a constable, police community support officer, or a person designated by a local authority or the Secretary of State.

The Health Protection (Coronavirus, Restrictions) (England) (No. 4) Regulations 2020.

424. The Fourth Restrictions Regulations were made at 14:45 on 3 November 2020 and came into force on 5 November 2020 (CW5/792 - **INQ000058851;** CW5/793 - **INQ000110011;** CW5/794 - **INQ000110010;** CW5/795 - **INQ000110009;** CW5/796 - **INQ000110014;** CW5/797 - INQ000234599). The Fourth Restrictions Regulations revoked all three Local Alert Level Regulations and imposed the second nationwide lockdown in England for a period of 28 days in order to slow the spread of COVID-19. These regulations introduced a number of social restrictions and business closures, including a requirement that no person may leave or be outside the place they are

living without reasonable excuse, restrictions on participation of gatherings (prohibiting gatherings of more than two people in public outdoor places or gatherings of two or more people in all other places, unless an exception applied), and required businesses listed in the Schedule to close to protect against the risks to public health arising from COVID-19.

425. The Fourth 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. These regulations contained an expiry provision of 28 days beginning with the day on which they came into force.

The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020.

426. The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 (the Tiers Regulations) were made at 13:30 on 30 November 2020 and came into force on 2 December 2020 (CW5/353 - INQ000059129; CW5/354 - INQ000110146; CW5/355 - INQ000110139; CW5/356 - INQ000110141; CW5/357 - INQ000110142; CW5/358 - INQ000110144; CW5/359 - INQ000110145; CW5/360 - **INQ000234628;** CW5/361 - **INQ000234629;** CW5/362 - **INQ000234630**). The Tiers Regulations revoked the Fourth Restrictions Regulations and introduced a revised tiering system. The three tiers in the Tiers Regulations were:

a. Tier 1: Medium Alert, which was the baseline measures nationally and represented the minimum level of restrictions considered appropriate given the levels of COVID-19 circulating nationally at the time; and
b. Tier 2: High Alert, which placed further restrictions on social contact aimed primarily at targeting areas of high transmission; and
c. Tier 3: Very High, which went further in restricting social contact to address household to household transmission and placed further restrictions and closures on businesses, where the toughest of restrictions were required for areas with a high transmission risk.

427. The Secretary of State was required to review the need for the restrictions in the Regulations at least once every 28 days, and to review whether each area that was part of Tier 2 or Tier 3 should continue to be part of that area at least once every 14 days.

428.The Tiers 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) (All Tiers and Obligations of Undertakings) (England) (Amendment) Regulations 2020.

429.The Health Protection (Coronavirus, Restrictions) (All Tiers and Obligations of Undertakings) (England) (Amendment) Regulations 2020 (the Tier 4 Regulations) were made and came into force on 20 December 2020 (CW5/410 - **INQ000234676;** CW5/411 - INQ000234672; CW5/412 - INQ000234673; CW5/413 - INQ000234674; CW5/414 - INQ000234675; CW5/415 - **INQ000234677;** CW5/416 - **INQ000234678;** CW5/417 - INQ000234679; CW5/418 - INQ000234680; CW5/419 - INQ000234681; CW5/420 - INQ000234682). The regulations amended the Tiers Regulations to introduced Tier 4, which was more restrictive than Tier 3. Tier 4 provided that no person could leave the place they were living without reasonable excuse, and limited gatherings to one household. A broad range of businesses and hospitality were required to close, though essential retail was allowed to remain open. The Tier 4 Regulations placed all 32 London boroughs and the City of London, as well as some local authority areas in the East and South East of England, into Tier 4.

The Health Protection (Coronavirus, Restrictions) (No. 3) and (All Tiers) (England) (Amendment) Regulations 2021.

430.The Health Protection (Coronavirus, Restrictions) (No. 3) and (All Tiers) (England) (Amendment) Regulations 2021 were made at 16:30 on 5 January 2021 and came into force on 6 January 2021 (CW5/798 - INQ000110296; CW5/799 - INQ000110291; CW5/800 - INQ000110297; CW5/801 - INQ000110298; CW5/802 - INQ000110295; CW5/803 - INQ000110299; CW5/804 - INQ000110292; CW5/805 - INQ000110293; CW5/806 - INQ000110300; CW5/807 - INQ000110301; CW5/808 - INQ000059474; CW5/809 - **INQ000113012;** CW5/810 - INQ000059475). The regulations imposed the third national lockdown and moved all areas of England into Tier 4. Restrictions in Tier 4 were also strengthened (for example to remove outdoor recreation as an exception from the restrictions on leaving home).

The Health Protection (Coronavirus, Restrictions) (Wearing of Face Coverings in Relevant Places and Restrictions: All Tiers) (England) (Amendment) Regulations 2021.

431. These regulations were made on 5 March 2021 and came into force on 8 March 2021 (CW5/534 - INQ000060158; CW5/535 - INQ000060159; CW5/536 - INQ000060160; CW5/537 - INQ000060162; CW5/538 - INQ000060163; CW5/539 - INQ000060164; CW5/540 - INQ000060165; CW5/541 - INQ000060166; CW5/542 - INQ000060167; CW5/543 - INQ000060168; CW5/544 - INQ000060169; CW5/545 - INQ000060170). The regulations amended the Tiers Regulations to implement Step 1A of the Government's Roadmap for exiting lockdown, which included permitting outdoor education as a reasonable excuse for leaving home.

The Health Protection (Coronavirus, Restrictions) (Steps) (England) Regulations 2021.

432. The Steps Regulations were made at 09:00 on 22 March 2021 and came into force on 29 March 2021 (CW5/560 - INQ000234823; CW5/561 - **INQ000059439**; CW5/562 - INQ000234825; CW5/563 - INQ000234826; CW5/564 - INQ000234827; CW5/565 - INQ000234828; CW5/566 - INQ000234829; CW5/567 - INQ000234830; CW5/568 - INQ000234831; CW5/569 - INQ000234832; CW5/570 - INQ000234833; CW5/571 - INQ000234834). The Steps Regulations revoked the Tiers Regulations and contained the legislative framework to implement Steps 1B-3 of the Government's Roadmap for exiting lockdown in England. The Steps Regulations set out the requirements for the different steps of the Roadmap:

a. Step 1: removing the requirement to stay at home and relaxing outdoor gathering restrictions to a maximum of 6 people or one other household unless an exemption applied. It allowed outdoor sports and leisure facilities to reopen for organised sports and introduced a requirement that people could only travel out of the UK if they had a legally permitted reason for doing so;
b. Step 2: social contact rules in England remained the same as in Step 1. indoor leisure facilities, libraries, community centres and personal care businesses and retail were permitted to reopen for individual use or within household groups. In addition, outdoor hospitality and outdoor attractions, such as zoos and theme parks would be able to reopen. Stay in the UK provisions remained but domestic overnight stays were permitted for household groups; and
c. Step 3: Amended gathering restrictions so that outdoor gatherings of up to 30 people and indoor gatherings of 6 people or two households were permitted. Reopened all remaining outdoor entertainment and indoor entertainment and attractions, such as museums, cinemas and children's play would also be able to reopen.

433.All of England moved to Step 1 on 29 March 2021 and further changes to restrictions were implemented through amending regulations. The Steps 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 the local authority or the Secretary of State. These regulations also imposed a duty on the Secretary of State to review the need for the restrictions imposed by these Regulations by 12 April 2021 and then at least once every 35 days (CW5/811 - INQ000060587; CW5/812 - INQ000110984; CW5/813 - INQ000110982; CW5/814 - INQ000110985; CW5/815 - INQ000110988; CW5/816 - INQ000110986; CW5/817 - INQ000110983; CW5/818 - INQ000110987; CW5/819 - INQ000110993; CW5/820 - INQ000110990; CW5/821 - INQ000110989).

Face Coverings Regulations

434.The first regulations made in respect of face coverings were the Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) (England) Regulations 2020 (the First Face Coverings Regulations), which were made on 23 July 2020 and came into force on 24 July 2020 (CW5/822 - INQ000234408; CW5/823 - **INQ000109576;** CW5/824 - INQ000234410; CW5/825 - INQ000234411; CW5/826 - INQ000234412; CW5/827 - INQ000234413; CW5/828 - INQ000234414; CW5/829 - INQ000234415). Those regulations required members of the public to wear a face covering when in a 'relevant place' (including shops, supermarkets and enclosed shopping centres) or a transport hub, unless they had a 'reasonable excuse' for not wearing one. The power to enforce the requirements was provided to a 'relevant person' which was defined as a constable, a police community support officer, or a TfL officer in a transport hub. The First Face Coverings Regulations had a 12-month expiry provision and required the Secretary of State to review the need for the restrictions imposed by these regulations within six months (starting from the date on which the regulations came into force).

435.The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) (England) (Amendment) Regulations 2020 were made on 6 August 2020 and came into force on 8 August 2020 (CW5/830 - INQ000234422; CW5/831 - INQ000234423; CW5/832 - INQ000234424; CW5/833 - INQ000234425; CW5/834 - INQ000234426; CW5/835 - INQ000234427; CW5/836 - INQ000234428). These regulations amended the First Face Coverings Regulations to require members of the public to wear face coverings in additional indoor premises in England such as places of worship, museums and public libraries.

436. The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) England (Amendment) (No. 2) Regulations 2020 were made on 20 August 2020 and came into force on 22 August 2020 (CW5/837 - INQ000234445; CW5/838 - INQ000234446; CW5/839 - INQ000234447; CW5/840 - INQ000234448; CW5/841 - INQ000234449; CW5/842 - INQ000234450). These regulations extended and clarified the scope of the First Face Coverings Regulations by specifying further indoor premises where face coverings must be worn and providing additional examples of circumstances where a person would be exempt from wearing a face covering.

437. The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place and on Public Transport) (England) (Amendment) (No. 3) Regulations 2020 were made at 10:30 on 23 September 2020 and came into force on 24 September 2020 (CW5/843 - **INQ000234038;** CW5/844 - INQ000234040; CW5/845 - INQ000234041; CW5/846 - INQ000234042; CW5/847 - INQ000234509). These regulations required members of the public to wear face coverings in additional indoor premises in England and required the wearing of a face covering by staff or other workers working in certain retail, hospitality and leisure settings.

International Travel Regulations

438. The Health Protection (Coronavirus, International Travel) (England) Regulations 2020 (the International Travel Regulations) were made on 2 June 2020 and came into force 8 June 2020 (CW5/848 - INQ000234372; CW5/849 - INQ000234373; CW5/850 - INQ000234374; CW5/851 - INQ000234375; CW5/852 - INQ000234376; CW5/853 - INQ000234377; CW5/854 - **INQ000060061;** CW5/855 - INQ000234379; CW5/856 - INQ000234380; CW5/857 - INQ000234381; CW5/858 - INQ000234382; CW5/859 - INQ000234383; CW5/860 - INQ000234383). These regulations imposed requirements on people arriving in England from outside the Common Travel Area to: (i) provide information including contact details and details of their intended onward travel; and (ii) to self-isolate for a period of 14 days following their arrival in the Common Travel Area. Certain categories of person, including flight crew, were exempt from the regulations. The International Travel Regulations were amended more than 50 times between June 2020 and May 2021. These regulations imposed a duty on the Secretary of State to review the need for the requirements imposed by the regulations at least once every 21 days, which was extended to at least once every 28 days (as amended by The Health Protection (Coronavirus, International Travel and Public Health Information) (England) (Amendment) Regulations 2020).

The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 7) Regulations 2021.

439.The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 7) Regulations 2021 were made at 11:00 on 12 February 2021 and came into force at 04:00 on 15 February 2021 (CW5/861- **INQ000234291;** CW5/862- **INQ000234292;** CW5/863- **INQ000234294;** CW5/864- **INQ000234295;** CW5/865- INQ000234744; CW5/866- INQ000234745; CW5/867- INQ000234746; CW5/868 - **INQ000234293)** These regulations amended the International Travel Regulations to introduce a new system of:

i. Managed quarantine – for travellers who had been in one of the designated countries which posed a high risk to the UK from importation of a variant of concern (a 'red-list country') in the 10 days prior to arrival in England; and
ii. Mandatory testing – for all travellers who had been outside the Common Travel Area in the 10 days prior to arrival in England.

The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 9) Regulations 2021.

440.The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 9) Regulations 2021 were made at 14:30 on 2 March 2021 and partly came into force on 3 March 2021 (CW5/869 - INQ000234786; CW5/**863** - **INQ000234294;** CW5/**871** INQ000234788; CW5/**862** - **INQ000234292;** CW5/**873** - INQ000234790; CW5/**874** - INQ000234791; CW5/**861** - **INQ000234291;** CW5/**864** - **INQ000234295**). The remainder of these regulations came into force at 04:00 on 4 March 2021. These regulations amended the International Travel Regulations including making changes to:

i. The managed self-isolation package to allow children (and those who were children at the beginning of the current school year) who were travelling unaccompanied for the purpose of attending boarding school in England to complete their self-isolation at school under controlled conditions;
ii. The managed self-isolation package for unaccompanied children (for whom there was no responsible adult who could join them in accommodation designated for their self-isolation). Unaccompanied children would be able to complete their self-isolation in an environment suitable to their specific needs as confirmed by the Secretary of State; and

iii. The mandatory testing regime in relation to private providers and reporting requirements.

The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 10) Regulations 2021.

441. The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 10) Regulations 2021 were made at 11:05 on 18 March 2021 and came into force at 04:00 on 19 March 2021 (CW5/**861** - **INQ000234291**; CW5/878 - INQ000234810; CW5/**863** - **INQ000234294;** CW5/880 - INQ000234812; CW5/881 - INQ000234813; CW5/**864** - **INQ000234295;** CW5/**862** - **INQ000234292;** CW5/884 - INQ000234816; CW5/885 - INQ000234817). The regulations amended the International Travel Regulations to include:

a. Amending the list of countries and territories subject to additional measures;
b. Exemptions for aviation and maritime crew from managed self-isolation, to support the resilience of freight routes and supply chains and crew welfare; and
c. Further medical exemptions for non-urgent medical and vulnerable cases from entering managed self-isolation when medical evidence is provided and in limited circumstances.

The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 11) Regulations 2021.

442. The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 11) Regulations 2021 were made at 11:56 on 1 April 2021 and came into force at 04:00 on 6 April 2021 (CW5/886 - INQ000234842; CW5/887 - INQ000234843; CW5/888 - **INQ000236073;** CW5/889 - INQ000234845; CW5/890 - **INQ000236077;** CW5/891 - **INQ000236075;** CW5/892 - **INQ000236076)**. These regulations amended the International Travel Regulations to introduce a new system of:

i. Mandatory testing for international arrivals who are exempt from quarantine where they are travelling with a sectoral exemption, including a duty on employers to take reasonable steps to facilitate this testing; and
ii. To amend the minimum standards for providers of international travel testing.

The Health Protection (Coronavirus, International Travel and Operator Liability) (England) (Amendment) (No. 2) Regulations 2021.

443.The Health Protection (Coronavirus, International Travel and Operator Liability) (England) (Amendment) (No. 2) Regulations 2021 were made on 6 June 2021 and came into force at 04:00 on 8 June 2021 (CW5/893 - INQ000234918; CW5/894 - INQ000234919; CW5/895 - INQ000234920; CW5/896 - INQ000234921; CW5/897 - INQ000234922; CW5/898 - INQ000234923; CW5/899 - INQ000234924; CW5/900 - INQ000234925). These regulations amended the Health Protection (Coronavirus, International Travel and Operator Liability) (England) Regulations 2021 (the 'ITOL Regulations') to:

i. Move countries between the designations of category 1 ('green-list') and category 3 ('red-list');
ii. Require direct flights from 'red-list' countries to arrive at airport terminals which only accepted 'red-list' direct flights;
iii. Amend the testing rules for short term visitors to England to require arrivals to book the applicable tests required for the category of country they were arriving from, even if they were staying for less than the period within which the tests were to be taken; and
iv. Provide that transit passengers from category 1 countries were not under an obligation to book and undertake tests.

The Health Protection (Coronavirus, International Travel and Operator Liability) (England) (Amendment) (No. 6) Regulations 2021.

444.The Health Protection (Coronavirus, International Travel and Operator Liability) (England) (Amendment) (No. 6) Regulations 2021 were made on 18 July 2021 and came into force at 04:00 on 19 July 2021 (CW5/901 - INQ000234981; CW5/902 - INQ000234982; CW5/903 - INQ000234983; CW5/904 - INQ000234984; CW5/905 - INQ000234985; CW5/906 - INQ000234986; CW5/907 - INQ000234987; CW5/908 - INQ000234988; CW5/909 - INQ000234989). These regulations amended the ITOL Regulations to:

a. Introduce the 'eligible category 2 arrival' which was an exemption to the self-isolation and day 8 test requirements for individuals arriving from an amber list county who had not been in, departed from, or transited through either a red list country or mainland France (including Corsica) in the 10 days prior to arrival in England and who were fully vaccinated with an 'authorised vaccine';
b. Introduce a requirement for operators to carry out the necessary evidence checks on individuals seeking to benefit from the above relaxations;

c. Update the provisions around private test providers to ensure that private provider data gathering, and reporting met the requirements of the amber vaccine relaxation and exemption; and
d. Add and remove countries from the category 1 ('green-list') and category 3 ('red-list') and update the list of countries that direct flights are permitted to arrive from provided they arrived at one of two designated red list terminals.

445. Further to the key regulations mentioned above, amending regulations were regularly made which included adding to or removing from the list of countries and territories which were subject to additional measures. Regulations were also frequently made to introduce limited exemptions from the requirements of the International Travel Regulations or the ITOL Regulations for specified persons. For example, persons attending or facilitating a G7 event were excluded from the requirement to self-isolate and to undertake mandatory day 2 and day 8 tests.

Self-Isolation Regulations

446. The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 (the Self-Isolation Regulations) were made at 17:00 on 27 September 2020 and came into force on 28 September 2020 (CW5/910 - INQ000234515; CW5/911 - INQ000234516; CW5/912 - INQ000234517; CW5/913 - INQ000234518; CW5/914 - INQ000234519; CW5/915 - INQ000234520; CW5/916 - CW5/915 - INQ000234521). The Self-Isolation Regulations imposed various requirements including requiring people who were notified that they were legally required to self-isolate, and to provide information to contact tracers about where they would be staying for the period of their self-isolation.

447. The Self-Isolation Regulations provided a power to an 'authorised person' to enforce the restrictions in the regulations. An authorised person was defined as a constable, a police community support officer, a person designated by the Secretary of State, and an officer designated by a local authority. The Health Protection (Coronavirus, Restrictions) (Self-Isolation and Linked Households) (England) Regulations 2020 were made at 11:00 on 11 December 2020 and came into force on 14 December 2020 (CW5/387 - INQ000234646; CW5/388 - INQ000234644; CW5/389 - INQ000234645; CW5/390 - INQ000234641; CW5/391 - INQ000234642; CW5/392 - INQ000234643). These regulations amended the Self-Isolation Regulations to reduce the time period of self-isolation for a close contact from 14 to 10 days and made changes to when a person's period of self-isolation began.

Coronavirus Act 2020

448.Please refer to paragraphs 263 – 267 of my First Witness Statement for this Module about the development and purpose of the CVA as it remained in force in the time period covered by this witness statement. In accordance with the obligation in section 97 of the CVA, the Secretary of State prepared and published reports on the status of the CVA every two months, with the first two-month reporting period beginning on the day on which the CVA was passed. Section 98 of the CVA obliged the Government to seek the House of Commons' agreement every six months to the continued use of non-devolved CVA powers that were in force.

449.During the period with which this statement is concerned Parliament provided its agreement to the continued use of the non-devolved CVA powers that were in force in accordance with section 98 on 30 September 2020 and 25 March 2021.

450.The first of the reports published during the period with which this statement is concerned was the September 2020 two-monthly report (CW5/**338** - INQ000234529). The report contained the required 'Appropriateness Statement' from the Secretary of State and the table on pages 9-30 set out for Parliament the status of and ways in which the powers under the CVA had been used.

451.The November 2020 two-monthly report (CW5/918 - INQ000235011) also contained the required 'Appropriateness Statement' from the Secretary of State and a table setting out the status of and ways in which the powers under the CVA had been used but also contained a summary of the impact of the CVA by reference to its five aims of: (1) increasing the available health and social care workforce; (2) easing and reacting to the burden on frontline staff; (3) supporting people; (4) containing and slowing the virus; and (5) managing the deceased with respect and dignity. The report also set out the benefits of maintaining the CVA as well as providing an update to Parliament on mechanisms to change the status of provisions following the debate on 30 September 2020 that led to the successful vote on the continuation of CVA powers.

452.The January 2021 two-monthly report (CW5/919 - INQ000234721) followed the same format as the December 2020 report but also contained a section setting out the consideration that the Government had given to its duty under section 149 of the Equality Act 2010. That review noted that, *"…the use of the powers contained within the* [CVA] *continues to be proportionate, in line with the ever-changing situation*

COVID-19 presents." The report specifically addressed equality concerns raised in respect of sections 15 and 51 of the CVA.

453.The March 2021 one-year report on the CVA (CW5/920 - INQ000235012) (and the subsequent corrections), which doubled as the next two-monthly report and which followed the structure of the January 2021 report, set out that *"One year on from the Royal Assent of the* [CVA]*, through a continuous procedure of regular and careful reviews and parliamentary scrutiny,* [the Government is] *confident that the* [CVA] *has been fundamental to facilitating a fast and effective response to the pandemic."*

454.The March 2021 one-year report also set out that:

> *"In all phases of the pandemic, the* [CVA] *has enabled action in the five key areas outlined above* [see paragraph 451] *and the provisions have helped achieve a balance between the Government's social and economic priorities, while preserving the health and safety of the country and supporting public service delivery."*

455.A total of twelve sections of the CVA were outlined in the March 2021 one-year report as expiring as no longer necessary to respond to the pandemic.

456.Further two-monthly reports were published during the period with which this statement is concerned in May 2021 (CW5/921 - INQ000235013) and July 2021 (CW5/922 - INQ000235014), both of which followed the format of the January 2021 report.

SECTION 7: VULNERABLE GROUPS

457.As set out in my First Witness Statement for this Module at paragraph 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).

458. The RWCS Oversight Board commissioned the Battle Plan workstreams on their consideration of ethnicity and deprivation from July to September 2020. Specifically, the Oversight Board requested information from Battle Plan Workstream Senior Responsible Officers (SROs) on 7 July 2020, on how they would review their workstream objectives and planned activities to ensure they reflected considerations for people from ethnic minority communities and for deprived populations. This was to be based on evidence from the first wave, as they planned for the next wave of the pandemic, using different planning scenarios. Starting with ethnicity, SROs were asked to demonstrate the evidence they had considered, how they had engaged with stakeholders in gathering or testing evidence and that stakeholders had been involved in the design of information and educational materials, research or new data collections.

459. SROs were further asked to state their workstream ambition for reduction in the health gap between 'Black, Asian and Minority Ethnic' ('BAME') and 'non-BAME' communities, the timeframe to achieve this and to demonstrate how progress towards achieving this ambition would be monitored (CW5/923 - INQ000234421). The results of this exercise indicated that there was good general awareness amongst workstreams of the PHE reviews but understanding of how their findings applied to individual workstreams and the impact of specific policies on 'BAME' / 'non-BAME' /deprived populations varied. There was a much lower understanding of health inequalities experienced in deprived populations (CW5/924 - **INQ000234665)**.

460. On 8 September 2020, I commissioned a 'deep dive', interrogating risks associated with vulnerable groups. At the time, there was significant Parliamentary interest in PHE's reports and the government's response to them. The Department assisted in this wider response by supporting the Race Disparity Unit and the Minister for Equalities, during Parliamentary debates and appearances before Women and Equalities Select Committee.

461. By September 2020, OGDs had set up a number of programmes to support vulnerable groups, such as the MHCLG rough sleeping programme, the Department for

Environment, Food and Rural Affairs programme for food, NHS Volunteer Responders, public mental health guidance issued by PHE, (this guidance is now managed by the Office for Health Improvement and Disparities, OHID), and an £8m 'Wellbeing for Education Return' programme jointly led by DfE and the Department. Signposting for mental health support was also made available online by the Department.

462. The COVID-19 Taskforce took on a direct interest in disproportionately impacted groups and commissioned several initiatives from the Department and OGDs. This was in response to concern from Ministers at data showing significant spikes in transmission/hospitalisation rates in Pakistani and Bangladeshi communities as well as for disabled people. For example, the CO commissioned DLUHC to work with the whole Government to produce a paper on disproportionate impacts for the COVID-O Committee. As part of this, the Department considered what health interventions could be made available to protect disproportionately impacted groups and worked with DLUHC to develop recommendations on protecting those living in multi-generational households from contracting COVID-19.

463. On 18 December 2020, I held an assurance meeting with Department colleagues to review progress on actions arising from the Department's response to PHE reviews. This followed the previous meetings held on 11 and 30 June 2020. Actions from this meeting related to a range of issues, including consideration of geographical inequalities and vaccine deployment (CW5/925 - **INQ000234666** and CW5/**924** - INQ000234665). These actions formed the agenda for a subsequent meeting, held on 23 February 2021 (CW5/927 - **INQ000234664;** .

464. At the February 2021 meeting, it was noted that considerable work was underway with the whole of Government and in the Department which considered geographical inequality alongside health inequalities and Prevention Strategy work (CW5/928 - INQ000234781 and CW5/929 - INQ000234772). Initial work on vaccines and vaccine deployment had been completed, and the need to review the COVID-19 vaccine uptake data to understand what was being achieved and where further work was needed to improve uptake in different communities was emphasised.

465. As set out in paragraph 53 of this Witness Statement, a Red Team Challenge session on health inequalities and the impact of COVID-19 took place on 29 April 2021 chaired by Jonathan Marron, Director General for Personal Protective Equipment (PPE) and Public Health (28 April 2020 – 30 September 2021). This session focused on vaccines,

social distancing, and Test and Trace and how health inequalities were considered. Mitigations identified, for inclusion in the workstreams, were improved identification of vulnerable groups/areas, better use of data, closer work between national programmes and local public health leaders and a need to conduct pilots where interventions have been increased in certain areas. (CW5/57 - INQ000234883 and CW5/58 - INQ000234904)

466. The Star Chamber session held on 28 May 2021, which I chaired, considered the potential impact of a third wave of COVID-19 upon more deprived communities. The session concluded that over the long term, the focus of the levelling up agenda and the formation of the Office for Health Promotion (now OHID) and UKHSA would provide greater depth in expertise and linkages to regional public health leadership to help target health inequalities (CW5/930 - INQ000234909, CW5/50 - INQ000234961 and CW5/49 - INQ000234962). In addition, it concluded that the Minister for Equalities' Final (4th) Quarterly Report on progress to address COVID-19 health disparities would focus on the effectiveness and impact of relevant policies.

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.

Personal Data

Signed: _____

Dated: 25 August 2023