Witness Name: David Williams
Statement No.: 1
Exhibits: DW/1 – DW/32
Dated: 20 September 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DAVID WILLIAMS

I, David Williams, Permanent Secretary of the Ministry of Defence, Whitehall, London SW1A 2HB, will say as follows:

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Inquiry (the Inquiry) dated 5 June 2023 made under Rule 9 of The Inquiry Rules 2006 (the Request) asking for a witness statement for Module 2 of the Inquiry, which is considering core UK-decision-making and political governance.

2. In preparation of this statement I asked Chris Wormald, the Permanent Secretary at the Department of Health and Social Care to fact-check a late draft of the statement. When the statement was shared, it was emphasized to Chris Wormald that this was not an invitation for him to make or suggest any alterations as to personal views, opinion or recollections. This statement is to the best of my knowledge and belief accurate and complete at the time of signing.

3. I understand that the Inquiry's Request identifies the period 1 January 2020 to 24 February 2022 as the timeframe for Module 2. During this period I was Director General and Second Permanent Secretary at the Department of Health and Social Care (the Department). I have therefore focused on my time in those two posts, within the period identified by the Inquiry as relevant to Module 2.

4. I also understand that future Inquiry modules will consider other issues related to the events I describe below and I stand ready to assist the Inquiry with evidence required to

support any future modules.

BACKGROUND

5. I am currently the Permanent Secretary of the Ministry of Defence (MOD), a position I have held since 6 April 2021.

6. I am a career civil servant, first joining the MOD in 1990, where I have spent the majority of my career and held a number of senior roles including Director General Finance from 2012. I have also worked on secondment in the (then) Department for Communities and Local Government, the Local Government Association and the East Sussex Hospitals NHS Trust.

7. On 16 March 2015, I was appointed as a Director General Finance and Group Operations (Director General) at the Department. As Director General my responsibilities included strategy, system oversight and performance, finance, human resources, workplace and Department transformation, commercial, procurement and property, and communications and engagement.

8. In addition to my role as Director General, I was asked to take on the role of Second Permanent Secretary in the early stages of the COVID-19 pandemic in March 2020. My appointment as Second Permanent Secretary had effect from 5 March 2020 and my final day in post at the Department was 1 April 2021.

ROLE AS SECOND PERMANENT SECRETARY

9. I was initially appointed as Second Permanent Secretary to lead on all non-COVID-19 related work for the Department, so that the Permanent Secretary, Sir Chris Wormald, could lead the Department's COVID-19 response (DW/1 - INQ000273561). I retained the responsibilities I had previously held as Director General. Upon my appointment as Second Permanent Secretary I became an Additional Accounting Officer for the Department (DW/2 - INQ000273562).

10. Like many of my colleagues, for the majority of the COVID-19 pandemic I routinely worked seven days a week and would liaise with the Permanent Secretary daily. We sat across from each other when we were in the office, and coordinated our attendance at meetings with the aim that either the Permanent Secretary or I would be at every meeting between

the Secretary of State and Department officials. The Permanent Secretary and I would have regular catch-ups during the day.

11. The pace of response and relentless focus on COVID-19 was unusual for a government department. In normal circumstances, occasionally the degree of work for a department intensifies in response to an event, but the scale and intense focus required for the Department's response to the pandemic, lasting well over a year, was unlike any response I have experienced within my career. In a typical model for emergency response, a specific team handles an incident for a number of weeks, the incident response is then normalised as part of departmental activity, and then the incident ends. A multi-year pandemic as the primary focus of Departmental and indeed Government business was without precedent.

12. The pandemic developed very quickly and by the time my formal appointment as Second Permanent Secretary was made, COVID-19 related work dominated my time. Aside from the 2020 Spending Review and work on the 40 hospitals programme and other core manifesto commitments, there was relatively little 'business as usual' work during my tenure as Second Permanent Secretary because the majority of the Department rapidly pivoted to responding to COVID-19. The number of personnel in the Department grew rapidly during my term as Second Permanent Secretary in order to respond to COVID-19.

13. My role as Second Permanent Secretary had the following major elements:

    13.1. Firstly, I provided support to the Permanent Secretary, Sir Chris Wormald. Initially he would attend meetings related to COVID-19 and I led on the Department's 'business as usual' work, but the rapid escalation in the volume of COVID-19 related work meant that I took on responsibility for and oversight of a range of COVID-19 related activity. This was inevitable to a degree because the COVID-19 response became the main activity of the Department. The Permanent Secretary worked closely with the Chief Medical Officer and Clara Swinson, the Department's Director General for Global Health, as the core official-level leadership for the clinical, legislative and policy response to COVID-19. The Permanent Secretary also led, from an official level, the Department's coordination across the whole of Government, international work, and work across the four nations. I continued to lead on the Department's operations, finance and approvals and the early stages of what became NHS Test & Trace, see paragraphs 23 to 35 below.

    13.2. Secondly, I had a corporate collegiate role. I was a member of the Department's Executive Committee (ExCo), which among other responsibilities reviewed

iterations of the Department's Battle Plan. I was also a member of the Departmental Board and Audit and Risk Committee. I chaired the Remuneration Committee, People Board and Performance and Risk Committee. I would attend daily meetings of the Department's Director Generals.

13.3. Thirdly, I was an Accounting Officer (AO) for the Department. Accounting Officers are personally responsible and accountable to Parliament for the use of public money and stewardship of public assets. The Permanent Secretary remained the principal Accounting Officer for the Department. I was the Accounting Officer for COVID-19 specific procurement activity, including ventilators, testing and tracing. On procurement issues, particularly for PPE (Personal Protective Equipment), I personally approved the Department's entry into contracts with a value of over £100 million. Authority for all contracts of a value of £100 million or less was delegated to Chris Young and Jon Fundrey. Chris Young was the Department's sole Director of Finance prior to the pandemic. Jon Fundrey, Chief Operating Officer at the Medicines and Healthcare products Regulatory Agency (MHRA), was brought in as a co-Director of Finance to assist during the pandemic. As Chief Executive of NHS England, Simon Stevens was formally the AO for NHSE spending, including to the best of my recollection, vaccine roll out, but I led engagement with His Majesty's Treasury (HMT) to secure spending approval.

13.4. Fourthly, before the appointment of Baroness Dido Harding, I was responsible for preparatory work for what became NHS Test & Trace. I remained the Accounting Officer for NHS Test & Trace following Baroness Harding's appointment.

13.5. Finally, I remained responsible for the elements of my previous Director General role. This included the Department's finance function, as well as the operational requirements of the organisation, for example IT, operations, building services and human resources, all of which had adapt to the pandemic. This involved supporting staff to work remotely during lockdown, ensuring that our office space was compliant with covid regulations, recruitment and onboarding at pace of substantial additional staff resources.

14. From 1 January 2020 until 1 April 2021 I attended a range of meetings to support the Government and the Department's response to COVID-19. This included:

14.1. Occasional attendance at the '9:15am call', a daily meeting chaired by the Prime Minister in No.10. My role was mainly to observe, though I will have been invited to

contribute at times, particularly between April and May 2020 when I had overall responsibility for the Department's testing workstream as part of the Battle Plan, and when we were both continuing to grow testing capacity and designing the programme which became NHS Test & Trace, see paragraphs 23 to 35 below;

14.2. Bespoke meetings with the Prime Minister, primarily to provide briefing about the testing and tracing programme as Senior Responsible Officer (SRO);

14.3. The COVID Operations officials meeting, chaired by the Cabinet Secretary and formed of senior officials; and

14.4. I will have attended a wide range of other meetings in support of the Secretary of State and Prime Minister during this period in line with my role as Second Permanent Secretary as identified at paragraph 13 above.

15. I did not have a primary role in engagement with the devolved administrations and regional and local authorities. I recall that I had some ad hoc engagement with the devolved administrations and local authorities on the Department's testing workstream while I was SRO for that work. I understand that the Department had some interaction with Local Resilience Forums to establish local testing sites and co-ordinate distribution of PPE, but otherwise was not personally engaged with Local Resilience Forums.

16. I also provided support for early meetings of the four-nations Health Ministers, known as the UK Health Minister Forum, chaired by the Secretary of State. I recall providing support particularly on testing and PPE, though did not necessarily attend these meetings.

THE DEPARTMENT'S ROLE AS LEAD GOVERNMENT DEPARTMENT

17. 'Lead Government Department' is not a phrase that I recall being used within the Department but I understand is phrasing used within Government's approach to civil emergencies as led by the Civil Contingencies Secretariat. My understanding of the Department's role as the Lead Government Department was that within the cross-Governmental machinery, the Department of Health and Social Care was the only Department formally charged with health, public health, and social care responsibilities and therefore it was important that the Department's voice was properly heard in decisions affecting these areas. The Department's response was effective in the areas for in which it had formal responsibility, particularly in the legislative and regulatory response to the pandemic, as well as testing and tracing. The development of vaccines was a joint and highly effective collaboration between the Department of Health and Social Care and the

Department for Business, Energy and Industrial Strategy.

18. Over time, the centre of gravity of decision-making did shift to the Cabinet Office and centre of Government as the pandemic progressed. This was a natural consequence of the policy decisions which were being made. These decisions affected every Government Department, to differing extents. Government was required to weigh numerous competing factors in complex decision-making. Managing decision-making which requires these complex trade-offs, for example the issue of school closures during the pandemic, is one of the roles of the Cabinet Office for which its structures are designed.

COVID-19 RESPONSE

January – March 2020

19. I had limited engagement with COVID-19 in the period from January to mid-March 2020. I will have been present at discussions in which the issue was raised within the Department's executive and with Ministers. I took no direct part in preparation for COBR meetings at this stage. I was present at a meeting with the Prime Minister on 4 February 2020 scheduled to discuss Departmental Performance in which the Chief Medical Officer and Permanent Secretary flagged concerns about COVID-19 to the Prime Minister.

20. My primary role during January to March 2020 was to pick up slack to allow others to concentrate on initial stages of understanding the threat; initial preparations around capturing costs and early engagement with HMT and NHS England.

21. I continued to lead on finance-related issues for the duration of my time as Second Permanent Secretary, see paragraphs 52 to 54 on the Department's approach to finance during my time in post.

22. Clara Swinson led on development of the Battle Plan. She chaired the COVID-19 Oversight Board, which was a sub-group of the Department's ExCo. I was a member of both the Oversight Board and ExCo which approved the Battle Plans and therefore had a general oversight and approval role of iterations of the Battle Plan by virtue of my membership of these groups. I also provided assurance that the various strands of activity were adequately funded. I contributed more directly to the development of the elements of the Battle Plan relating to testing, which later included tracing, in line with my work described at paragraphs 23 to 35 below.

April 2020 – May 2020

23. My role developed as the scale of the pandemic and its impact on the Department increased. I took on responsibility for the 'testing' workstream of the Department's response.

24. Day to day this work was led ably at Director level. My role was to provide support and constructive challenge, offer advice, help unblock issues as needed - all at pace. The Department's initial versions of the Battle Plan, 1.1 and 1.2, dated 22 and 27 March 2020 respectively, record that Kathy Hall, Director of Technology and Data Strategy at NHSX, was the lead on testing (DW/3 - INQ000049756) and (DW/4 - INQ000273560).

25. On 2 April 2020 the Secretary of State announced a plan for 100,000 tests per day by the end of the month. This goal galvanised activity on testing and it quickly became clear that the testing programme would become a major national endeavour and require substantial resources and an appropriate governance structure.

26. The Department's testing strategy, 'Coronavirus (COVID-19) Scaling up our testing programmes' was published on gov.uk on 4 April 2020 (DW/5 - INQ000106325).

27. Version 1.3 of the Battle Plan, dated 14 April 2020 (DW/6 - INQ000273566) records that I had taken on responsibility for the testing workstream as SRO. This version of the Battle Plan records the goals of the testing workstream as:

> *At least 100,000 tests per day by the end of April across the UK (with the aim of reaching 250,000 per day), from:*
>
> *i. 25,000 NHS swabs from Pillar 1 of the Strategy; and*
>
> *ii. 75,000-100,000 commercial swab tests from Pillar 2.*

28. Version 2.0 of the Battle Plan sent to the Department's Secretary of State on 11 May 2020 records that the 'testing' workstream had become the 'test & trace across the population' workstream (DW/7 - INQ000106902). The workstream had three pillars; scaling up testing programmes, effective contact tracing, and digital tools to support test and trace. I was the SRO for the first two pillars relating to testing and tracing, and Matthew Gould. CEO of NHSX, was the SRO for the digital tools pillar.

29. It quickly became clear that the testing programme would require its own full-time and authoritative senior lead with relevant experience. I discussed this with the Permanent Secretary on 11 April 2020 (DW/8 - INQ000273565), and recall suggesting the need for a Tsar to lead the programme to Dominic Cummings in the margins of a meeting at No.

10. I cannot recall with certainty, but this was most likely at a meeting between the Department's Secretary of State and Prime Minister on 14 April 2020 to discuss the progress of the COVID-19 National Testing Programme (DW/9 - INQ000088702).

30. The testing programme was an enormous operation and needed to be brought onto a sustainable footing after the initial sprint to achieve the end of April testing target, as I noted in an email on 17 April 2020 (DW/10 - INQ000273568).

31. In the period prior to the appointment of Baroness Harding, as SRO and AO I was responsible for delivery of the testing programme and the implementation of ministerial decisions. For example, I approved advice dated 21 April 2020 which outlined the key commercial agreements to expand lab capacity as part of the Department's testing strategy (DW/11 - INQ000273570) and I attended a meeting at No. 10 on 5 May 2023, to discuss the overall testing strategy, see (DW/12 - INQ000273577, DW/13 - INQ000273576, and DW/14 - INQ000273575).

32. Part of the challenge during this period was considering how to integrate contract tracing capacity with the testing programme to allow a means for Non-Pharmaceutical Interventions (NPIs) to be lifted, particularly by integrating local data. This work ultimately spawned NHS Test & Trace as a distinct organisation with the Department as well as the Joint Biosecurity Centre (JBC).

33. I was notified on 5 May 2020 that Baroness Harding had been appointed by No. 10 as the lead of the testing programme (DW/15 - INQ000273578). I remained the Accounting Officer for the programme as before, with Baroness Harding as a 'Tsar' brought in from outside the civil service to provide leadership.

34. By 23 May 2020 The Department was planning for phase two of the testing strategy (DW/16 - INQ000273580).

35. NHS Test & Trace was launched on 29 May 2020.

June 2020 – April 2021

36. In the period after Baroness Harding's appointment I continued to have AO responsibility for the testing programme, including approval of procurement decisions, but Baroness Harding and her team were responsible for the operation, direction and delivery of the programme.

37. My role as Second Permanent Secretary therefore continued to consist of supporting the

Permanent Secretary and the Department's response to the pandemic and operations as described in paragraphs 13 and 14 above.

38. I recall that at the end of the first wave there were discussions about how lockdown would be exited. Various approaches were discussed, including whether a certification program could be established, where people could offer proof of immunity, so that those who were believed to be immune would be let out as opposed to shutting in those who were infectious. The Department purchased a number of antibody tests in the hope that these would allow individuals to prove their immunity. The tests were ineffective. However, this work and experience later informed the development of the testing programme, where individuals who tested negative on lateral flow tests were allowed to leave isolation.

39. I have been asked to comment on my role with 'Project Moonshot' and understanding of its purpose. In July and August 2020 there were discussions between No. 10, Cabinet Office, NHS Test & Trace and The Department about population testing as means to avoid future lockdowns; I was copied into slides prepared for No.10 about potential population testing and attended a meeting about 'Project Moonshot' in August 2020. I was involved to the extent that I was the relevant AO, and therefore provided policy input and scrutiny of contractual commitments of over £100 million as discussed above. I understood that the purpose of 'Project Moonshot' was to consider whether mass population testing would be a viable mechanism to avoid future lockdowns. As I recall, the work was prompted in part by approaches being trialled elsewhere in Europe, but the thinking - and plan - quickly moved to more practical approaches to community testing and the widespread use of lateral flow devices to test for covid and to manage individual release from periods of self-isolation.

40. As outlined above at paragraphs 23 to 35, I was involved in the development of the testing programme, as SRO for a short time and then as the Accounting Officer.

41. I was involved at arms-length in the development of vaccines, in the Department's finance team supported work of the Vaccines Task Force to arrange contracts for vaccine development and purchases. I had greater involvement in negotiating with HMT to secure financing for the roll-out of the vaccine programme.

42. I had limited involvement in the development of therapeutics; I acted in a 'trouble-shooting' capacity where there were procurement issues.

NON-PHARMACEUTICAL INTERVENTIONS (NPIs)

43. The national lockdowns were implemented to help manage the spread of the disease, minimize harm to the population and help prevent NHS capacity from being over-matched. In the first wave, there was uncertainty about peak and duration of the disease; in the second wave, concern over impact during winters when the NHS is traditionally stretched. From a health and care perspective, the decision to lock down was driven by a combination of epidemiological data on spread of disease, new variants and by assessments of NHS capacity. Local lockdowns were subsequently implemented as a more tailored, focused measure rather than the blunt instrument of full national lockdown.

44. I have been asked to comment on the extent to which I played any role in decisions concerning the imposition of, easing of, or exceptions to a range of NPIs, including: the three national lockdowns (March 2020 – July 2020; November 2020 – December 2020; January 2021 – April 2021); Local and regional restrictions (including the tiered system); circuit breakers, in particular the proposed circuit breaker in September 2020; working from home; reduction of person to person contact/social distancing; self-isolation requirements; the closure of schools; the use of face-coverings; and the use of border controls.

45. I would have engaged with these issues in my capacity as Second Permanent Secretary, but did not take decisions on NPIs nor did I have lead responsibility for advising Ministers of these issues during my term as Second Permanent Secretary, with the exception of my time as SRO for the testing programme in April – May 2020, where I and other officials were considering the scale of testing and contact tracing that would be required to ease lockdown. This included consideration of how the duration of self-isolation, numbers of contacts to be "caught", testing on release and so forth factored in to planning around a test and trace system, especially around capacity and scale.

46. To the best of my recollection I had no direct engagement in conversations on the idea of "herd immunity", nor do I recognize that such a policy was formulated and implemented. I do not remember widespread use of 'herd immunity' as a term in the Department or in government. I was involved in some discussions of alternative international approaches as the Government considered approaches to individual, local and national lockdowns in the early phases of establishing the NHS Test & Trace regime, for example, our understanding of the experience of Sweden, but this was not pulled through into the approach the UK adopted. But in a pre-vaccine world, understanding and monitoring exposure to the disease, including early work in the first lockdown on the feasibility of "certification" through antibody testing, was part of understanding immunity for the future.

47. The potential wider health, social and economic impacts of lockdown were a central consideration when I considered and advised on issues relating to NPIs and on a broad range of procurement and spending decisions, particularly those relating to testing and tracing and vaccine development. The peak of the pandemic had a devastating impact in terms of loss of life, along with an impact on the wider ability of the NHS to offer care, on social care and economically in terms of lockdown, as well as wider issues such as the impact on schooling. This meant that spending large sums of money which would have been unthinkable in normal circumstances to explore options for shortening lockdown or duration of the disease, even if risky and not certain of success, was fundamentally a sound choice to save lives and reduce overall economic cost and therefore represented value for money.

48. Though I did not lead on this aspect of the COVID-19 response personally, my recollection is that that the impact of NPIs was considered in relation to at-risk groups and those who were clinically vulnerable, particularly by the Chief Medical Officer and in the context of the scientific advice that the Department received. The Department was able to use data through GP records to determine groups who would be advised to shield on the basis of clinical vulnerability. Where this data was not a complete match for all those potentially clinically vulnerable, the Department was able to adjust advice as necessary relatively quickly. Specific policies and support packages were in place for clinically vulnerable and "at risk groups" during periods of national lockdown.

49. Similarly, 'bubbles' were introduced to address the social impact of isolation.

50. Kevin Fenton's June 2020 report, 'Beyond the data: Understanding the impact of COVID-19 on BAME groups' (the Fenton report) was seminal and informed thinking within the Department on the impact of NPIs on BAME communities, which was the subject of focused follow up in the Department of Health and Social Care.

51. Additionally, by the time the Fenton report was released, there were weekly meetings of the Joint Biosecurity Centre which allowed consideration of data on a District Council level, which allowed much finer analysis of where the disease was spreading and consideration of areas' demographics. This data allowed for more targeted intervention and support, including financial support for councils in light of the economic consequences of local lockdowns.

RELATIONSHIP BETWEEN THE DEPARTMENT AND HMT

52. The Department's ability to respond to the pandemic in the way that we did was fundamentally dependent on the strength of support and flexibility shown by HMT during this period, including through access to substantial additional funds in excess of the core health and social care budget; increases in Departmental delegations and relaxation of a range of business as usual spending controls; and equivalent flexibility and pace to Departmental working in those cases and issues that needed specific Treasury approval. This was very much a joint endeavour and the good, established prior working relationships between my Team and HMT meant that work between the two departments was highly effective and swift, decisive action was possible.

53. The Department established a COVID-19 finance team, led by two experienced civil servants, Chris Young and Jon Fundrey, which liaised regularly with HMT, see the organogram at (DW/17 - INQ000273563). The beginning of the pandemic posed a set of highly challenging circumstances for the Department's finance and commercial teams and for HMT. There was a need to procure at volume and pace; rely on new suppliers, many of whom were foreign; and compete in what was essentially an international 'seller's market'. Decisions were made in the context of a predicted Reasonable Worst Case Scenario, but there was no real confidence in the anticipated duration of the first wave, nor any certainty about what would happen next, which meant that Government's appetite for risk was much higher than it would be in normal circumstances and Government was willing to spend money to plan against a Reasonable Worst Case Scenario, which by definition will include spending which ultimately proves to be surplus or excess capacity.

54. I summarised the principles behind the Department and NHS England (NHSE)'s early approach to COVID-19 related spending in an email on 5 March 2020 in response to a request for funding for a data and AI hub to help with COVID-19 related planning (DW/18 - INQ000273557):

> *"• Work on the principle that budget availability should <u>not</u> be a barrier to progressing necessary bits of our response*
>
> *• Seek to manage costs in the first instance through reprioritization and reallocation of resource to covid response work*
>
> *• Capture the costs – but only the genuinely net additional ones – of the coronavirus response to support any subsequent engagement with HMT on reserve claims."*

55. Colleagues from the Cabinet Office's central procurement team were seconded into the

Department, which also meant that teams needed to be integrated. Procurement teams from the Ministry of Defence also supported this effort.

56. The Department and HMT officials had good working relationships and worked together closely prior to the pandemic. The response to COVID-19 meant that officials continued to work together closely as before, but at an unprecedented speed and degree of intensity. Established patterns of working were adapted to reflect unprecedented circumstances, but controls were maintained. Rolling budget envelopes were agreed for different strands of work, and the approvals process was streamlined to reflect the urgency and pace of the work (DW/19 - INQ000273583).

57. There are established mechanisms for Departments to request additional funding from HMT beyond what they have been delegated authority to spend in response to exceptional events. The Department engaged early with HMT to establish additional funding streams for the Department in response to COVID-19 and requested additional funding for various COVID-19 related workstreams from HMT throughout my time as Second Permanent Secretary.

58. For example, on 25 March 2020 the Chief Secretary to the Treasury approved:

    - *"A CDEL ['Capital Departmental Expenditure Limit'] envelope of £330m (excl. VAT) for ventilator and all linked purchasing including monitors (this includes the £130m you already approved for monitors);*

    - *A £100m RDEL ['Resource Departmental Expenditure Limit'] envelope for PPE purchases (excl. VAT);*

    - *Expanded scope and size of the home testing kit delegated fund to cover all testing kit workstreams and increase it to £300m RDEL in total (excl. VAT);*

    - *All envelopes allow DHSC to cover standard purchases as well as payments in advance of need where necessary (deposits and prepayments)."* (DW/20 - INQ000273559).

59. These funding envelopes were delegated on the condition that the Department must:

    - *"Ensure any foreign companies are considered reputable by FCO and the local British Embassy, and assurances provided to DHSC in writing;*

    - *Ensure all equipment has the appropriate medical certification and commercial*

colleagues have sought and taken all reasonable action to review time-stamped pictures of the equipment;

- *Confirm that all stock will be medically inspected as fit for purpose before distribution to NHS Trusts and/or use;*

- *Ensure commercial teams have reviewed purchase contracts and confirmed they see no terms and conditions that represent unacceptable risk to Government;*

- *Make all reasonable attempt to ensure prices are <25% above the average unit price paid to date;*

- *Ensure DHSC AO has signed off each payment given potential issues with propriety, regularity, vfm [value for money] and feasibility;*

- *Share details with HMT of all individual procurements; including supplier, product type, volume of goods purchased, unit cost, certification details and written assurances from Embassy/FCO;*

- *Provide HMT with a weekly tracker on purchases made and potential upcoming purchases, and how progress tracks against demand in the system; and*

- *Keep any deposit payments and prepayments to a minimum."* (DW/20 - INQ000273559).

60. As discussed at paragraph 13.3 above, I delegated my authority as Accounting Officer to Chris Young and Jon Fundrey so that they could approve the Department's entry into contracts with a value of £100 million or less. It is not uncommon for government departments to delegate authority in this manner, but this was unusual for the Department, primarily because prior to the COVID-19 pandemic the Department did not have particularly high levels of delegated authority from HMT to spend public money. Delegating my AO authority to Chris Young and Jon Fundrey allowed the Department to meet the volume of spending required to respond to the pandemic, enabled by the funding approved by HMT.

61. The Department received significant funding to respond to COVID-19. This funding is summarised in the Department's Annual Report and Accounts for 2020-2021.

62. For example, in financial year 2020-2021 the Department received £58.9 billion additional Resource Departmental Expenditure Limit ('RDEL') funding, including:

62.1. £18 billion for the NHS to support the frontline response to the pandemic;

62.2. £20.4 billion for the Test and Trace programme;

62.3. £14.7 billion for the procurement and supply of personal protective equipment;

62.4. £4 billion for the deployment of the covid- 19 vaccine and other COVID-19 treatments;

62.5. £1.3 billion for the infection control fund and other grants and £0.1 billion for Ventilators and the Critical Care National Stockpile.

63. In financial year 2020-2021 the Department also received £4 billion additional Capital Departmental Expenditure Limit ('CDEL') funding, including £0.6 billion for the NHS, £2.7 billion for the Test and Trace programme and £0.4 billion for Ventilators and the Critical Care National Stockpile.

64. Exceptional funding is and was formally subject to approval by the Chief Secretary to the Treasury, often with associated conditions. My colleagues at HMT will be better placed to comment on the extent to which the Chancellor was involved in decision-making. From memory, the principal example I recall of direct engagement from the Chancellor related to support payments to local authorities for local lockdown measures.

65. The Cabinet Office also plays a role in government procurement, and has a control function in relation to the contractual commitments, including use of external consultancy which it exercised during my terms as Second Permanent Secretary. In March 2020 I received a copy of guidance from the Cabinet Office on public procurement in the context of COVID-19, 'Procurement Policy Note – Responding to COVID-19' (DW/21 - INQ000273558). This Note confirmed that there was scope in within the existing procurement regulatory framework for authorities to procure with extreme urgency in exceptional circumstances, including in response to COVID-19.

66. There were cases where the Treasury relationship did not deliver all that the Department was asking for. To put this in a non-pandemic context, the normal relationship between HM Treasury and Departments on spending issues is one of scrutiny, challenge, prioritisation, but rarely if ever full agreement of 100% of the ask. That is not the Treasury role nor in my experience is it the expectation of any major spending department in their approach to spending negotiations. The remarkable thing during COVID-19 is how supportive HM Treasury was to our funding requests. I emphasise that these incidences when they said "No" were the exceptions, due to our extremely close collaboration

throughout the pandemic. The Department faced three different types of challenges when engaging with HMT to secure funding for COVID-19 related expenditure during my time as Second Permanent Secretary:

66.1 Occasions where the Department's requests for funding were not agreed in full and therefore the Department did not act, or did not act in the way previously planned;

66.2 Occasions where the Department acted before requests for funding were agreed, but those requests were then agreed retrospectively. This occurred in relation to delivery of the vaccine roll-out, where the roll-out commenced shortly before the business case was formally approved;

66.3 Occasions where HMT did not agree the Department's requests for funding, the Department acted and funding was not retrospectively agreed and therefore the spending was formally classed as irregular. A very small number of cases fall into this category; see (DW/22 - INQ000273584 and DW/23 - INQ000273586).

67. Examples of the first category of challenge I can recall are:

67.1 A request for additional funding for NHS winter resilience bed capacity made in spring 2020;

67.2 A request for funding for testing megalabs in late 2020/early 2021; and

67.3 A request for the final stages of economic support to Local Authorities in local lockdown.

68. It is difficult to estimate what impact the refusal of funding for these three initiatives had on the effectiveness of the Department's response to COVID-19. Additional winter resilience funding was provided to improve A&E departments and continue access to independent sector capacity. Had additional funding for broader winter resilience been provided there may have been extra bed capacity in the NHS in winter 2020, but given that NHS capacity was not exceeded in this period, in part due to the second lockdown, it is difficult to say what effect extra bed capacity would have had. Part of the rationale for refusing the ask was doubts over the feasibility of building up useful additional capacity in the time available so the issue may well have been moot anyway. One factor that was considered when the decision to implement a second lockdown was taken was NHS capacity, therefore technically speaking a slight increase in capacity may have had an effect on the decision to lock-down, though given the rate of spread of the virus prior to the second lockdown the impact of any increased capacity may have been marginal.

RELATIONSHIP BETWEEN THE DEPARTMENT AND PHE

69. I have been asked to comment on my understanding of the relationship between the Department and Public Health England (PHE). I did not attend meetings between PHE, the Chief Medical Officer and Government Chief Scientific Adviser.

70. In my view, PHE are outstanding public health experts but were not scaled for activity on the level demanded by pandemic. PHE provided initial tracing support but were quickly swamped by the scale of tracing required. There was a clear boundary with the Department, but the Department had to step in as delivery challenges became apparent. PHE's relationship with NHS England was less consistent, for example in early testing ramp up to an initial 10,000 tests, where each organisation was essentially pursuing its own route to expansion of capacity rather than acting in a co-ordinated way.

71. The medical and scientific expertise at the core of PHE was first class, and informed the development of NHS Test & Trace.

72. My personal observation is that I expected PHE to be more proactively joined up with Local Authority public health counterparts. There were early concerns from Local Authority Directors of Public Health about engagement, and what would be done at a national versus a local level. These were issues I expected PHE to manage. For example, in April 2020, I was involved in engagement with the President of the Directors of Public Health and with a broader group of these Directors, facilitated by Professor Chris Whitty, as the Department sought to design the testing and contact tracing programme which became NHS Test & Trace (DW/24 - INQ000273574). This local dimension became central to the direction and operation of NHS Test & Trace, both with secondment by Dido Harding of a Local Authority Chief Executive on to her executive team and through the local focus of the work of the Joint Biosecurity Centre.

MEDICAL & SCIENTIFIC EXPERTISE, DATA AND MODELLING

73. I had no direct involvement in production or dissemination of advice involving medical and scientific expertise or data and modelling in relation to COVID-19.

74. Medical and scientific expertise did inform work which I was responsible for at a SRO level. For example, modelling the peak of ventilator use in the first wave was used to inform decisions about purchasing ventilators. Models of NHS capacity through winter and then Local Authority pandemic data through JBC meetings informed decisions about

NPIs.

75. I was a recipient and user of the data in the Coronavirus Daily Dashboard but did not contribute to it directly. I supervised the testing team in the Department as SRO prior to the establishment of NHS Test & Trace, including the period of reporting to Health Ministers and beyond of progress in meeting the 100,000 testing target as discussed above at paragraphs 25 and 27. For example, on 27 April 2020 I approved advice to the Department Secretary of State on methodologies for reporting testing data (DW/25 - INQ000273571). These reports will have been shared with the Prime Minister and others.

76. I had limited direct personal involvement with expert scientific and analysis advisory groups. However, I received regular briefings and cleared ministerial briefings written by officials informed by the work of these groups. The Chief Medical Officer and the Deputy Chief Medical Officer were also an integral part of the work of the Department and had a central role feeding back information from SAGE and other groups into policy discussions and advice to Ministers at the Department.

77. I recall working more directly with SPI-M in the early stages of what became NHS Test & Trace. For example, SPI-M provided advice on track and trace strategies which informed the development of the testing response, see (DW/26 - INQ000273569). The major data limitation when designing the testing programme was that we had no population level incidence data on levels of COVID-19, as this had stopped as the disease took off but the prevalence studies element was important part of restarting and growing test capacity.

78. One challenge during the pandemic was that medical and scientific advice could change quickly as experts learned more about the disease, and we were operating in an environment of considerable uncertainty. This had an impact upon decision-making and expenditure; a decision to spend significant sums might be rendered otiose quickly as the expert advice changed. Similarly, planning for a reasonable worst case scenario meant that sometimes more capacity was commissioned than was used. For example, it was difficult to predict the capacity which would be required for call centres for contact tracing. We commissioned capacity based on SPI-M's analysis of a reasonable worst case scenario, which was greater than was ultimately needed.

79. My team authorised funding for wider research and development work, which was also a central feature of the Department's response to the pandemic. For example, the Ventilator

challenge for UK made equipment, the Make elements of the PPE programme under Lord Deighton and substantial investment in scientific research and applied research and development enabled us to develop lateral flow tests and related testing techniques.

80. I did not have a significant role working with the Joint Committee on Vaccination and Immunisation (the JCVI). The JCVI provided advice on vaccination priorities, which were directly relevant to the sequencing of vaccine rollout in late 2020 and beyond. The advice of the JCVI was an input into that programme, led by NHS England. I was present and contributed to discussions that agreed the vaccine roll-out plan. In particular I remember that there was a discussion over the first group to be immunised, as it would be easier logistically to deliver vaccines to NHS and care staff, but the JCVI advice was that elderly and vulnerable populations were the clinical priority. As delivered the roll out followed the JCVI prioritisation.

COMMUNICATIONS AND MESSAGING TO THE PUBLIC

81. I have been asked to describe the role I played in the development, including financing, of the Department's communications. As discussed at paragraph 7 above, as part of my role as a Director and then Second Permanent Secretary I had overall responsibility for the Department's communications team, led by Wendy Fielder, the Director of Communications.

82. During the pandemic I did agree additional funding for Departmental communications campaigns (DW/27 - INQ000273582). I understand that a business case for the National Resilience Communication Hub's central COVID-19 communication activity was approved by the Chancellor of the Duchy of Lancaster in February 2021, and a single budget bid covered all Government COVID-19 communication activity, including £44 million from the NHS Test & Trace budget (DW/28 - INQ000273585).

83. As with other programmes for which I was AO during my time as Second Permanent Secretary, the chief principle guiding my decision-making was to enable the Department's response to the pandemic.

84. More practically, I had a pastoral role in supporting the team, and worked to coordinate between the Department and NHS Test & Trace communications teams. I also provided an informal link to the Behavioural Insights Team.

85. On 29 April 2020 I agreed to set up a one-year call off contract with the Behavioural Insights Team, see (DW/29 - INQ000273572 and DW/30 - INQ000273573). This contract allowed the Department to make multiple small commissions of the Behavioural Insights Team, without the need for repeat tendering for different projects. In a world where the effectiveness of NPIs in essence depended on compliance and the public's willingness to change behaviour and accept substantial constraints on personal freedoms, this sort of insight - linked to communications campaigns - was valuable. My sense is that there was substantial cut through in the simplicity of messages such as "Hands. Face. Space". Initial messaging around the need to stay home to "protect the NHS" was perhaps too effective in that it risked deterring some people with health needs from accessing care they needed.

LEGISLATION & REGULATIONS

86. I had no direct leadership responsibilities for advice or briefings on the public health and coronavirus legislation and regulations that were proposed and enacted, including the Coronavirus Act 2020. I will have been aware and engaged with the development of the Coronavirus Act 2020 by virtue of my presence in Ministerial meetings, the Director Generals daily catchup, ExCo and other meetings, but Chris Wormald and Clara Swinson led on this area. I did suggest that provision should be made to address NHS pension issues which may have prevented medical staff from returning to the NHS (DW/31 - INQ000273556). I also had responsibility through the "Group Operations" element of my role to ensure that the Department was itself then compliant with regulations once made, for example around social distancing in the workplace.

87. I have been asked to comment on why the Department took over responsibility for preparing submissions and advice on legislation and regulations following the initial involvement of the Department of Levelling Up, Housing and Communities. In my view, the Department was a natural home for much of the legislation regulation which in essence were matters of public health; so this squarely within the Department's remit and ambit.

88. As above, my personal engagement in the development of legislation and regulations was peripheral. Submissions or advice on legislation and regulations could either be papers for specific cross-Government approval and decision or Departmental submissions to the Department's Ministers for the technical and legal sign off of the legislation and regulations themselves. Cross-Governmental policy decisions will have been supported by the former and reflected in the latter.

89. Generally I think the legislation and regulations worked well and levels of compliance seemed pretty high. I recall seeing communications polling data on public understanding of the rules, which was generally positive, but I am less sure if we routinely saw data on compliance.

90. Simple to understand messages were important as the basis for the communications campaign, so encouraging compliance became more difficult as complexity increased or where rules were changing. For example, the local lockdown approach brought more change in shorter timescales and different approaches in neighbouring geographies.

KEY CHALLENGES AND LESSONS LEARNED

91. I have been asked to identify any key areas which I consider worked well, and any key areas in which I consider there were issues, obstacles or missed opportunities, focusing on the adequacy of information and advice sought and received; information sharing and communication; coordination with any relevant teams, bodies or departments; and strategy and planning.

Data and Decision-making

92. Dashboards were ultimately a really useful tool for communication and information sharing and coordination as they were timely and covered a wealth of data. They ensured that science and data was at the heart of the response in a way that not guaranteed at the outset. There were some challenges in sharing data across the NHS/Government boundary. The social care landscape was necessarily more fractured, so it was much harder to establish the true picture of what was happening on the ground quickly.

93. On strategy and planning, as discussed at paragraph 12 above, the volume and intensity of day to day activity to manage the disease meant during the initial phase of the pandemic and first lockdown it was very difficult to break out of a cycle of reactive response into proactive management.

94. The Department's Battle Plans were an attempt to manage the response more proactively by capturing the breadth of response and allowing us to see how focus shifted from one area to the next over time. During the first wave, getting ahead of the disease was very difficult because we were still learning about the disease, its symptoms and how it was transmitted. Going into the Autumn of 2020 we had the JBC and prevalence studies to track the spread of new variants, and were establishing the population-level lateral flow

testing system, and our ability to respond proactively rather than just reactively improved. By December 2020 vaccines were on stream and we were able to take an even more proactive approach to managing the pandemic. This more proactive approach to combatting the virus was not possible until we had a better understanding of the virus and more tools at our disposal.

95. Red-teaming was carried out in the Department over the course of the pandemic. This took a variety of guises including clinical and scientific review led by Chris Whitty and use of our Board and Non-Executive Directors in a challenge function. Hugh Harris, Director of Ministers, Accountability and Strategy, led a team which worked with an external consulting firm to consider scenario planning for the health and social care system in winter 2020/21 (DW/32 - INQ000273581). This planning included consideration of 'black swan' events. This process was helpful and should be used in future emergency responses.

96. The goal for 100,000 tests a day by the end of April 2020 was helpful as a galvanizing totem and shifted the Department's mindset about what the scale of its goal and response needed to be. It was certainly important to rapidly accelerate the growth of testing capacity. I do not think that we would have reached these levels anywhere near as quickly without the target, partly because of the way it injected pace but as much because it prompted people to think differently about the requirement - this was a material jump in scale rather than incremental change. However, the drive to meet the 100,000 tests goal meant that the system built to achieve the goal was not as sustainable as it could have been, and work was needed in later months to put the system on a sounder footing, rather than designing a more sustainable system from the start. Nonetheless, on balance my view is that the 100,000 goal was net beneficial because of the increase in testing capacity it facilitated.

Capacity and Resilience

97. I was asked a question about planning for spare NHS capacity at a meeting of the Public Accounts Committee on 18 January 2021. I speculated that NHS capacity, in terms of both critical care and general acute capacity would be looked at as part of wider lessons from the response to the pandemic. I indicated then that *"there are clearly some questions that we will want to examine to judge what the right peacetime capacity is and how we surge when we need to."* I remain of that view.

98. COVID-19 highlighted the importance of resilience in our public services in a period

where a focus on efficiency and productivity over a sustained number of years meant little flex at the margin. There is not a straightforward way in which resilience, surge capacity and/or "insurance for the future" can be factored in to the way that public sector views value for money or does its resource allocation. This plays both into provision of public services themselves as well as addressing specific challenges like UK manufacturing capacity and the ability to surge when required.

99. The COVID-19 response involved a huge degree of uncertainty. We did not know the characteristics of the disease, including whether asymptomatic transmission was possible, or how long it would last. Building for a sustainable response and building for a rapid response are different. During our response it was challenging to both response to immediate challenges while carving out headspace and decision bandwidth for the month ahead, next wave, and next potential variant. There were too many people doing both the 'here and now' and the 'what next?'.

Civil Service Organisation

100. The scale of the pandemic response meant there was a challenge in transitioning from one Department's emergency response, with a small group of incident managers, to whole of Government main effort.

101. Rapid surging of the Department workforce required teams to be formed from other Government departments, the armed forces, individual recruitment, external organisations and consultancy support. This was necessary to meet the challenges of COVID-19. But this brought challenges itself; we had no established mechanisms for such rapid and extensive team growth in an emergency or protocols for how new units docked in to existing governance. Ideally this would be planned and practised. It was sensible that decision-making structures evolved over time to reflect the changing nature and duration of pandemic. Looking across Government, for the very start of the pandemic, we had established mechanisms through the Civil Contingencies Secretariat (CCS) and Cabinet Office Briefing Rooms (COBR) meetings to manage discrete, time-bound incidents; later the central COVID-19 Taskforce and the system of COVID(S) and COVID(O) meetings in my view worked well. However, surging from the initial CCS and COBR response to that final response structure, in the period from around early April 2020 through to the autumn, was difficult: the model at the end was quite different to the model at the beginning and I doubt that it was optimal to go through quite so many evolutions.

102. NHS Test & Trace was prime example of establishing a fundamentally new, population level, public service on the fly. Ultimately tracing, lateral flow testing and local lockdowns all major contributors alongside vaccines to getting disease under control and opening country back up again in a sustainable way. There was no 'playbook' for how to set up a new public service in an emergency at the time. One of the lessons must be to capture how to do this better next time.

103. By 'playbook', I mean a practical framework that offers Government departments guidance about how to establish public services or perform administrative functions at pace in a sustained crisis. For example, very practical matters about how to set up appropriate decision-making committees and governance, and how to manage staffing when almost all of Central Government is involved in responding to an incident over several months. The Department's later iterations of the Battle Plans provide a template for how a Department could respond to a similar event, but is important that memories are captured before they fade, to draw practical lessons to inform future responses to other incidents.

104. In the Department, we had four different Tsar(ina)s; for PPE, vaccines, NHS Test & Trace and social care. Each model was very different, and the Government need to capture or design a 'playbook' here too. There also need to be clarity about the relationship between No.10 appointed Tsars, Departmental Ministers and governance and funding.

105. Working relationships were most effective where teams had established relationships prior to the challenges of the pandemic. For example, my finance team and HMT had worked together closely for years prior to the pandemic on complex challenges relating to health and social care funding, and although the pandemic required an acceleration in terms of the volume and pace of work, the strength of established relationships meant that the Department and HMT teams worked together highly effectively.

106. There was greater challenge where teams were working together from different Departments and agencies under enormous stress without strong prior relationships. For example, I had limited interaction with my counterparts in the devolved administrations prior to the pandemic. With hindsight had those relationships been more developed through routine interaction during normal circumstances they would have been stronger and therefore may have facilitated closer collaboration during the pandemic.

Personal Reflections

107. In concluding this statement, I want to acknowledge the extent and impact of the disease of the UK public - on communities, families and individuals - both in direct health impacts through devastating loss of life, through the impact of long COVID-19 and through the knock-on effect of the displacement of other treatments and through the enduring economic and social impacts of prolonged but necessary lockdowns. I offer my heartfelt condolences to the families who lost loved ones during this pandemic. I also want to call out the immense professionalism of staff in the NHS and in the social care sector for the dedication and compassion they showed in continuing to provide care in the most trying of circumstances.

108. When talking about the Government or Departmental responses, it is very easy to default to viewing these through an impersonal, institutional lens. But the Department is not an entity or a set of buildings. It is in the end a group of people; people who during this period were dealing with personal exposure to COVID-19 , the impact of the disease on family and friends, the challenges of adjusting to lockdown, remote working, managing childcare and other caring responsibilities while working to help bring the pandemic under control, to help ensure that the public had access to the health and care services they needed and to support staff in the system in dealing with the demands placed on them. It was not difficult in the Department during this period to know why you got out of bed in the morning. We did not get everything right, but we acted from strong motivation on the best information we had available at the time and I for one am immensely proud of the people I worked with and led during this time.

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.

Name: DAVID WILLIAMS

Date: 20/09/2023

Signature: **Personal Data**